

**Commission to Expand Access to Oral Health Care by Studying Alternative Pathways
for Obtaining a License to Practice Dentistry**

Wednesday, October 22

10 AM – 1 PM

Room 209 (Health & Human Services Committee Room)

Cross State Office Building, Augusta, ME

Agenda: Meeting #2

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| 10:00 | Welcome |
| 10:05 | Pathways to licensure in dentistry in Massachusetts
<i>Barbara Young, Executive Director – Massachusetts Board of Registration in Dentistry</i> |
| 10:30 | Barriers to licensure for foreign trained dentists
<i>Dr. Badamia (commission member)</i>
<i>Luis Trasvina (Colorado)</i> |
| 11:00 | Integrating immigrants into the workforce
<i>Angelina Klouthis Jean – Maine Dept of Labor</i> |
| 11:30 | Information request responses |
| 12:00 | MaineCare dental enrollment, reimbursement and initiatives
<i>Courtney Pladsen, Medical Director, Office of MaineCare Services</i> |
| 12:30 | Committee discussion of next steps and recommendations |
| 1:00 | Adjourn |

Next meeting date: Wednesday, November 5th, 10am in Room 209 (HHS) CSOB

**Maine Board of Dental Practice
Foreign Trained Dentists Licensure Information
Calendar Year 2025 to present**

Disclaimer: Demographic information is not captured in OPOR's licensing system (ALMS). However, below is information taken from memos prepared by board staff that are part of the application materials reviewed by the Board. Please note that 7 out of 9 applicants were licensed via endorsement as highlighted in yellow.

1. **Kirana Kantikosum, D.D.S., dentist applicant (p. 212 Board book):** Dr. Kantikosum filed an application for dentist licensure via endorsement licensure. Although the applicant did not report any current or previous licenses on the application, she does currently hold a dentist license in Thailand (5/2023 – 5/2028); and previously held three dental intern limited licenses in Massachusetts (9/2021 – 8/2024). Below are additional qualifications as part of the application materials:
 - a. Education: Doctor of Dental Surgery, Kohn Kaen University, Kohn Kaen, Thailand (2012-2018).
 - b. Other: Boston University, Boston, MA – Certificate of Advanced Graduate Study in Prosthodontics and Doctor of Science in Dentistry in Prosthodontics (2019-2024).
 - c. Transcript review: Report issued by Educational Credential Evaluators on September 12, 2024 determined that the equivalency was "Doctor of Dental Surgery degree".
 - d. Examination: INBDE – passed 2023; ADEX (10/2023 - 1/2024) – passed all sections.
 - e. Work History: According to the curriculum vitae and an email providing clarification, Ms. Kantikosum practiced as a dentist in Thailand from 2018 – 2019, and then again beginning 9/2024 following completion of the residency training; and practiced in Massachusetts with the dental intern limited licenses from 9/2021 – 8/2024 as part of the residency training program.
2. **Nikhil H. Darji, B.D.S. (p. 59 Board book):** An online application for dentist licensure via endorsement. The applicant currently holds an active dentist license in Ontario, Canada (3/2019 - current) and holds a current dentist license in India (3/2012 – 12/2028). He was previously licensed as a dentist in Saskatchewan, Canada (2/2018 – 3/2019), and was previously licensed as a dental assistant in British Columbia, Canada (9/2014-3/2018). Below is additional information as part of the application:
 - a. Education: Bachelor of Dental Surgery – Ahmedabad Dental College and Hospital, Gujarat, India (2006-2012);

- b. ECE Transcript review: Report issued by Educational Credential Evaluators on September 6, 2011 determined that the equivalency was: “High school diploma and Completion of four years of study in a dentistry program”.
 - c. Examination: National Dental Examining Board of Canada; written passed 11/18/2017; OSCE passed 11/19/2017; Assessment of Clinical Skills passed 6/3/2017; Assessment of Clinical Judgement passed 12/2/2016; and Assessment of Fundamental Knowledge passed 8/13/2016.
 - d. Non-Disciplinary Action: The license verification from Saskatchewan, Canada provides details of a Consent to Conditions for Case #18-46 dated November 15, 2018.
 - e. Work History: Worked as a licensed dentist in India (7/2012-7/2013), Province of Saskatchewan (2/2018-1/2019), and in Ontario (3/2019 to present).

- 3. **Parinda Rattanapian, D.D.S., dentist applicant (p. 111 Board book)**: Dr. Rattanapian filed an application for dentist licensure via endorsement. The applicant currently holds a dentist license in Thailand (5/2020 – 5/2029); a dentist license in Illinois (3/2025 – 9/2027); and a dental intern limited license in Massachusetts (11/2024 – 11/2025). She previously held three dental intern limited licenses in Massachusetts (9/2021 – 9/2024). Below are additional qualifications as part of the application materials:
 - a. Education: Doctor of Dental Surgery, Rangsit University, Bangkok, Thailand (2012-2018).
 - b. Other: Tufts University, Boston, MA – Master of Science in Dental Research (5/2024); Certificate of Achievement in Advanced Esthetic and Operative Dentistry (2021-2024).
 - c. Transcript review: Report issued by Educational Credential Evaluators on September 12, 2024 determined that the equivalency was “Doctor of Dental Surgery degree”.
 - d. Examination: INBDE – passed 2024; ADEX (4/2024 - 10/2024) – passed all sections (failed Prosthodontic section 1 time).
 - e. Work History: According to the curriculum vitae and an email from the applicant, Dr. Rattanapian practiced as a dentist in Thailand from 2018 – 2021. Following that, she continued her clinical training and practice as a resident at Tufts.

- 4. **Konstantinos Megkousidis, D.D.S. – dentist (p. 52 Board book)**: Applicant Megkousidis filed a dentist application via endorsement licensure. The applicant holds an active dentist license in New Hampshire (2/2024 – 2/2026), an active dentist license in Greece (2/2019 – Present) and an active dental assistant license in MA (12/2024-10/2025). He previously held a dentist license in WA (1/2024-

10/2024) and three dental intern limited licenses in MA (10/2021-11/2024).
Below are additional qualifications as part of the application materials:

- a. Education: Doctor of Dental Surgery – National and Kapodistrian University of Athens Department of Dentistry, Athens, Greece (2013-2018)

***Note**: See link to University of Athens degree program:

<http://en.dent.uoa.gr/>

“Welcome to the School of Dentistry, University of Athens, one of the two Dental Schools in Greece. The School offers a five year undergraduate program leading to a Doctor of Dental Surgery degree (DDS). Additionally, it provides two cycles of Postgraduate Studies. The first cycle is two or three years in duration and leads to a Postgraduate Specialty Diploma. The second cycle is 3 years in duration and leads to a Doctorate Degree (PhD).”

- b. Other: Certificate of Advanced Graduate Study in Orthodontics and Master of Science in Dentistry in Orthodontics, Boston University, Boston, MA (2021-2024). The applicant also provided documentation showing that he is a Board Certified Orthodontist effective 12/1/2024 through 12/31/2034.
 - c. Transcript review: Report originally issued by World Education Services on June 25, 2020 determined that the equivalency was “Five years of professional study in dentistry at a regionally accredited institution”, with additional remarks “The Ptychio Odontiatrakis is the first professional degree in dentistry in Greece.”
 - d. Examinations: Integrated National Board – passed 8/2022; the applicant completed all required sections of the ADEX examination administered by the CDCA/WREB/CITA in January 2024.
 - e. Work History: 2019 - 2021 worked as a dentist in Greece; and has practiced as a dentist in New Hampshire from July 2024 to the present.
5. **Ahmed Messahel, B.D.S., MD (p. XXX Board book)**: An online application for dentist licensure via endorsement. The applicant currently holds an active dentist license in the United Kingdom (7/1996 – 12/2025). Dr. Messahel also holds active medical licenses in the UK (10/2005 – 8/2025) and in Maine (5/2020 – 9/2025). Below is additional information as part of the application:

- a. Education: Bachelor of Dental Surgery – University of Liverpool (1991 - 1996); Oral & Maxillofacial Surgery – University Hospital Birmingham (1997 – 2000); Degree of Bachelor of Medicine & Surgery – University of Birmingham (2000 - 2003).
- b. Transcript Review: Report issued by ECE on May 7, 2025 determined that the equivalency was: “Doctor of Dental Surgery degree”.
- c. Examination: Dr. Messahel is requesting a waiver of both the national and regional examinations.

- d. Work History: According to his CV, Dr. Messahel has been practicing as an Oral & Maxillofacial Surgeon at Northern Light Eastern Maine Medical Center since November 2020.
6. Manav Nayyar, B.D.S. (p. 220 Board book): Manav Nayyar filed an application for dentist licensure via endorsement licensure. The applicant currently holds an active dentist license in Ontario, Canada (4/2013 - current), an active dental intern limited license in Massachusetts (2/2024 - 2/2025) and was previously licensed in India (first issued 1995). At its September 13, 2024 meeting, the Board tabled its review of the application in order to request further information (see September 17, 2024 letter). Below is additional information as part of the application:
 - a. Education: Bachelor of Dental Surgery – J.N. Kapoor D.A.V. Centenary Dental College, Yamuna Nagar, Haryana, India (1990-1994);
 - b. ECE Transcript review: Report issued by Educational Credential Evaluators on August 28, 2024 determined that the equivalency was: “Five years of study in a dentistry program” with the comment “This credential is equivalent to at least a bachelor degree in the United States, but it represents a professional field of study not offered in bachelor degree programs in the United States.”
 - c. Updated ECE Transcript review: Report issued by ECE on April 28, 2025, which included the applicants Master of Dental Surgery degree states: “Master degree, major area of study: Dentistry, specialization in Conservative Dentistry and Endodontics”.
 - d. Examination: National Dental Examining Board of Canada; written passed 11/16/2012, Virtual OSCE Examination passed 12/14/2012, OSCE passed 11/18/2012, Assessment of Clinical Judgement passed 6/11/2012, Assessment of Clinical Skills passed 6/9/2012, and Assessment of Fundamental Knowledge passed 2/4/2012. Applicant is requesting a waiver of the regional examination requirements.
 - e. Work History: According to the curriculum vitae provided, Mr. Nayyar has been practicing dentistry as a licensed dentist in Ontario for 10+ years.
 - f. Other: September 28, 2024 email from applicant in response to the Board request for further information.
 7. David Chubb, B.D.S., Dentist Applicant (p. 108 Board book): The applicant filed an online application for dentist licensure via standard licensure. The applicant currently holds an inactive dentist license in Alberta, Canada (2/2019 - 12/2025). He previously held dentist licenses in Texas (7/2020 - 6/2025); and Newfoundland (2/2019 - 3/2019); and a Student Registrant – Post Graduate registration in British Columbia (6/2019 - 6/2020). Below is additional information as part of the application:

- a. Education: Bachelor of Dental Surgery – The University of Adelaide, Australia (2014 – 2018); University of British Columbia, General Practice Residency (2019 – 2020); University of Texas, OMFS – Non-Categorical Internship (2020 – 2021); and University of Texas, OMFS Residency (2021 – 2025).
 - b. Transcript Review: Report issued by ECE on June 24, 2025 determined that the equivalency was: “Five years of study in a dentistry program”, with additional comments: “This credential is equivalent in level to at least a bachelor degree in the United States, but it represents a professional field of study not offered in bachelor degree programs in the United States”.
 - c. Examination: National Dental Board Examination – Part I – Passed 7/2018 and Part II – Passed 4/2019; ADEX passed 6/2024.
 - d. Work History: According to the CV, the applicant practiced dentistry in private dental practices beginning January through June of 2019, and then during his GPR Program from June 2019 – May 2020.
8. **Yu-Hsin Chen, D.D.S., Dentist Applicant (p. 130 Board book)**: The applicant filed an online application for dentist licensure via endorsement. The applicant currently holds an active dentist license in Taiwan (9/2019 – No expiration date). Below is additional information as part of the application:
 - a. Education: Doctor of Dental Surgery – Taipei Medical University, Taiwan (2013 – 2019); and University of Pennsylvania, Masters in Oral Biology (2022 – 2025) and certificate of postgraduate studies in periodontics (2022 – 2025).
 - b. Transcript Review: Report issued by ECE on March 16, 2020 determined that the equivalency was: “Doctor of Dental Surgery degree”.
 - c. Examination: National Dental Board Examination – Part I – Passed 2018 and Part II – Passed 2020; ADEX passed 7/2024 (previously failed posterior restorative 1 time).
 - d. Work History: According to the CV, the applicant practiced dentistry in Taiwan from 2019 – 2022; and as part of her residency training program (2022-2025) where no license was required.
9. **Megha I. Shah, B.D.S., Dentist Applicant (p. 55 Board book)**: The applicant filed an online application for a dentist license via standard licensure. Although not disclosed, the applicant currently holds an active dentist registration in India (9/2012 – 12/2025). The applicant previously held dental intern limited licenses in Massachusetts (8/2022 – 8/2025), and although not disclosed, she previously held a dental assistant license in Massachusetts (3/2017 – 10/2019). Below is additional information as part of the application:
 - a. Education: Bachelor of Dental Surgery – Rajiv Gandhi University of Health Sciences, Bangalore, Karnataka, India (2007 – 2011) which included a one-year internship (2011 – 2012); and a Master of Healthcare Administration from Framingham State University (2016 – 2018).

- b. Transcript Review: Report issued by ECE on March 14, 2014 determined that the equivalency was: "Completion of four years of study in a dentistry program and a one-year compulsory rotating internship", with additional comments: "Admission to this program required completion of the United States equivalent of a high school diploma. The diploma for this program was awarded in 2013."
- c. Additional Education: Certificate of Advanced Graduate Study and Doctor of Science in Dentistry in Prosthodontics – Boston University (2020 – 2025)
- d. Examination: National Dental Board Examination – Part I – Passed 10/2014 (previously failed 1 time), and Part II – Passed 2/2018 (previously failed 2 times); ADEX passed 2/2025.
- e. Work History: According to the CV, the applicant last practiced dentistry in India in May of 2018.

MAINE BOARD OF DENTAL PRACTICE

Application Checklist for Dentist Licensure

PATHWAY I – STANDARD APPLICATION is for an applicant that is **not actively licensed** as a Dentist in another jurisdiction.

The following is a list of required items when filing an online licensure application. Some of the items can be submitted directly by the applicant, submitted directly from a third party such as an academic institution verifying a degree program, or Board staff verifying passage of certain regional examination scores.

- ☐ Verification of Doctoral Degree (either official transcript submitted by applicant or form submitted directly by the academic institution). Link to access the form: www.maine.gov/dental/documents/certificate_of_education_form.pdf.
- ☐ Official Educational Equivalency Report issued by a recognized professional organization if doctoral degree is not CODA accredited. The report may be submitted online but the original must be filed via USPS mail. Link to access organizations that perform educational evaluations: <https://www.naces.org/>
- ☐ Official documentation of passing scores on the National Dental Board Examination (either Parts I and II, or the Integrated examination)
- ☐ Official documentation of passing scores on the Regional Examination or other state board examination approved by the Board. Link to access board approved examinations: www.maine.gov/dental/documents/dentist_examination_chart.pdf
- ☐ Curriculum vitae (resume)
- ☐ Passing Score on Jurisprudence Examination. Link to access the examination: www.maine.gov/dental/jurisprudence-examinations.html
- ☐ Current; valid life support certification (**BLS required effective 10/25/2023**)
- ☐ National Practitioner's Data Bank (NPDB) Self-Query Report. NPDB link: www.npdb.hrsa.gov/
- ☐ Payment of \$871.00 in fees (includes \$21.00 Maine criminal background fee, \$100.00 application fee, and \$750.00 license fee)

PATHWAY II – ENDORSEMENT APPLICATION is for an applicant that is **actively licensed** as a Dentist in another jurisdiction. Applicants with an active limited, resident or faculty dentist license seeking a full dentist license would file an application under Pathway 1 – Standard Application noted above.

The following is a list of required items when filing an online licensure application. Some of the items can be submitted directly by the applicant, submitted directly from a third party such as an academic institution verifying a degree program, or Board staff verifying passage of certain regional examination scores.

- ☐ Verification of Doctoral Degree (either official transcript submitted by applicant or form submitted directly by the academic institution). Link to access the form: www.maine.gov/dental/documents/certificate_of_education_form.pdf.
- ☐ Official Educational Equivalency Report issued by a recognized professional organization if doctoral degree is not CODA accredited. The form may be uploaded but the original must be filed via USPS mail. Link to access organizations (e.g. ECE, WES) that perform educational evaluations: <https://www.naces.org/>

Application Checklist for Dentist Licensure (cont.)

- ☐ Official documentation of passing scores on the National Dental Board Examination (either Parts I and II, or the Integrated examination); applicant may request an examination waiver when completing the online application,
- ☐ Official documentation of passing scores on the Regional Examination or other state board examination approved by the Board. Link to access board approved examinations: www.maine.gov/dental/documents/dentist_examination_chart.pdf; applicant may request an examination waiver when completing the online application
- ☐ Curriculum vitae (resume), including references to verify clinical patient experiences while licensed
- ☐ Passing Score on Jurisprudence Examination. Link to access the examination: www.maine.gov/dental/jurisprudence-examinations.html
- ☐ Current; valid life support certification (**BLS required effective 10/25/2023**)
- ☐ National Practitioner's Data Bank (NPDB) Self-Query Report. NPDB link: www.npdb.hrsa.gov/
- ☐ If actively licensed and practicing during three consecutive years immediately preceding the application, then you will be prompted to include a link to the licensing jurisdiction(s) regulations as part of the online licensure application
- ☐ Payment of \$871.00 in fees (includes \$21.00 Maine criminal background fee, \$100.00 application fee, and \$750.00 license fee)

For more information regarding qualifications for all categories of dentist licensure please review Board Rules Chapter 6 "Qualifications for Dentist Licensure" here: [Maine Board of Dental Practice Rules](#)

Board Contact Information:

Board of Dental Practice
143 State House Station
Augusta, Maine 04333-0143

Telephone: (207) 287-3333
TTY users call Maine relay 711
Fax: (207) 287-8140
Email: dental.board@maine.gov

Website: www.maine.gov/dental

Summary: This chapter sets forth the qualifications for licensure as a dentist.

I. GENERAL QUALIFICATIONS; APPLICATION; FEES

- A. An applicant seeking licensure to practice under this chapter must submit an application with the appropriate fee, and any other materials required by the Board.
- B. An applicant has 90 days after being notified of any additional materials needed to complete the application to submit those materials to the Board. Failure to complete the application within that 90-day period may result in a denial of the application.
- C. Verification of passing the jurisprudence examination administered by the Board with a grade of 90 percent. Applicants who do not pass the jurisprudence examination in three attempts may be preliminarily denied licensure.
- D. Verification of current certification in BLS. For purposes of meeting the BLS certification requirements under this chapter, online trainings are not accepted, unless the licensee can verify hands-on participation with the instructor as a component of the training.

II. SPECIFIC QUALIFICATIONS FOR DENTIST LICENSURE

- A. Verification of a doctoral degree in dentistry, such as a D.M.D. or D.D.S., from a dental school whose program is accredited by CODA or the educational equivalent of a doctoral degree in dentistry as determined by the Board;
- B. Verification of passing all parts of the National Dental Board Examination or the successor to that examination; and
- C. Verification of passing all sections of a regional or state dental board examination approved by the Board.

III. SPECIFIC QUALIFICATIONS FOR FACULTY LICENSURE

- A. Verification of an active dental license in good standing issued under the laws of another jurisdiction;

- B. Credentials, satisfactory to the Board, including:
 - (1) A letter from the employing school of dentistry, dental hygiene or denturism indicating that the applicant satisfies the credentialing standards of the school and that the applicant will teach dentistry, dental hygiene or denturism in this State as part of a clinical and didactic program for professional education for dental students and dental residents accredited by CODA or a successor organization approved by the Board; and
 - (2) Previous employment experience relevant to the subject to be taught (including dates of employment).

IV. SPECIFIC QUALIFICATIONS FOR LIMITED DENTIST LICENSURE

- A. Verification of a doctoral degree in dentistry, such as a D.M.D. or D.D.S., from a dental school whose program is accredited by CODA or the educational equivalent of a doctoral degree in dentistry as determined by the Board;
- B. Verification of an active, inactive, or expired dentist license in good standing issued under the laws of this State, or of an active dental license in good standing issued under the laws of another jurisdiction; and
- C. Verification that the applicant will be practicing dentistry in a nonprofit dental clinic without compensation for work performed at the clinic.

V. SPECIFIC QUALIFICATIONS FOR RESIDENT DENTIST LICENSURE

- A. Verification of a doctoral degree in dentistry, such as a D.M.D. or D.D.S., from a dental school whose program is accredited by CODA or the educational equivalent of a doctoral degree in dentistry as determined by the Board.
- B. (RESERVED)
- C. (RESERVED)
- D. Verification from a Board-approved post-graduate dental residency program that includes the following:
 - (1) Affirms that the applicant has an academic affiliation and is enrolled in a dental residency program;
 - (2) Affirms that the applicant has completed satisfactory training and is ready to perform dental services in limited settings under the supervision of a sponsoring dentist; and
- E. A supervision plan submitted by the sponsoring dentist that describes the following:
 - (1) Board-approved setting that identifies the location(s), and the start and end dates of the clinical experience;

- (2) Identifies that the level of supervision and control over the services to be performed by the applicant are adequate, and that the performance of these services are within the applicant's dental knowledge and skill.

VI. SPECIFIC QUALIFICATIONS FOR TEMPORARY LICENSURE

- A Verification of an active dentist license in good standing issued under the laws of another state and payment of applicable fees. The Board may waive the license fee if the purpose of the temporary license is to provide free dental care in conjunction with a charitable nonprofit organization.
 - B. The Board may waive the BLS and jurisprudence examination requirements set forth in Chapter 6(I)(C) and (D) for good cause.
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STATUTORY AUTHORITY:

32 M.R.S. §§ 18324, 18341, 18342, and 18347-A.

EFFECTIVE DATE:

April 5, 2020 – filing 2020-075

AMENDED:

December 15, 2021 – filing 2021-252

May 12, 2024 – filing 2024-110

02 DEPARTMENT OF PROFESSIONAL AND FINANCIAL REGULATION

313 BOARD OF DENTAL PRACTICE

Chapter 11: QUALIFICATIONS FOR LICENSURE BY ENDORSEMENT; REQUIREMENTS FOR RENEWAL, LATE RENEWAL, AND REINSTATEMENT OF LICENSURE AND AUTHORITIES

Summary: This chapter sets forth the qualifications for licensure by endorsement and the requirements for renewal, late renewal, and reinstatement for licenses and authorities to practice under the *Maine Dental Practice Act*.

I. GENERAL QUALIFICATIONS; REQUIREMENTS

- A. An applicant seeking licensure by endorsement, or an applicant seeking to renew, renew late, or reinstate a license or an authority must submit an application with the appropriate fee, and any other materials required by the Board.
- B. An applicant has 90 days after being notified of any materials needed to complete the application to submit those materials to the Board. Failure to complete the application within that 90-day period may result in a denial of the application.

II. SPECIFIC QUALIFICATIONS FOR LICENSURE BY ENDORSEMENT; APPLICANTS AUTHORIZED TO PRACTICE IN ANOTHER JURISDICTION

The Board is authorized, at its discretion, to waive the examination requirements, consider an educational equivalency in meeting the educational requirements, and issue a license or grant an authority to an applicant who is licensed under the laws of another jurisdiction who furnishes proof, satisfactory to the Board, that the other requirements for licensure have been met.

- A. Substantially Equivalent License. The Board will review materials submitted by the applicant as outlined below to determine if the applicant has actively practiced with a substantially equivalent license at the level of licensure applied for under the laws and rules of the Board. An applicant seeking licensure by endorsement pursuant to this provision must provide:
 - (1) Verification of all licenses in good standing under which the applicant actively practiced during the 3 consecutive years immediately preceding application to the Board;
 - (2) Documentation of the laws and rules of all jurisdictions in which the applicant actively practiced during the 3 consecutive years immediately preceding application to the Board;
 - (3) A summary in the nature of a resume or curriculum vitae describing the applicant's practice during the 3 consecutive years immediately preceding application for

licensure to the Board. The summary must contain references with sufficient contact information to enable verification by email address, mail, and telephone; and

- (4) Verification of current certification in BLS. For purposes of meeting the BLS requirement, online trainings are not accepted unless the applicant can verify hands-on participation with the instructor as a component of the training.
- B. Substantially Similar Qualifications. The Board will review materials submitted by the applicant as outlined below to determine if the applicant's qualifications are substantially similar to the requirements for initial licensure for the level of licensure applied for under the laws and rules of the Board. An applicant seeking licensure by endorsement pursuant to this provision must provide:
- (1) Verification of all licenses in good standing under which the applicant is actively licensed;
 - (2) All application materials for qualifications required for initial licensure as a dentist, dental hygienist, dental hygienist authorities pursuant to 32 M.R.S. §18345(2), a denturist, a dental radiographer, or an expanded function dental assistant, as applicable; and
 - (3) Verification of current certification in BLS. For purposes of meeting the BLS requirement, online trainings are not accepted unless the applicant can verify hands-on participation with the instructor as a component of the training.

III. SPECIFIC REQUIREMENTS FOR RENEWAL AND REINSTATEMENT OF LICENSURE

- A. Renewal Requirements – Prior to the Date of Expiration
- (1) An applicant must apply for renewal on or before the date of expiration; and
 - (2) An applicant must complete the continuing education requirements pursuant to Chapter 13 as a condition to renew.
- B. Late Renewal – Within 90 Days after Expiration
- (1) An applicant who applies for renewal after expiration of the license, but within 90 days of expiration, must pay the required fees. The licensee will remain subject to disciplinary action for all other violations; and
 - (2) An applicant must complete the continuing education requirements pursuant to Chapter 13 as a condition to renew. Continuing education hours earned after the date of license expiration will not be applied to the late renewal application.
- C. Reinstatement Requirements – Between 91 Days and Two Years of Expiration
- (1) An applicant who applies for reinstatement after expiration of the license, but between 91 days and two years of expiration must pay the required fees and meet all qualifications for initial licensure. The Board may, giving due consideration to the protection of the public, waive the examination requirements.

An applicant whose license has been expired more than two years must submit an application for initial licensure, pay the required fee and meet all of the qualifications as outlined in Board statute and rule.

IV. SPECIFIC REQUIREMENTS FOR THE RENEWAL AND REINSTATEMENT OF DENTAL HYGIENE AUTHORITIES

- A. The following are requirements to renew and reinstate a dental hygiene practice authority in the practice areas of local anesthesia, nitrous oxide analgesia, independent practice dental hygiene and public health dental hygiene:
- (1) A dental hygienist who at the time of renewal has a practice authority identified in Section IV(A) must meet the dental hygiene renewal requirements of this Chapter.
 - (2) A dental hygienist who at the time of a late renewal has a practice authority identified in Section IV(A) must meet the dental hygiene late renewal requirements of this Chapter.
 - (3) A dental hygienist who at the time of license expiration held a practice authority identified in Section IV(A) must meet the dental hygiene reinstatement requirements, file an initial authority application, pay the required fees, and meet all the requirements for the practice authority. The Board may, giving due consideration to the protection of the public, waive the examination requirements.
 - (4) A dental hygienist who at the time of license expiration held a practice authority identified in Section IV(A) and whose license expired more than two years from the date of expiration must submit an application for dental hygiene licensure and any practice authority, pay the required fees, and meet all requirements for licensure and the practice authority.
- B. The following are requirements to renew and reinstate a dental hygiene authority in the practice areas of dental therapy and provisional dental therapy:
- (1) A dental hygienist who at the time of renewal has a practice authority identified in Section IV(B) must meet the dental hygiene renewal requirements of this Chapter, and submit a current, valid practice agreement(s) with a supervising dentist(s) pursuant to Board Rule, Chapter 2.
 - (2) A dental hygienist who at the time of a late renewal has a practice authority identified in Section IV(B) must meet the dental hygiene late renewal requirements of this Chapter, and submit a current, valid practice agreement(s) with a supervising dentist(s) pursuant to Board Rule, Chapter 2.
 - (3) A dental hygienist who at the time of license expiration held a practice authority identified in Section IV(B) must meet the dental hygiene reinstatement requirements, file an initial authority application, pay the required fees and meet all the requirements for the practice authority. The Board may, giving due consideration to the protection of the public, waive the examination requirements.

- (4) A dental hygienist who at the time of license expiration held a practice authority identified in Section IV(A) and whose license expired more than two years from the date of expiration must submit an application for dental hygiene licensure and any practice authority, pay the required fees, and meet all requirements for licensure and the practice authority.
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STATUTORY AUTHORITY:

32 M.R.S. §§ 18324, 18341, 18347, 18349, and 18350.

EFFECTIVE DATE:

April 5, 2020 – filing 2020-083

AMENDED:

December 15, 2021 – filing 2021-253

May 12, 2024 – filing 2024-111

Maine Board of Dental Practice – Reference Sheet of Regulatory Changes Since 2015

Legislative Changes

127th Legislative Sessions

1. Public Law 2015, c. 326 “An Act to Allow Dental Hygienists to Prescribe Fluoride Dentifrice and Antibacterial Rinse”
2. Public Law 2015, c. 155 “An Act to Expand the Scope of Practice for Denturists”
3. Public Law 2015, c. 2 “An Act to Allow Independent Practice Dental Hygienists To Expose and Process Radiographs under Protocols Developed by the Board of Dental Examiners”
4. Public Law 2015, c. 192 “An Act to Benefit the Education of Denturism Students”
5. Public Law 2015, c. 135 – “An Act Regarding the Board of Dental Examiners”
6. Public Law 2015, c. 429 “An Act to Revise the Laws Regarding Dental Practices” (complete repeal and replace of the Dental Practice Act)
7. Public Law 2015, c. 488 “An Act to Prevent Opiate Abuse by Strengthening the Controlled Substances Prescription Monitoring Program

128th Legislative Sessions

8. Public Law 2015, c. 326 “An Act to Allow Dental Hygienists to Prescribe Fluoride Dentifrice and Antibacterial Rinse”
9. Public Law 2017, chapter 213 “An Act to Clarify the Opioid Medication Prescribing Limit Laws”
10. Public Law 2017, chapter 186 “An Act to Inform Patients of the Dangers of Addicting Opioids”
11. Public Law 2017, chapter 210 “An Act to Update Professional and Occupational Licensing Laws”
12. Public Law 2017, chapter 139 “An Act to Amend the Requirements for Licensure as an Independent Practice Dental Hygienist”
13. Public Law 2017, chapter 288 “An Act to Correct Errors and Inconsistencies in the Laws of Maine”
14. Public Law 2017, chapter 388 “An Act to Implement the Recommendations of the Board of Dental Practice”

129th Legislative Sessions

15. Public Law 2019, chapter 92 “An Act to Set Maine Dental Provider Licensing Fees”
16. Public Law 2019, chapter 388 “An Act to Align the Laws Governing Dental Therapy with Standards Established by the American Dental Association Commission on Dental Accreditation”

130th Legislative Sessions

17. Public Law 2021, chapter 44 “An Act to Remove the Advanced Cardiac Life Support Certification Requirement for Dental Therapists”
18. Public Law 2021, chapter 88 “An Act to Modify the Qualifications for Resident Dentist Licensure”
19. Public Law 2021, chapter 134 “An Act to Allow a Dentist to Administer Botulinum Toxin and Dermal Fillers”
20. Public Law 2021, chapter 163 “An Act to Modify Dental Licensure Requirements to Consider Credentialed Individuals from Other Jurisdictions”
21. Public Law 2021, chapter 223 “An Act Amend the Dental Practice Act to Define “Supervision” and Authorize Teledentistry”
22. Public Law 2021, chapter 106 “An Act to Allow Veterans, Active Duty Service Members and Their Spouses to Apply for Temporary Occupational Licenses and Certifications”

131st Legislative Sessions

23. Public Law 2023, chapter 165 “An Act Regarding Dental Licensure for Charitable Care”
24. Public Law 2023, chapter 354 “An Act Regarding Dental Hygienists and Dental Therapists”
25. Public Law 2023, chapter 17 (Part P) – budget bill merging the Board of Dental Practice with OPOR.
26. Public Law 2024, chapter 515 “An Act to Restore the Board of Dental Practice's Authority to Issue Letters of Guidance”
27. Public Law 2024, chapter 664 “An Act to Join the Dentist and Dental Hygienist Compact”

132nd Legislative Sessions

28. Public Law 2024, chapter 71, “An Act Regarding the Establishment of Fees and Fee Caps for Dental Provider Licensing and Permits”
29. Public Law 2024, chapter 83 “An Act to Amend the Scope of Practice for Expanded Function Dental Assistants”

Rulemaking Changes

1. June 2015: Board Rules, Chapter 17 “Requirements for Establishing a Board Approved Dental Hygiene Therapy Program”
2. December 2015: Board Rules, Chapter 16 “Rules for Independent Practice Dental Hygienists to Process Dental Radiographs
3. December 2015: Board Rules, Chapter 5 “Requirements for Licensure as a Denturist”
4. August 2017: Board Rules, Chapter 14 “Rules for the Use of Sedation and General Anesthesia:
5. November 2018: Board Rules, Chapter 13 “Continuing Education”
6. July 3, 2019: Board Rules, Chapter 7 “Establishment of Fees”
7. November 8, 2019: Board Rules, Chapters 1 through 6, and 8 through 12
8. December 15, 2021: Board Rules Chapters 1, 2, 3, 5, 6, 11, and 17
9. September 7, 2022: Board Rules, Chapter 15 “Practice Requirements for Teledentistry Services”
10. January 15, 2023: Board Rules, Chapter 14 “Rules for Use of Sedation and General Anesthesia”

Legislative Reports and/or Ad Hoc Stakeholder Processes

1. Dental Hygiene Therapy (2014-2015)
2. Dental Practice Act Review (2016-2017)
3. Supervision and Teledentistry (2019)
4. Teledentistry Rulemaking (2022)
5. Legislative Reports<https://www.maine.gov/dental/board-information/resources.html>)
 - a. April 28, 2017
 - b. November 1, 2019
 - c. January 31, 2020
 - d. January 27, 2022

FMI:

Link to Board’s Website: <https://www.maine.gov/dental/index.html>

Link to Board’s Legislative Reports: <https://www.maine.gov/dental/board-information/resources.html>

MAINE BOARD OF DENTAL PRACTICE – Work Session Information – March 29, 2023

LD 876 “An Act to Expand Access to Oral Health Care in Rural Maine by Allowing Certain Out-of-State Dentists to Practice in Dental Clinics in Maine”

The Board of Dental Practice is providing additional data to the Committee regarding dentist the minimum standards for licensure and the various pathways for foreign-trained or foreign-licensed dentists obtain licensure. There are two minimum standards required to demonstrate competency as follows:

Standard #1 – Education Requirement:

- Earned doctoral degree in dentistry from either a CODA academic program or an equivalent degree from a non-CODA academic program*.

Standard #2 – Examinations:

- National Dental Board Examination
- Clinical Examinations (proctored by regional examiners and/or state licensure boards)

*Equivalent Degree Determination:

- A transcript analysis from a credentialed third-party evaluator (World Education Service – WES and/or Educational Credential Evaluators).
- Consideration of any post-graduate advanced clinical training.
- Consideration of any post-graduate clinical practice within the past three years preceding an application for licensure.

Similarly, there are two pathways for a foreign-trained/licensed dentist to obtain licensure as noted below:

Pathway #1 – Standard/Initial Licensure:

- Meets the minimum standards noted above with regards to education and examinations.

Pathway #2 – Endorsement Licensure:

- If an applicant is actively licensed and practicing in another jurisdiction the Board will review the jurisdiction’s governing regulations to determine its equivalency, if not then the Board will determine whether the individual holds substantially similar minimum standards as noted above.
- The Board may has the discretion to waive the examination requirements if an applicant is applying by endorsement and has successfully passed licensure examinations in other jurisdictions.

In 2020, the Board amended its rules governing licensure by endorsement and in 2021 the Board proposed legislation to recognize foreign trained/licensed dental professionals in jurisdictions outside of the US and Canadian provinces. Below is licensure data reflecting those changes:

Dentist Licensure Data Beginning 2020 - 2023

Calendar Year	License Type	# of Licenses Issued	# of Foreign Trained Dentists++
2020	Dentist – Full Licenses	76	2
2021	Dentist – Full License	75	10
2022	Dentist – Full License	82	8
2023 +	Dentist – Full License	21	2

+ Three months data

++8 out of the 22 foreign-trained dentists held a limited license from MA – so Maine has an existing pathway for individuals who hold a limited license in MA.

As noted in the Board's testimony, Limited Dentist License in Massachusetts is a restricted license requiring a supervision of a dentist and prohibits the use of sedation at any level, including the administration of nitrous oxide analgesia. Below is additional information:

- ✓ **MA Limited license (intern);** with the following restrictions:
 - license term restricted to one year,
 - scope restricted – cannot provide sedation at any level, nor administer nitrous oxide analgesia
 - settings limited to specifically named prisons, schools, hospitals or public clinic
 - supervision by a licensed dentist
 - passage of a regional examination if seeking licensure beyond a fifth year

As concerns resource allocation of staff to conduct a statewide research study, below is complaint data for the Committee's consideration:

Board Complaints

- 178 open cases against 117 licensees (involves 280+ patients).
 - 169 cases filed against individual dentists (10 dentists have more than 1 open case).
 - 9 cases filed against 9 individual dental professionals (RDH-5, Denturist – 3, RAD-1).
- 100 complaints filed per year (average) – however cases are more complex in nature.
- Complaint Case Information
 - Complaints filed by patients, family members, and third parties – third parties may be law enforcement, referral from another state agency (MaineCare), employer, supervisor/supervisee, the Board, etc.
 - Types of complaints often involve several allegations such as failed dental procedures (restorations, crowns, dentures, implants, ortho); excessive and costly treatment; failure to transfer records; unsafe sedation care; unsanitary conditions; rude and/or discriminatory behavior; substance use; sexualized behavior; and patient abandonment.
- Board's Strategic Plan
 - In February 2021, the Board identified additional resources necessary provides the resources it needs, including funding necessary to obtain additional board staff.

MAINE BOARD OF DENTAL PRACTICE
QUALIFICATIONS FOR STANDARD LICENSURE FOR DENTAL PROFESSIONALS (May, 2023)

LICENSE TYPE	EDUCATION/PROGRAM	EXAMINATION	OTHER
Dental Radiographer (RAD)	RAD Program approved by the Board*	- RAD Examination approved by the Board* - Board jurisprudence	
Expanded Function Dental Assistant (EFDA)	EFDA Program approved by the Board*	Board jurisprudence	Must be either licensed as RDH or certified as a dental assistant
Dental Hygienist (RDH)	Associate degree or higher in a dental hygiene program (CODA accredited or equivalent as determined by the Board)	- National Board - Regional Board (clinical) - Board jurisprudence	
Public Health Dental Hygienist Practice Authority (PHDH)	Must be licensed as RDH		Written practice agreement with dentist (general supervision)
Independent Practice Dental Hygienist Practice Authority (IPDH)	Must be licensed as RDH		Written agreement with dentist to have dental radiographs read w/in 21 days

LICENSE TYPE	EDUCATION/PROGRAM	EXAMINATION	OTHER
Dental Therapist Practice Authority (DT)	- Must be licensed as RDH - Master's degree in a dental therapy program (CODA accredited or equivalent as determined by the Board)	DT examination approved by the Board*	- Completion of 2,000 hours of clinical experience either as a Provisional DT or hours earned in another state - Written practice agreement with dentist (direct and general supervision)
Provisional Dental Therapist Practice Authority (PDT)	- Must be licensed as RDH - Master's degree in a dental therapy program (CODA accredited or equivalent as determined by the Board)	DT examination approved by the Board*	Written practice agreement with a dentist to complete 2,000 hours of clinical experience (direct and general supervision)
	•		•
Denturist (DTR)	DTR Program approved by the Board*	- DTR Examination approved by the Board* - Board jurisprudence	
Dentist (DEN)	Doctoral degree in a dentistry program (CODA accredited or equivalent as determined by the Board)	- National Boards - Regional Boards (clinical) - Board jurisprudence	

*See accompanying charts identifying board approved programs and examinations by licensure category

MAINE BOARD OF DENTAL PRACTICE
Licensure by Endorsement Chart – March 2024

32 M.R.S. §18347 reads in part:

“The Board is authorized at its discretion, to waive the examination requirements and issue a license or grant an authority to an applicant who is licensed under the laws of another state, a United States territory, a foreign nation or a foreign administrative division that issues licensed in the dental professions who furnishes proof, satisfactory to the board, that the requirements for licensure under this chapter have been met.”

SUBSTANTIALLY EQUIVALENT LICENSE Three (3) years active practice preceding application	SUBSTANTIALLY SIMILAR QUALIFICATIONS Less than three (3) years active practice preceding application
<u>Application materials:</u> In addition to other application materials, the Board reviews the applicant’s license to determine its equivalency • Verification of licensure demonstrated three years of active licensure preceding application • Statutes and rules of jurisdiction(s) which applicant is licensed* • Curriculum vitae describing applicant’s practice with contact information • BLS certification	<u>Application materials:</u> In addition to other application materials, the Board reviews the applicant’s qualifications • Verification of licensure • Submit application materials similar to initial application requirements such as education*, examination information, etc. • BLS certification

*Note: Board review is required if an applicant submits information requiring determinations of equivalency.

MAINE BOARD OF DENTAL PRACTICE – Reference Sheet (March 2023)

LD 876 “An Act to Expand Access to Oral Health Care in Rural Maine by Allowing Certain Out-of-state Dentists to Practice in Dental Clinics in the State”

<u>ME Dental Practice Act – Dentist Licensure Categories</u>	<u>MA Dental Practice Act – Limited Licensure Categories</u>
- There are two pathways (standard and endorsement) and several licensure categories for a foreign trained/ foreign licensed dentist to obtain licensure: ✓ Dentist (unrestricted) ✓ Faculty dentist, limited dentist (restricted to setting) ✓ Resident dentist (restricted to setting and supervision) ✓ Temporary dentist (restricted to length of license) - The requirements for a foreign trained/foreign licensed dentist are as follows: ✓ CODA accredited doctoral degree or the equivalent* ✓ Passage of the national examination and the regional examination (if applicant is licensed in another jurisdiction the Board may waive the examination requirements.) ✓ All other application requirements (fees, NPDB report, etc.) (*Applicants submit a professional report that provides an academic equivalency determination for the Board’s review.) <u>Licensing data:</u> 20+ full dentist licenses have been issued to foreign trained dentists once regulations were changed in 2020 and 2021, and one dental hygiene license. (See 32 M.R.S. §§ 18342, 18347)	- There is one pathway/one license category for a foreign trained/ foreign licensed dentists to obtain licensure: ✓ Limited license (intern); with the following restrictions: • license term restricted to one year, • scope restricted – cannot provide sedation at any level, nor administer nitrous oxide analgesia • settings limited to specifically named prisons, schools, hospitals or public clinic • supervision by a licensed dentist • passage of a regional examination if seeking licensure beyond a fifth year - The requirements limited dentist license are as follows: ✓ Evidence of employment ✓ Degree in dentistry from a reputable dental college ✓ English proficiency, as applicable ✓ Physician’s statement – statement attesting to health of applicant ✓ All other application requirements (fees, NPDB report, etc.) (MA dental regulations: https://www.mass.gov/lists/board-of-registration-in-dentistry-laws-and-regulations)

MEDICAID FINANCIAL SUSTAINABILITY TOOLKIT:

An Operational Guide for Dentists Wishing to Treat Medicaid Beneficiaries

October 2025

The ADA is dedicated to making improvement to Medicaid access and prepared this toolkit to support dentists who participate in Medicaid or are considering participation. This document offers policy grounded guidance and operational strategies to help practices delivery high-quality care while maintaining financial viability. It aligns with ADA advocacy priorities to reduce administrative burdens, improve reimbursement rates, and enhance program design so that participation is financially and professionally suitable for all dentists and beneficial for all beneficiaries.

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The ADA encourages state dental associations, in partnership with their Medicaid agency, oral health coalition, dental advisory committee(s), and participating dentists, develop state-specific toolkits and checklists. These resources can provide greater detail on enrollment, credentialing, and recredentialing processes, covered services, peer-mentor opportunities, and lessons learned to improve efficiencies and guide advocacy priorities, while reflecting the unique policies and operational requirements of each state's Medicaid program.

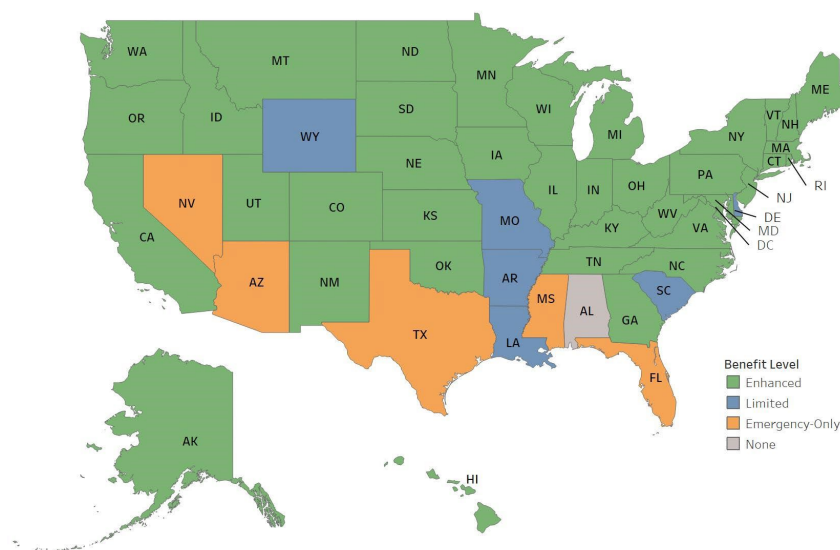
Disclaimer: This resource was current at the time it was published or uploaded onto ADA.org. Federal and state laws around Medicaid can and do occasionally change, and it is recommended to be aware of changes. This resource was prepared as an informational tool to assist dentists and is not intended to grant rights or impose obligations. Although every reasonable effort has been made to assure the accuracy of this information, the ultimate responsibility for remaining in compliance with federal/state Medicaid regulations and for sustaining a viable business model lies with the provider of items and services. The American Dental Association makes no representation, warranty, or guarantee that this compilation of Medicaid information is error-free or results in a profitable practice and will bear no responsibility or liability for the results or consequences of the use of this resource, which provides general expectations and tips for remaining a successful dentist participating in the Medicaid program, but it is not a legal document. The official Medicaid program provisions are contained in the relevant laws, regulations, and rulings and can be found in your state or managed care organization's provider manual.

Acknowledgement

This toolkit was developed by the American Dental Association (ADA), with input from dentist who participate in Medicaid across the United States. The ADA extends its gratitude to the practicing dentists, dental teams, and state leaders whose experience and insights shaped this resource, ensuring it reflects the realities of having a successful practice that accepts Medicaid and manages the operational complexities of serving Medicaid beneficiaries.

Background

Medicaid is a joint federal-state program established under Title XIX of the Social Security Act of 1965. It provides health coverage to eligible low-income individuals.¹ Medicaid's dental benefit varies across age and enrollment categories and is a vital access point for all people – children, adults, pregnant women, and individuals with intellectual and developmental disabilities. Dental benefits are an essential and mandatory component of Medicaid for children under the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit. Currently for adults, however, dental coverage is optional, and states determine whether to include preventive, restorative, or emergency dental services in their benefit packages. As a result, adult dental benefits vary substantially across the country.

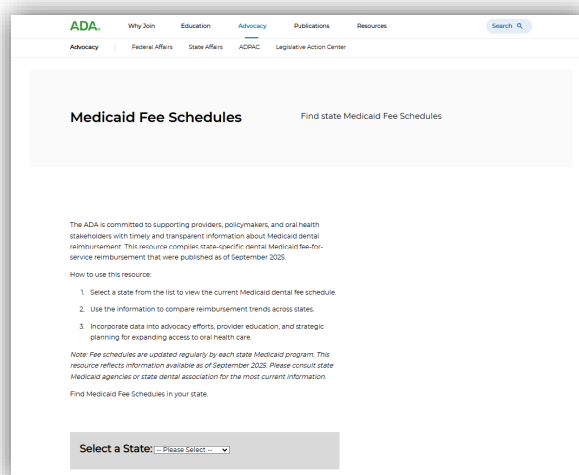


Source: Health Policy Institute analysis of data from state Medicaid websites and the CareQuest Medicaid Adult Dental Coverage Tracker (2025)

¹ Title XXI of the Social Security Act established the Children's Health Insurance Program (CHIP) in 1997 to provide health coverage to uninsured children families with incomes too high to qualify for Medicaid but too low to afford private insurance. CHIP programs are administered by states within broad federal guidelines, and each state designs its own structure, benefits, and eligibility standards, often operating as a stand-alone program, a Medicaid expansion, or a combination of both.

Because Medicaid is administered at the state level with federal guidelines, the administration of the program are state specific, meaning provider and administrative processes are state specific. Enrollment and credentialing requirements, reimbursement rates, covered services, and prior authorization protocols differ from one state Medicaid program to another and may also vary across the managed care organizations (MCOs) that administer Medicaid dental benefits in the state. A dentist participating in Medicaid should be familiar with how the program is administered in the state and review the dental provider manual(s) for their state and MCO specific differences. For this reason, dentists should consult their state Medicaid dental program manuals, MCO provider handbook(s), and state dental associations to ensure compliance with current requirements.

Understanding the program administration and operational implications can help dentists identify opportunities for advocacy, program improvement, and feedback to the state during the managed care procurement process. [To understand your state's fee-for-service schedule, you may refer to your state's fee schedule collected by the ADA's Health Policy Institute.](#)



Source: www.ada.org/MedicaidFeeSchedules

Purpose

Providing dental care to Medicaid beneficiaries can be professionally fulfilling for many dentists. They can help serve their communities, while you keep operating the practice and model that is beneficial for them. A successful practice model is one that balances patient-centered care, provision of high-quality, mission, financial viability and sustainability, and staff and operational efficiencies.

By understanding enrollment and reimbursement policy, patient engagement, and adoption of structured processes and operations, practices can integrate Medicaid participation without compromising standards. **The Medicaid Financial Sustainability Toolkit is designed to support dentists and their practices in delivering care to Medicaid beneficiaries with greater confidence, efficiency, and financial sustainability.** The ADA recognizes that the dentist and their team are making a substantial commitment by treating Medicaid beneficiaries, especially when low reimbursement and administrative burdens are a part of the equation.

Practice Management Strategies for Financial Sustainability

The following sections will outline dentist and practice-level strategies to achieve success while serving Medicaid beneficiaries.

Enrollment and Credentialing: Preventing Avoidable Revenue Loss

Credentialing is not a one-time administrative hurdle—it is recurring and should be carefully monitored. Proper enrollment and credentialing ensure timely reimbursement and minimize administrative burdens. Lapses in licensure documentation, expired malpractice certificates, or missed credentialing windows not only cause payment holds that can persist for months but will not allow the dentist or hygienist to serve Medicaid beneficiaries. *Improper or delayed dentist enrollment and credentialing is one of the biggest causes of denied claims and lost revenue.*

A practice-level “credentialing program” should at least include: a single individual in your office who is selected to help complete the entire process. These steps include assembling and auditing a digital dossier of required documents from all licensed team members, working with the licensed team members to maintain and adhere to a calendar of renewal dates with pre-set reminders, and establishing confirmation protocols with each MCO. When multiple MCOs are involved, it can be important to maintain separate confirmation logs and any plan-specific onboarding or verification steps.

Practical safeguards include verifying effective dates before the first scheduled Medicaid patient, maintaining payer contact channels, establishing a peer-mentor, and documenting all correspondence. While state Medicaid dental programs publish plan-specific checklists or portals, it may be important to link them with your own practice guide or tools for accepting new patients. A single practice team member could be trained to prevent single-point failure. However, despite delegating the collection of submission of documents to a person within your practice, the dentist must still be involved with attesting or certifying their credentialing before submission.

HEAR IT FROM YOUR DENTAL COLLEAGUES ... ABOUT NAVIGATING THE PAYER'S ADMINISTRATIVE PROCESSES

“[Find] a practicing mentor that has been accepting Medicaid for a while and can give advice on how to handle.”

— Dentists from Arizona, Kansas, and Mississippi.

Here are six key steps to dentist enrollment:

1. **Understand the pathway:** Centers for Medicaid & Medicare Services (CMS) → State Medicaid Agency → Managed Care Organizations (MCOs), if applicable → Board of Dentistry for licensure verification → Dentists
2. **Understanding your credentialing channels:** Find out whether your State's managed care organizations or your state Medicaid agency use CAQH for credentialing so you do can reduce the amount of time spent on credentialing applications.

Medicaid Financial Sustainability Toolkit

An operational guide for dentists

3. **Maintain a credentialing binder or digital dossier with all essential documents if you don't already use the [CAQH system](#)** (i.e., licenses, NPI, DEA, malpractice insurance, IRS W-9, etc.): This should be maintained for all licensed team members, whether it is a dental hygienist or an expanded function dental auxiliary (EFDA) professional. The CAQH system provides a free digital lockbox to store up-to-date credentialing information and provides a reminder system, so your profile always remains current. Even when your state or MCO does not automatically use CAQH, often a download of the application form is a suitable to transmit credentials stored in CAQH when it is time to renew.
4. **Create a credentialing calendar to track renewals and recredentialing deadlines.**
5. **Assign responsibility:** a staff member could serve as an official or unofficial Credentialing Coordinator or Medicaid Coordinator and be the lead for all-things credentialing or Medicaid.
6. **Follow-up:** always ensure confirmation is obtained.

By implementing these practical safeguards, practices protect reimbursement reliability, maintain uninterrupted access for Medicaid beneficiaries, and reduce administrative strain that often discourages dentist participation.

Quick Win	Develop a one-page Credentialing Checklist and review it quarterly to prevent lapses.
Patient Impact	Smooth enrollment and timely credentialing ensure faster dentist availability for patients who need access to dental care.

Operational Efficiency: Appointment Design, Roles, and Office Culture = Patient Compliance and Continuity

Financial sustainability in dentistry hinges on the ability to preserve quality and time with the patient, while making considerations for efficiency as it is critical to sustainability. Practices with strong scheduling protocols, optimized staff utilization, and a shared value and office culture are better positioned to provide care without overwhelming financial losses.

Schedules should be designed around predictable administrative steps: eligibility verification, benefit checks for planned procedures, pre-visit prior authorization (if applicable), effective patient communications, and all members of the dental team working at the top of their license or ability. While each practice may develop a different strategy, those who adopt layered reminders (e.g., a call one-week out from the appointment, a reminder text at 48 hours, a call at 24 hours, same day text) reduce no-shows; when coupled with a same-day standby list and a defined rescheduling protocol, overall chair-time utilization improves without compromising care or patient safety. Other scheduling and no-show management strategies include double-booking slots where no-shows are common, maintain a

Medicaid Financial Sustainability Toolkit

An operational guide for dentists

standby list to fill-last minute cancellations, adopt a clear no-show policy that is consistent for all patients, and offer same day treatment or services when possible. These operational choices are consistent with best-practice recommendations for reducing avoidable cancellations and aligning services to meet patient needs.

Below is a productivity goal that some safety-net clinics have used to ensure they can remain financially sustainable. It helps them understand the necessary pace and how to use the clinic's resources most effectively.

Productivity Based on Practice Assets

# of Chairs/ # of DA's	1 Dental Chair	2 Dental Chairs	3 Dental Chairs
1 Dental Assistant	1.2 patients per hour	1.4 patients per hour	No recommendation
2 Dental Assistants	No recommendation	1.6 patients per hour	2.2 patients per hour

Source: A clinic in Wisconsin

Utilizing all dental team members efficiently and effectively, through expanded utilization of allied personnel, where permitted by state law, preserves dentist time for complex diagnostics and procedures. For example, if a hygienist is trained or certified in your state to inject local anesthetic, you can use a short window of their time to do so while you work on other patients for an additional 15-20 minutes. This can be done under general, direct, indirect, or unsupervised supervision depending on your state.

An emerging trend in some state Medicaid programs is the reimbursement of teledentistry. However, the modalities and rules/regulations around teledentistry vary in every state. [14 states reimburse for D9995 \(synchronous\) and D9996\(asynchronous\)](#), which are CDT codes often used in teledentistry encounters. Some states have very unique situations for reimbursement in their Medicaid programs. [For example, Georgia's Medicaid program only reimburses for store-and-forward services related to teledentistry in a school-based setting for Medicaid. However, there are states like Oregon that reimburses dental dentists for remote monitoring.](#)

There are multiple modalities for incorporating teledentistry in your practice. A common modality is to the Virtual Dental Home (VDH) model. VDH allows community-based clinical team to upload the patient information through a secure web-based cloud storage system for review by a dentist at a clinic or dental office. The records are not reviewed in real time, but at the convenience of the dentist (i.e. before and after office hours, during openings in the schedule including downtime created by patient cancellations). Some dentists have partnered with hygienists that visit multiple sites such as residential facilities for people with mental illnesses or developmental disabilities, nursing home facilities, and community centers using this model. Another modality, which is dependent on state regulations, is for practices to link with school-based programs that do not have a dentist on site and helping prescribe SDF application, which can then be performed by a hygienist.

Another way to improve efficiency is to implement morning huddles, which provide an opportunity to discuss all patients and not stigmatize Medicaid beneficiaries. Rather, these short 10–15-minute meetings can be used to discuss patient appointment history and whether the appointment is

confirmed, as well as the required items needed prior to the planned services (i.e., prior authorization, documentation, etc.), regardless of insurance type. This discipline shortens cycle time and reduces post-visit documentation gaps or delays that lead to inaccurate clinical documentation or claims denials.

The ADA has created a [Medicaid Provider Resource: Strategies to Reduce Missed Appointments](#) which outlines more detailed opportunities for a practice to incorporate standardizations. As a reminder, a successful practice engages the patient and creates understanding of time and value, utilizes scheduling best practices, maximized practice staff and expanded workforce models, and demonstrates compassion. *It is important to note that despite the desire to charge a fee for a cancelled or missed appointment, Medicaid beneficiaries are excluded from such charges due to federal statutes and regulations.* Also, the practice must maintain one unified policy for all patients as to the protocol for missed appointments.

Patient compliance is one of the greatest challenges for Medicaid dental practices. Missed appointments, transportation constraints, work and caregiving conflicts, lack of treatment adherence, and limited health literacy create inefficiencies and lost revenue. A sustainable practice addresses these barriers systematically. Transportation and logistics assistance may be something the state Medicaid program or the managed care organization offers. Practices may ask patients coming to their office if they have reliable transportation to the appointment to help facilitate a linkage between the transportation company or MCO. Many practices have found ways to utilize motivational interviewing to help build trust, understanding, and in return improved appointment retention.

MCOs are required to provide translation services at no cost to the beneficiary, including oral interpretation and written translation of important materials, for individual with limited English proficiency or communication needs. Other [interpretation services](#) can help develop strong communication and trust between your staff and patients. Including regular review of your print and electronic materials will help [make health literacy part of your practice](#).

In all efforts, it is essential to reframe attendance to the necessity to have a dental home, and as a shared commitment to oral health. Compassion, patience, and the ability to actively listen will support Medicaid beneficiaries and alleviate practical barriers before they lead to disengagement.

HEAR IT FROM YOUR DENTAL COLLEAGUES...ABOUT EFFICIENCY AND SCHEDULING

“We do what we can to accommodate same day treatment on a patient's exam day. This bumps production significantly. We also have a robust confirmation system. More than any of that, my front office team works hard to get to know the families and treat them as our own extended family. That level of trust helps us to minimize failed appointments which is the biggest killer of production.”

— Dentist from Missouri

“Have a strict no-show policy- one no-show or two cancellations within 24hrs of their appointment, and they are "same-day" or "walk-in" only.”

— Dentist from Illinois

Here are seven key steps to improving operational scheduling efficiency:

- 1. Design efficient schedules:** Build scheduling systems around predictable administrative needs, including eligibility verification, benefit verification, and prior authorization status. Set up scheduling templates that can maximize chair use for your patients. Incorporate layered patient reminders, maintain a standby list, and adopt a consistent no-show policy to maximize chair-time utilizations without compromising patient care. Some dental practice owners or leaders may suggest double or triple booking Medicaid beneficiaries. While some dentists may be comfortable with this workload, many dentists have suggested that this frequently leads to burnout and job dissatisfaction.
- 2. Leverage the full dental team:** Ensure all team members work at the top of their license, training, or skill. Expanded utilization of allied personnel, where permitted by law, preserves dentist time for complex procedures and improves overall productivity.
- 3. Incorporating teledentistry into your practice:** Check with your state Medicaid program to see if it reimburses for any teledentistry modality. Offer to partner with community-based programs that can help you provide access to care while receiving reimbursement when there is an opening in your schedule.
- 4. Frequently review your exact no-show rate:** Practices have as small as 4% in their no-show rates, even among Medicaid beneficiaries, ultimately because they are frequently reviewing their no-show rate and engaging in improvement activities. These activities can include scheduling improvements, more reminders or stringent enforcement of their no-show policies.
- 5. Conduct structured morning huddles:** Begin each day with a team review of all patients, confirming appointment status, identifying required documentation or prior authorizations, discussing treatment complexity, outstanding needs or history of diversion, and addressing any risk factors for missed visits. This prevents delays, reduces documentation errors, and promotes shared accountability across the team. Having an individual designated as the Medicaid Coordinator can help improve efficiencies. Incorporating a checklist that includes eligibility and prior authorizations, required forms, and appointment confirmation, with the designated individual signing their initials in your electronic health record can ensure accountability and improve practice operations.
- 6. Minimize scheduling whole families into blocks:** While some families may prefer to do multiple's family members' dental visits all in one day, this can be detrimental to a dental practice if a family does not show for the appointment and leads to multiple hour vacancies in your schedule. If transportation is a factor, offer to connect them with the MCO transportation hotline, if available, or the direct number for the non-emergency transportation company that has been approved by Medicaid.
- 7. Engage patients with compassion and clarity:** Communicate the value of appointments, use clear and consistent messaging about attendance expectations, and provide alternatives when barriers arise. While Medicaid regulations prohibit charging missed-appointment fees, practices can foster accountability through education, accessibility, consistent follow-up, or limited

appointment options (such as same-day or waiting list) for those who consistently break or cancel appointments.

By implementing these, practices protect their operational efficiencies which will ensure continuity of care, preserve reimbursement reliability, and promote long-term viability of Medicaid participation.

Quick Win	Run a monthly no-show report to understand your practice's exact no-show rate, and work with your front desk to minimize no-shows across all payer types.
Patient Impact	Offering empathy and solutions, patients will feel respected, supported, and valued, rather than judged, which will strengthen trust in their dental home, improve adherence to future visits and treatment completion, and promotes better long-term oral health outcomes.

Patient - Payer Mix and Other Revenue Strategies: Balancing Mission and Margin

Policies and sudden changes of coverage within Medicaid can potentially create losses that are difficult to recoup in the short term. Dentists have reported successfully participating in Medicaid with a mix of anywhere between 2% - 50% of a practice's patient mix having Medicaid, and this will be dependent on your state's fee schedule or MCO reimbursements for dental services. In a survey of 83 dentists in private general or pediatric dental practices, the average share of patients having Medicaid was 24%, and the most commonly cited percentage of Medicaid beneficiaries in the patient mix was 20% (Source: Internal ADA Survey).

Understanding annual limits and non-covered services in Medicaid are important and will be listed in the state Medicaid agency's provider manual or the MCO's dentist manual. As many as 12 states have annual dollars limits for the pediatric dental benefit, and even more states have annual or biannual dollar limit. While most treatments are covered for the pediatric population through the Early Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit, there are some limitations on orthodontics for children that vary by state. Non-covered services can often be found in a state's adult dental Medicaid benefit and greatly vary by state. For example, many state Medicaid programs do not cover topical application of fluoride for adults, and a few states with an adult dental benefit do not provide coverage for dentures.

A Medicaid-inclusive practice can remain financially stable by also balancing the procedure mix, managing chair-time, and offering the full portfolio of all non-covered services and preventive services offered by the dentists. Federal law prohibits Medicaid beneficiaries being balance billed for covered services, and dentists should expect to write off the difference between the practice's charge and what Medicaid/MCO reimburses. However – Medicaid beneficiaries may have unique circumstances (i.e., a small line of credit or help from a family member) that still allow them to pay full fee for non-covered services.

Service diversification should be evidence-based and transparent for patients. Clear, written estimates for non-covered services and straightforward in-office payment options reduce confusion and help patients make informed decisions. It is also important for the administrative or operations team to ascertain before a patient's appointment if they have visited a dentist within the last year – as many Medicaid programs will not reimburse for cleanings, comprehensive oral exams, or bitewing x-rays within the same year. States also have varying fee schedules that may underpay or incentivize prevention – and it is important to check the rates for these particular services closely.

To reduce wait time and revenue losses, it is best practice to schedule initial visits for patients with dentists instead of dental hygienists. Creating initial visits (in 15–20-minute blocks) as staggered appointments for x-rays and limited/comprehensive oral exam for an hour with a dentist and dental assistant(s) can yield better results and return as opposed to scheduling an initial visit with a dental hygienist. If the patient requires treatment, a dentist can then immediately have them scheduled for their next appointment, develop a treatment plan, and submit prior authorizations. This will allow the patient to be treated by a dentist in a faster time frame and allow individuals to later join the hygiene schedule and schedule dental recall visits. When considering implementing such strategy, practices should ensure it aligns with the dentist's professional philosophy and complies with all applicable state regulations.

Continued oversight of revenue, production, and other key operational performance metrics will drive operational decisions, like addition of a team member, that support a sustainable and financially healthy practice. Balancing commercial insurance and cash-pay patients will also stabilize revenue. For further information, you can download the [ADA's Guidelines for Practice Success: Managing Finances](#).

HEAR IT FROM YOUR DENTAL COLLEAGUES ... ABOUT FEES, COVERED SERVICES

“Look at the fee schedule first and ensure that it is at least in line with what other PPO plans you take pay, understand non-covered services and how to present them to patients. [Familiarize yourself] with how Medicaid wants you to present non-covered services ... Give them their options whether the service is covered or not.”

— *Dentist from Utah*

“Train your team - this is likely a new patient group with different needs than what your team is used to... The more you have your team bought into this change, the better the experience for the patient and the whole team, decide your metrics. Are you only going to take referred patients? Are you going to limit to a certain percentage? Another metric? Like any other business venture, it is important not to over-extend and ruin the experience for yourself, your team, and your patients. The more prepared you are to take on your desired metric, the more likely to succeed, Be open. You will hear and experience life through a different lens from your own. Be curious and not judgmental. The more you show your community you are there for them, the more you will build that trust, especially with a group of folks that are not often used to being treated with value.”

— *Dentist from Missouri*

Medicaid Financial Sustainability Toolkit

An operational guide for dentists

Here are four key steps to optimize reimbursement:

- 1. Understand your patient mix:** Understand the percentages of Medicaid, commercial, and cash-pay patients that may make up your patient mix.
- 2. Monitor and adjust patient-payer mix:** Review patient-payer mix monthly with administrative and operations staff and do so when a new dentist joins the team. You can often generate a report or query on this mix through your electronic dental record or practice management software. If the Medicaid volume exceeds sustainable levels, adjust scheduling protocols or market to new patients of a different payor to rebalance schedule templates while maintaining access for vulnerable populations and ensuring your internal protocols do not create further disparities. Contrary to popular belief, you are able to tell your state Medicaid agency or managed care organizations that you are at capacity for accepting new patients from Medicaid. However, you cannot deny access to some Medicaid beneficiaries while selecting some Medicaid beneficiaries to become patients who you believe will acclimate to your practice—this may violate your contract with managed care organizations and federal law.
- 3. Diversify services transparently:** Offer all evidence-based services that complement Medicaid-covered care, whether these be preventive or non-covered services. Provide clear written estimates and consent forms outlining the patients' responsibility for non-covered services. Offer several payment options that may help patients make informed decisions. You can use [this fee schedule to negotiate your fees with MCOs](#) and define production and revenue goals that align with your practices' financial stability.
- 4. Check on preventive care rates, then customize initial visits and recall systems:** After understanding rates, build optimal schedules around initial visits and risk-based recall interval.

By implementing these strategies, practices protect their revenue strategy without compromising mission, patient safety, and promote long-term viability of Medicaid participation.

Quick Win	Select your benchmark for how many Medicaid beneficiaries will make up your payer mix and schedule a meeting with your administrative or operations team after the first month or quarter to ensure your team is not exceeding the benchmark.
Patient Impact	Diversified revenue allows practices to continue serving Medicaid beneficiaries without compromising financial viability.

Reimbursement Optimization: Documentation, Claims, and Prior Authorizations

Reimbursement challenges are among the most significant barriers faced by Medicaid dentists. Denied claims not only delay payment but also increase administrative burden and reduce staff morale. Practices that consistently submit clean claims, submit accurate CDT codes and required narratives/documentation, and maintain denial logs recover significantly more revenue.

Medicaid claims can be paid promptly and consistently, just like private insurance, when clinical documentation and submission processes match program expectations. Practices should institute a standard that includes eligibility verification at scheduling and again day-of, coding accuracy aligned to the current [CDT manual](#), and mandatory inclusion of narratives and radiographical/clinical evidence for procedures commonly denied without documentation.

Denial management should be a measured, data-driven function. Practices should maintain a denial log, review trends monthly or quarterly, and update pre-submission requirements when patterns emerge. Commitment by the entire team to improve claims processing through improving identified roadblocks, like labeling tooth numbers on an intraoral camera picture, strengthen results. Developing templates for appeals that cite the clinical notes, additional documentation, and the medical necessity with attached clearly labeled supporting evidence will improve the success rate. Referencing your state Medicaid agency manual and MCO(s) provider handbook will also improve prompt claim payment.

Medical necessity in dentistry refers to the professional determination that a dental service or procedure is essential to prevent, diagnose, or treat a dental disease, injury, or condition that affects a patient's oral or overall health. For Medicaid claims, this means the treatment must be justified as more than cosmetic and must address a functional or health-related need, such as relieving pain, eliminating infection, restoring normal chewing or speech, or preventing significant deterioration of oral structures. Documentation is critical; dentists must provide clear clinical notes, diagnostic findings, and supporting evidence (such as X-rays or periodontal charts) to demonstrate that the service meets Medicaid's criteria for coverage. In many states, this may require the dentist to also document [corresponding ICD-10 codes](#).

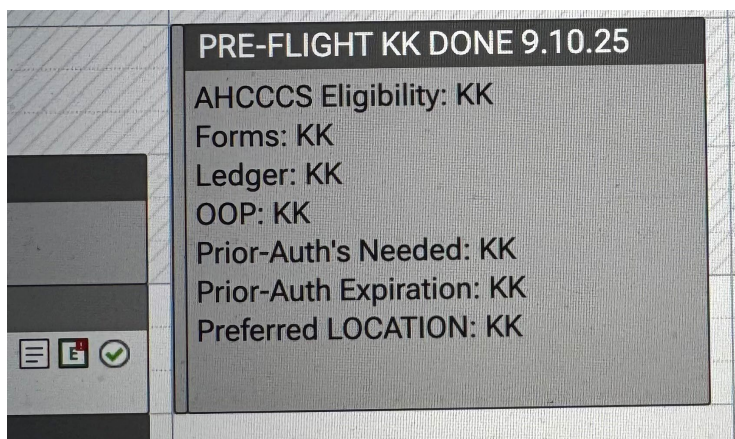
Checking your provider manual around medical necessity is crucial because some states mandate a medical necessity statement or narrative on every claim beyond preventive care. Others only require it when the procedure is outside standard frequency limits, requires prior authorization, or is typically considered elective/cosmetic. Narratives or statements should not be vague (i.e. "needed for oral health") and should include a concise but specific narrative in the claim explaining why the procedure is medically necessary. Without adequate proof of medical necessity, Medicaid may deny or recoup payment even if the procedure was performed appropriately.

While commercial dental plans may support "predetermination" -- an assessment of benefit availability on the date of such determination with no guarantee of payment, many states Medicaid agencies require "prior authorization" -- an assessment of medical necessity with a guarantee of payment. Adhering to prior authorization guidance and participating in modernization will ensure the patient's eligibility for services and subsequent claim payment. As a reminder, a Medicaid beneficiary cannot be charged for a covered service, and in the instance of a non-covered service, a practice standard of having the patient sign a consent form is a best practice. The ADA has created a [Medicaid Provider Resource: Strategies to Reduce Denials and Improve Efficiency](#) which outlines more detailed opportunities for a practice to incorporate standardizations.

Medicaid Financial Sustainability Toolkit

An operational guide for dentists

Whether you plan on implementing a morning huddle or not, designating an individual in your practice can improve efficiencies. Incorporating a checklist that includes eligibility and prior authorizations, required forms, and appointment confirmation, with the designated individual signing their initials in your electronic health record can ensure accountability and improve practice operations.



Source: A clinic in Arizona

Note: AHCCS = Arizona Health Care Cost Containment System [AZ's Medicaid Program], OOP = Out of Pocket Payment

While this example above is specific to one practice, you may utilize your dental electronic health record (EHR) to model this checklist to improve pre-appointment planning preparations and efficiencies.

Beyond the strategies discussed in this section, these additional tactics will maximize payment or improve payment timeliness include:

- Train staff on annual CDT updates or changes made by the state Medicaid program (i.e., changes to the state Medicaid provider manual or MCO provider handbook and the required narratives). This will help support standardized protocols for clinical notes and documentation.
- Submit claims electronically with required documentation (i.e., x-rays, intraoral images, clinical notes, medical necessity, etc.) and diagnostic codes, if applicable.
- Use standardized appeal templates that cite payer policy and clinical justification

HEAR IT FROM YOUR DENTAL COLLEAGUES ... ABOUT NAVIGATING DOCUMENTATION, PRIOR AUTHORIZATION, AND DENIAL

“Form a relationship with caring champion (or provider representative) inside the Medicaid entity [or MCO] who can give you direction and have a network of resources who understand how to navigate the space.”

— *Dentist from Massachusetts*

Medicaid Financial Sustainability Toolkit

An operational guide for dentists

Here are six key steps to optimize reimbursement:

- 1. Develop clean claim workflow:** Eligibility Verified → Treatment Plan or Preventive Visits Review with Patient → Patient Scheduled → Eligibility Verified → Services Rendered → Accurate Documentation and Clinical Notes Attached → Claim Submitted → Payment/Denial Logged → Appeal (if necessary)
- 2. Understand the pathway:** Reimbursement depends on alignment with state Medicaid program rules at every level – CMS established federal requirements, state Medicaid agencies set program-specific guidelines such as non-covered services and potentially included MCO(s) administer day-to-day operations and set their own fees and billing requirements. Dentists should ensure their documentation and billing practices are consistent throughout the pathway.
- 3. Maintain a documentation binder:** Just as credentialing requires organized records, reimbursement success requires a central repository for claims-related essentials: CDT coding updates, payer specific requirements, clinic notes and documentation, radiographic or clinical requirements, prior authorization forms, and sample appeal template.
- 4. Create a claims/denial tracker:** Tracking prior authorizations, denials, and outstanding claims can decrease delay in payment. In creating a tracker, list the patient, date of service, CDT code(s), claim submission date, denial reason (if applicable), action taken, resolution, resolution date, and additional notes. Analyze trends of frequent claim denials to help develop a centralized solution for similar claims to move forward in the pipeline in the future.
- 5. Assign responsibility:** A staff member could serve as the Medicaid Claims or Reimbursement Coordinator to oversee claim submission, denial logging, and appeals. This individual should also serve as the practice's main contact with MCO representatives and stay informed of policy updates.
- 6. Follow-up and confirmation:** Always secure of claim receipt (at any level), prior authorization status, and appeal determinations. Documenting payer correspondence protects the practice in case of disputes and prevents unresolved revenue loss.

By implementing these, practices protect reimbursement reliability, maintain uninterrupted access for Medicaid beneficiaries, and reduce administrative strain that often discourages dentist participation.

Quick Win	Assign a “Reimbursement Champion” on staff to monitor claims, oversee denials, lead appeals, and monitor trends to offer changes in practice protocols and standardizations.
Patient Impact	Accurate and timely claims prevent billing disputes which helps ensure patient satisfaction, dentist and staff morale, and financial success.

Risk Management and Quality Assurance

Medicaid participation should be embedded within the practice's overall framework for quality and risk management. This requires standardization of informed consent, post-operative instructions, documentation of medical necessity, and incident report. Clinical protocols must be aligned with evidence-based guidelines, and dentists should be routinely calibrated to reduce variability that leads to denials, retreatment, or inconsistent outcomes. Quarterly chart review of Medicaid cases should be prioritized to confirm that documentation, coding, and narratives meet payer expectations and reflect current clinical standards.

Quality assurance (QA) in dentistry encompasses the systematic processes that ensure care consistently meets professional, regulatory, and payer standards. QA functions on two levels:

- Clinically, it safeguards safety, enforces adherence to evidence-based practice, calibrates dentists, and monitors outcomes.
- Administratively, it secures accurate documentation, ensures compliance with payer requirements, and incorporates regular internal audits of records and workflows.

For Medicaid-inclusive practices, QA is especially critical because reimbursement is directly tied to documentation, accuracy, coding precision, and evidence of medical necessity. Integrating QA into daily operation through chart audits, staff training, continuing education, incident tracking, and policy updates reduces denials, enhances patient safety, and demonstrates accountability to patients and peers.

This extends beyond error prevention. It represents a culture of continuous improvement, compliance, patient-centered care. This culture sustains Medicaid participation, strengthens program integrity, and builds patient trust by ensuring that beneficiaries receive safe, effective, and equitable treatment.

HEAR IT FROM YOUR DENTAL COLLEAGUES ... ABOUT MITIGATING RISK AND IMPROVING PATIENT-CENTERED CARE.

“Make sure you document, code for what you do and support it with diagnostic films, treat all patients equally (don't label them by their form of payment).”

— *Dentist from Arizona*

Here are four key steps to prioritize quality assurance:

1. **Standardize documentation:** Use consistent templates for informed consent, medical necessity, narratives, and post-operative instructions.
2. **Conduct regular audits:** Review a sample of Medicaid charts quarterly to verify coding accuracy, documentation completeness, and alignment with payer requirements.
3. **Calibrate dentists and staff:** Hold periodic case reviews and clinical calibration sessions to reduce variability and ensure consistency across the dental team.

4. **Train and update staff:** Provide ongoing training on payer policies, compliances requirements, and changes in Medicaid guidelines to minimize errors and denials. This could be mentioned at a morning huddle.

By implementing these practices, dental teams strengthen quality assurance systems, safeguard compliance, reduce preventable denials, and promote sustainable Medicaid participation while maintaining patient safety and trust.

Quick Win	Implement a quarterly “Medicaid Quality Check” by auditing five randomly selected charts for documentation and coding accuracy. Share results with the team at a staff meeting to highlight strengths and correct areas of improvement.
Patient Impact	Strong QA practices ensure accurate, safe, and consistent care. Patients benefit from fewer delays, improved trust, and confidence that their treatment is both clinically sound and properly supported for Medicaid coverage.

Advocacy and Policy Engagement: Practice Data to Policy Impact

Medicaid reimbursement, policies, and administrative rules are determined at the state and payer level. Medicaid dentists can help influence change by engaging in targeted advocacy efforts through their state dental association and/or oral health coalition.

Practical advocacy actions for dentists includes:

- Participate in state Dental Advisory Committee(s) to provide input on coverage and administrative barriers.
- Submit practice-level de-identified data (denials, prior authorizations delays, reimbursement companions) to advisory committees and policy makers to support legislative efforts.
- Maintain a one-page summary of Medicaid practice data and why you serve these patients will support both advocacy and payer negotiations. It highlights trends and reinforces the dentist perspective.
- Ask patients (with written and informed consent) if you can share their stories about how the Medicaid dental benefit has improved their lives with state government officials.
- Participate in your state dental association/society’s advocacy day.
- Contacting the State Medicaid Agency or MCO if there are continual issues with a patient’s non-emergency medical transportation benefit.

HEAR IT FROM YOUR DENTAL COLLEAGUES ... ABOUT ADVOCACY.

“Keep a running list of concerns/issues that need change or improvement and get involved with all other dentists in the state [through your dental society] to organize and schedule a conversation with state Medicaid agency to show them that you are a good resource for them to improve and thus gain more providers in broader coverage of the state.”

— *Dentist from Nebraska*

The ADA continues to support efforts to reduce administrative burden and make reimbursement more adequate and predictable. Utilizing the [ADA's State Medicaid Advocacy Toolkit](#), submitting dentist or patients' testimonies into the [ADA's StoryBank](#), and engaging with the state dental association will only enhance advocacy efforts. More information can be found at [ADA.org/Medicaid](#) and [ADA.org/MedicaidResources](#).

While there are not always quick wins in advocacy – what might be small, meaningful changes can help improve the system at large for both the dentists and patients. For example:

- In 2025, West Virginia lawmakers extended their \$1,000 annual limit to \$2,000 every two years so that Medicaid beneficiaries would have dentures fully covered.
- In 2025, Wisconsin lawmakers recently passed a funding increase for dental services to individuals with intellectual or developmental disabilities. This means these services will be paid at a significantly higher Medicaid reimbursement rate, which could help broaden access for this population.
- In 2024, Nebraska lawmakers removed their annual monetary limits on dental services in Medicaid while the State Medicaid Agency is moving towards centralized credentialing among multiple MCOs.

This list is not fully inclusive of all recent advocacy victories around Medicaid dental services, but it does demonstrate that creating avenues for small change may have larger buy-in and still make meaningful difference in access and experiences for patients.

Appendix I: Checklist for States' Adoption of State Toolkit

While this toolkit can help provide general strategies, ultimately each practice will need to make decisions and better understand their workflow based on state-specific items that can only be found with a state Medicaid agency or applicable MCOs. While not fully inclusive, here are some items that may be considered when creating a state-specific toolkit.

- State FFS Fee Schedule
- Treatment Coverage for State (List of Qualifying Procedures w/Limitations)
- Provider handbook for Medicaid & MCO(s) provider manual(s) hyperlinked
- Credentialing/Enrollment Webpage and Best Contact (in case they have one or two reliable people to use)
- State Contacts for Non-Emergency Transportation
- Resource list of physicians and other healthcare providers who accept Medicaid to aid in facilitating referrals

Appendix II: Glossary of Terms

CAQH System – [*Council for Affordable Quality Healthcare Credentialing System*](#): a centralized database that gathers essential data like education, work history, and licenses to facilitate credentialing and network management with payers and dentists.

CHIP – *Children's Health Insurance Program*: a joint federal-state program similar to Medicaid that provides low-cost health coverage to children and pregnant women in families that earn too much money to qualify for Medicaid.

CMS – *Centers for Medicaid & Medicare Services*: the federal agency that provides health coverage to more than 160 million Americans through Medicare, Medicaid, the Children's Health Insurance Program, and the Health Insurance Marketplace.

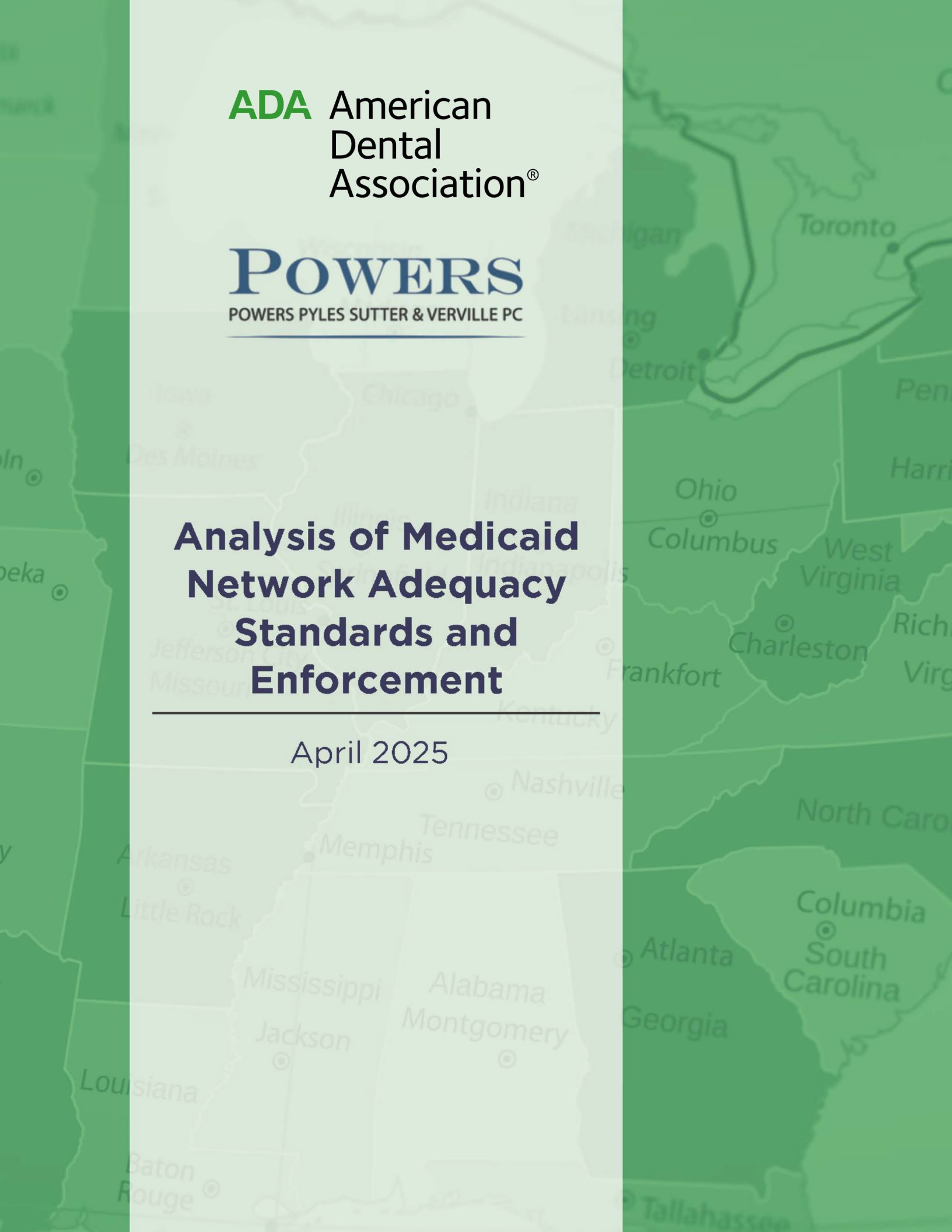
EPSDT – [*Early and Periodic Screening, Diagnostic, and Treatment Services*](#): a comprehensive package of Medicaid services for children and youth under age 21 that provides necessary preventive, diagnostic, and treatment services to identify and correct health conditions early, ensuring children receive the care they need, even for services, such as dental, not covered by a state's standard Medicaid plan.

MCO – *Managed Care Organization*: a healthcare plan that coordinates and delivers healthcare services on behalf of Medicaid beneficiaries by contracting with a network of providers. MCOs are the predominant delivery system for state Medicaid programs, and delivers tiered networks similarly to Health Maintenance Organizations (HMOs) and Preferred Provider Organizations (PPOs).

Analysis and Recommendations for Medicaid Network Adequacy Standards and Enforcement

September 2025

This report was commissioned by the American Dental Association (ADA) to support assessment of the Centers for Medicare & Medicaid Services' (CMS) enforcement of network adequacy standards in Medicaid dental programs.

A faint, green-tinted map of the Eastern United States serves as the background for the entire page. It shows state boundaries and major cities. States visible include Michigan, Ohio, West Virginia, Kentucky, Tennessee, Mississippi, Alabama, Georgia, South Carolina, North Carolina, and Virginia. Cities labeled include Toronto, Detroit, Lansing, Chicago, Des Moines, Columbus, Charleston, Frankfort, Nashville, Memphis, Little Rock, Jackson, Montgomery, Atlanta, Columbia, and Tallahassee.

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Analysis of Medicaid Network Adequacy Standards and Enforcement

April 2025

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Executive Summary

Federal and state governments share statutory and regulatory authority over Medicaid network adequacy, although historically, enforcement has almost exclusively been left to the states. This has resulted in a significant state patchwork approach to both the management and enforcement of Medicaid network adequacy with lack of transparency for dentists, patients and other stakeholders. **The Centers for Medicare and Medicaid Services' regulatory history between differing Administrations shows there is little consensus over what network adequacy means in practice, how to assess it, and how to enforce standards.**

This report reviews the broad federal statutory and regulatory framework for network adequacy for Medicaid Managed Care Organizations (MCOs) and more recent efforts to regulate fee-for-service Medicaid programs and establish far more transparency for providers and patients. It assesses state efforts to comply with loose federal requirements and to set and monitor state-imposed requirements. **In the absence of strong measurable standards, Medicaid network adequacy has largely been dictated by how the managed care organizations (MCOs) have interpreted regulatory terms and responded to federal and state quantitative requirements. This presents a challenge for federal regulators to assess and enforce state compliance and for states to police themselves.**

This report identifies policy recommendations for consideration on ways to enhance and/or enforce Medicaid network adequacy requirements and dental network adequacy, specifically:

- **Ensure Any Willing Dental Provider Can Participate in Medicaid with Reasonable Contract Terms:** Model after Medicare statute and rules that seek to ensure convenient access standard requirements are in place and that payer contract terms for dentists are reasonable, including reasonable reimbursement. Provide data to demonstrate benchmarks for setting reasonable dental payment rates that can help to attract dentist network participation.
- **Encourage Rural Dental Residency and Other Incentive-Focused Programs to Address Dentist Deserts:** Explore whether programs that provide enhanced payments to other providers for serving in rural and underserved communities can serve as a model to enhance dental network adequacy.
- **Adopt Transparent Metrics:** Encourage states to publish annual reports on provider participation and reimbursement rates as some states have begun to do and as 2024 federal rules envisioned. Such information should be reported by states and made available and accessible on the CMS website. Encourage a different standard for comparing FFS dental rates, given the lack of Medicare coverage and payment for dental services.
- **Enforce Rewards and/or Penalties to Address MCO/PAHP Compliance/Noncompliance:** Support implementation of final 2024 federal rule requirements that establish remedy plans for MCOs. Encourage state legislation that sets benchmarks for dental network participation and establishes rewards for plans that meet requirements and imposes fines on plans that are not compliant.

Introduction

In the Medicaid program there are federal and state rules that set parameters around network adequacy in an effort to ensure that Medicaid beneficiaries have timely access to services, including dental care. **For many years, federal statute and rules governing the Medicaid Managed Care Program have outlined a “general expectation” of what network adequacy is supposed to mean. However, the authority for overseeing and enforcing the rules around network adequacy has long been left to the states and largely without any federal interference.** New Medicaid rules finalized in 2024 sought to take a much more proactive federal step into the oversight and enforcement of Medicaid network adequacy, with implications for both managed care plans and fee-for-service Medicaid programs, but whether those rules will be rescinded under a new administration remains unclear. This report provides an overview of the historical and current regulatory framework for dental network adequacy within Medicaid MCOs and Medicaid FFS programs and identifies policy reforms and options that can support dentists and dental stakeholders in working toward Medicaid dental network adequacy improvements.

Study Approach

To consider federal and state Medicaid dental network adequacy requirements, the authors first assessed all federal government requirements for network adequacy in Medicaid plans. The authors reviewed federal laws, regulations, and subregulatory guidance as well as federally-required state reports submitted on state Medicaid network adequacy activities. Federal regulatory review focused on regulations and guidance issued by the federal government over the last ten years (2015-2025). Included in the review was an assessment of Centers for Medicare and Medicaid Services-approved Medicaid waivers and amendments and memorandum concerning state correspondence on network adequacy, and dental network adequacy specifically.

A significant research review was conducted for each of the 50 states and the District of Columbia, including an assessment of state Medicaid regulations that address network adequacy requirements, state government agency memos, reports, and any corrective action plans (CAPs) for addressing network adequacy concerns in relation to dental access. Included was a review of the research conducted by the Medicaid and CHIP Payment and Access Commission (MACPAC), National Conference of State Legislatures (NCSL), national think tanks, policy foundations and others on federal and state actions to address Medicaid dental network adequacy requirements. We undertook an effort to outline each state’s dental Medicaid arrangement to understand which states administer their Medicaid pediatric dental benefit and any adult dental benefits on a fee-for-service (FFS) basis; through a comprehensive managed care benefit with a managed care organization(s) (MCOs) with carved in or carved out dental benefits; through dental-only Pre-Paid Ambulatory Health Plans (PAHPs); through a combination of FFS-MCO(s), FFS-PAHP(s), MCO-PAHP(s); or any of these options with the support of a Dental Benefit Manager, Dental Administrative Service Officer or a similar dental administrative entity.

Background

I. Overview of the Medicaid Act (42 U.S.C. § 1396a(30)(A))

Network adequacy standards for the provision of services under Medicaid (42 U.S.C. § 1396a(a)(30)(A)) were passed as part of the Medicaid Act¹ in 1965 and require state Medicaid plans to “provide . . . methods and procedures . . . as may be necessary . . . to assure that payments . . . are sufficient to enlist enough providers so that *care and services* are available under the plan at least to the extent that such care and services are available to the general population in the geographic area.”² In other words, this section requires state Medicaid plans to have processes in place to evaluate and ensure that there are sufficient available providers under a Medicaid plan in a particular geographic area at least to the extent available to other people. It’s important to note that **federal Medicaid regulations do not explicitly require states to directly compare their network adequacy standards to commercial, employer, or exchange plans when assessing compliance with the statutory requirement to ensure care availability comparable to the general population. However, the regulatory framework creates indirect mechanisms that could involve such comparisons through broader access monitoring requirements encouraged or required by the Centers for Medicare and Medicaid Services (CMS) or states themselves.** Under 2016 regulatory requirements, “the State agency must have in effect a monitoring system for all managed care programs (emphasis added). The State’s system must address all aspects of the managed care program, including the performance of each MCO, Prepaid Inpatient Health Plan (PIHP), Prepaid Ambulatory Health Plan (PAHP), and Primary Care Case Management (PCCM) entity (if applicable) in at least the following areas...Availability and accessibility of services, including network adequacy standards.” **While not explicitly requiring network adequacy comparisons, this rule could be amended directly or through CMS guidelines to support a framework where states could analyze geographic distribution of providers serving Medicaid in comparison to exchange markets or commercial populations.**

In its current form, the very broad statutory directive for Medicaid network adequacy has led to great flexibility in the ability for the federal government and state governments to define what is meant by network adequacy through regulation. Regulations implementing the statute have shifted considerably over time, with significant differences in approach depending on the Presidential Administration in office, their policy priorities and philosophies regarding federal engagement and oversight over Medicaid.

Is There Any Relationship Between Federal Medicaid Network Adequacy Requirements and Federal Health Professional Shortage Areas?

Federal Medicaid network adequacy standards and federal Health Professional Shortage Area (HPSA) designations represent two distinct but related approaches to addressing healthcare access challenges.

¹ Section 1902(a)(30) of the Social Security Act (42 U.S.C. 1396a(a)(30)).

² 42 U.S.C. § 1396a(a)(30)(A).

Both frameworks aim to identify areas with provider shortages and ensure access to care for vulnerable populations, and both use quantitative measures, such as provider-to-population ratios, though with different methodologies and thresholds. However, there is no clear direct integration between these two regulatory frameworks.

- Network adequacy requirements ensure health plans maintain sufficient provider networks that allow patients to access covered services without unreasonable delay. These requirements typically include quantitative standards such as provider-to-enrollee ratios, time and distance standards, and appointment wait times.
- Health Professional Shortage Areas (HPSAs) are federally designated areas with insufficient healthcare providers to meet the needs of the population. As of March 2025, there are 7,054 dental HPSA designations covering nearly 60 million Americans.³

Several factors limit the usefulness of HPSAs as a direct basis for broadly setting or supporting network adequacy standards. Specifically, according to MACPAC, “the pervasive use of [HPSA/Medically Underserved Area-MUA] designations limits the usefulness of MUAs and HPSAs as a tool for targeting high-need areas. The majority of the United States has received some sort of HRSA designation.” That said, **as some states seek to identify policy options for improving dental access and meeting network adequacy requirements, they may want to consider model efforts in Medicare:**

- **Medicare pays a 10% quarterly bonus to physicians who provide services in primary care HPSAs and psychiatrists practicing in mental health HPSAs.**⁴

What is the Responsibility of State Medicaid Agencies and CMS for Meeting These Requirements?

The responsibility for carrying out the requirements of 42 U.S.C. § 1396a(30)(A) is primarily delegated to each state in constructing its state plan.⁵ As demonstrated throughout the analysis that follows, there has been considerable deference to states to develop and enforce network adequacy standards.

CMS, however, has exerted oversight of Medicaid network adequacy by referencing its authority over other provisions of the Social Security Act, Section 1932(b)(5) and (c)(1)(A)(i) [42 U.S.C. § 1396u-2(b)(5) and (c)(1)(A)(i)] and Section 1902(a)(4) [42 U.S.C. § 1396a(a)(4)].⁶

- Section 1932(b)(5) requires MCOs to “provide the State and the Secretary [of HHS] with adequate assurances,” as determined by the Secretary, that the MCO “offers an appropriate range of services and access to preventive and primary care services,” and

³ Bureau of Health Workforce, Health Resources and Services Administration; Designated Health Professional Shortage Areas Statistics. March 31, 2025.

⁴ MLN Learning Network, Centers for Medicare and Medicaid Services; Health Professional Shortage Area Physician Bonus Program. February 2021.

⁵ See 42 U.S.C. § 1396(a)(30)(A).

⁶ See Proposed Rule, Medicaid and Children's Health Insurance Program (CHIP) Programs; Medicaid Managed Care, CHIP Delivered in Managed Care, and Revisions Related to Third Party Liability, 80 Fed. Reg. 31098, 31144 (June 1, 2015) (“2015 Proposed Rule”).

“maintains a sufficient number, mix, and geographic distribution of providers of services.”⁷

- Section 1932(c)(1)(A)(i) requires states to develop a “quality assessment and improvement strategy” which provides that “covered services are available within reasonable timeframes and in a manner that ensures continuity of care and adequate primary care and specialized services capacity.”⁸ Such improvement strategy is required to be consistent with standards developed by the Secretary.⁹
- Section 1902(a)(4) requires state Medicaid plans to include “methods of administration... as are found by the Secretary to be necessary for the proper and efficient operation of the plan.”¹⁰

Medicaid Managed Care Versus Fee-for-Service: Disparity in Regulatory Specificity for Network Adequacy

The question of whether federal Medicaid dental network adequacy standards apply to both FFS and managed care delivery systems (of any form) requires a nuanced analysis of regulatory frameworks, historical policy shifts, and rule interpretations over the years. **While managed care plans have been subject to explicit federal network adequacy requirements for years, FFS programs have operated under a distinct set of access assurance mechanisms—a dichotomy that has begun to change course with new regulations finalized in 2024, setting first-time requirements for FFS Medicaid programs.**

Historically, dental Medicaid benefits have been delivered through both FFS and a variety of different MCOs or types of MCOs, with states having flexibility in how they structure their dental benefits, including carve-in, carve-out models.¹¹ States have considerable flexibility in how they structure their dental benefits, with some states having FFS dental systems within a Medicaid managed care medical delivery system. Some states provide dental services through a dental-only PAHP, a non-comprehensive prepaid limited health plan that provides only certain outpatient services. Other state FFS programs and/or state MCOs will subsequently contract with a Dental Benefits Manager to support the administration and management of the dental Medicaid program.

⁷ 42 U.S.C. § 1396u-2(b)(5).

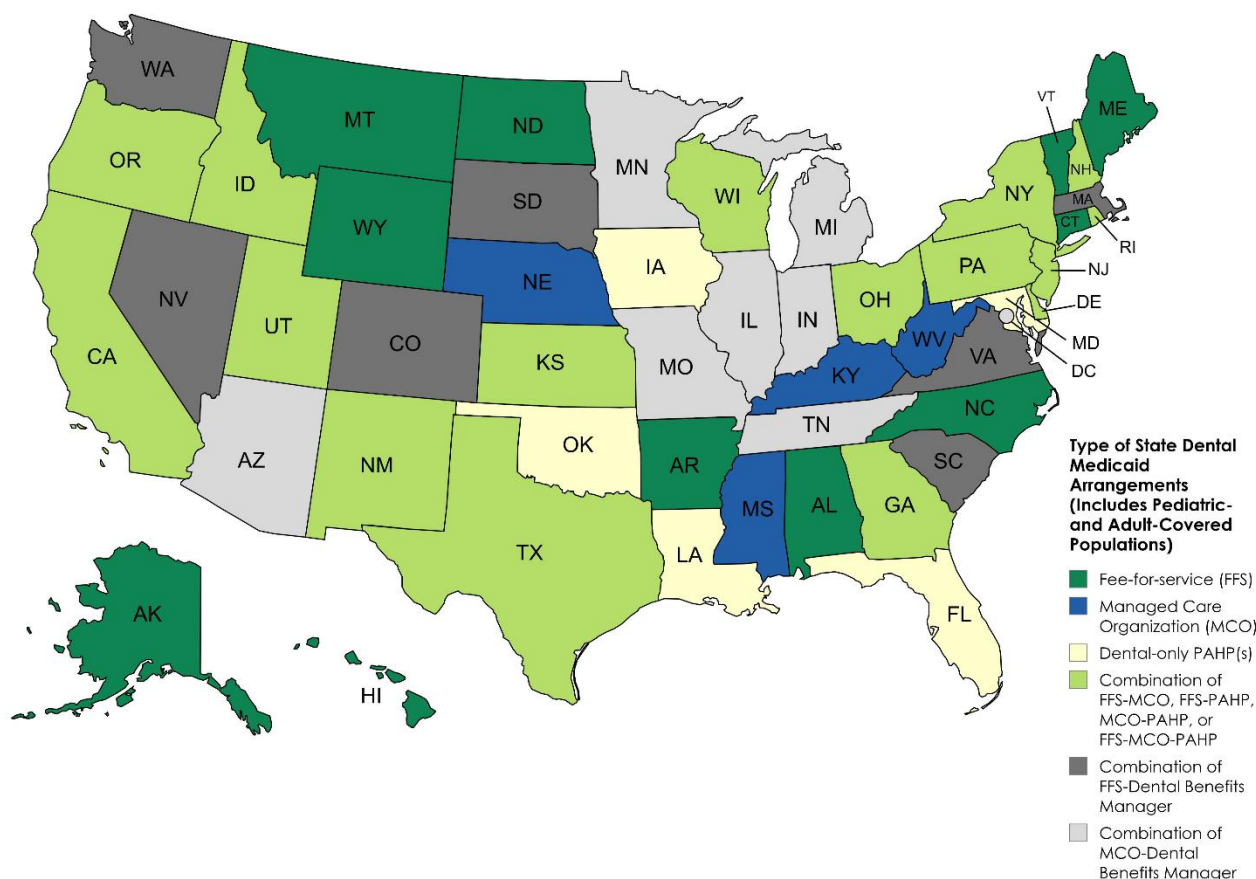
⁸ 42 U.S.C. § 1396u-2(c)(1)(A)(i).

⁹ 42 U.S.C. § 1396u-2(c)(1)(B).

¹⁰ 42 U.S.C. § 1396a(a)(4).

¹¹ National Conference of State Legislatures, [Medicaid Managed Care 101](https://www.ncsl.org/health/medicaid-managed-care-101), (Sept. 21 2023), <https://www.ncsl.org/health/medicaid-managed-care-101>.

Breakdown of State Dental Medicaid Arrangements



Network adequacy requirements under Medicaid managed care are detailed with much more specificity than under FFS Medicaid. Implementing regulations for managed care¹² provide further detail on what is required of states to meet this network adequacy statutory directive. These standards are intended to apply universally to managed care entities that are contracting with states. In contrast, Medicaid FFS programs have historically operated without formal network adequacy requirements, relying only on the broader "equal access" provisions available in statute under 42 U.S.C. § 1396a(a)(30)(A). States are required to ensure payments sufficient to enlist enough providers but faced minimal specificity regarding provider distribution or availability metrics.¹³ **Inherent statutory flexibility has permitted significant variability in state network adequacy standards, with some states conducting sporadic access reviews while others relied on compliance-driven oversight.**¹⁴

It is important to understand that despite the statute requiring that access in Medicaid MCOs be at least as similar to other people's access (presumably as similar as those who are covered under another insurer), 42 U.S.C. § 1396a(a)(30)(A) directs the states to ensure

¹² 42 C.F.R. § 438.68.

¹³ Ensuring Access to Medicaid Services—A Guide for States to the Fee-For-Service Provisions of the Final Rule, CMS (2024).

¹⁴ California Health Care Foundation, Network Adequacy Standards in California: How They Work and Why They Matter (Dec. 2021), <https://www.chcf.org/wp-content/uploads/2021/12/NetworkAdequacyStandardsHowTheyWorkWhyTheyMatter.pdf>.

that network adequacy requirements are met, rather than CMS. CMS exerts discretionary rulemaking authority, but primary authority pertaining to adherence to the statute rests with the states. CMS has discretionarily regulated in this space via its power to approve state plan and state plan amendments, demonstration projects and waivers, and review of state expenditures for compliance with Medicaid law.

What Are the Requirements of 42 U.S.C. § 1396a(a)(30)(A) of the Medicaid Act as It Relates to Network Adequacy and its Implementing Regulations?

Changing Administrations, Changing Priorities: A Timeline of Key Network Adequacy Developments

2015-2016: Obama Administration Establishes Network Adequacy Regulations

Greater oversight of network adequacy in Medicaid began with the Obama administration with two proposed rules, one related to managed care, released in June of 2015¹⁵ and finalized in May of 2016,¹⁶ and one related to fee-for-service finalized in 2015 and related to proposals first published in 2011.¹⁷

In the 2016 rule, the administration sought to align requirements governing Medicaid managed care with those governing qualified health plans and Medicare Advantage plans.¹⁸ A major priority of the administration was to determine a state's readiness to implement and sustain managed care programs, which it determined network adequacy was a primary component of. The managed care rulemaking¹⁹ constitutes the primary regulations governing Medicaid managed care network adequacy to this day. The Obama administration stated that these changes were intended to "maintain state flexibility while modernizing the current regulatory framework to reflect the maturity and prevalence of Medicaid managed care delivery systems, promoting processes for ensuring access to care, and aligning, where feasible, with other private and public health care coverage programs."²⁰ Prior to 2016, Medicaid network adequacy standards were deferred to each state to develop specific standards. CMS relied heavily on attestations and certifications from states about the adequacy of their network.

In the 2015 rule, CMS sought to enable states to transparently "document whether Medicaid payments are sufficient to enlist providers to assure beneficiary access to covered care and services consistent with section 1902(a)(30)(A)."²¹ This rule implemented standards that were proposed in 2011, but never finalized. In this final rule, CMS emphasized that it aimed to provide "increased state flexibility within a framework to document measures supporting beneficiary

¹⁵ Proposed Rule, Medicaid and Children's Health Insurance Program (CHIP) Programs; Medicaid Managed Care, CHIP Delivered in Managed Care, and Revisions Related to Third Party Liability, 80 Fed. Reg. 31098 (June 1, 2015) ("2015 Proposed Rule").

¹⁶ Final Rule, Medicaid and Children's Health Insurance Program (CHIP) Programs; Medicaid Managed Care, CHIP Delivered in Managed Care, and Revisions Related to Third Party Liability, 81 Fed. Reg. 27498, 27498 (May 6, 2016) ("2016 Final Rule").

¹⁷ Final Rule, Medicaid Program; Methods for Assuring Access to Covered Medicaid Services, 80 Fed. Reg. 67576 (Nov. 2, 2015) ("2015 Final Rule").

¹⁸ 2016 Final Rule at 27498.

¹⁹ 42 C.F.R. § 438.68.

²⁰ *Id.*

²¹ 2015 Final Rule at 67576.

access to services.”²² **Rather than setting nationwide standards, which the agency stated would be difficult given “limitations on data, local variations in service delivery, beneficiary needs, and provider practice roles,” CMS prioritized federal guidelines that would establish a framework for states to document beneficiary access to services.**

Time and Distance Standards

The regulations finalized in 2016 required states to establish “time and distance” standards for Medicaid MCO plans. The regulations do not specify detailed time and distance standards but instead defer to each state to develop specific standards for themselves.²³ In the rule, CMS described “the primary role of states in Medicaid” in articulating its reasoning for this approach. The agency stated that this approach was also consistent with existing requirements for Marketplace plans and qualified health plans.²⁴ The agency required each state to establish time and distance standards for services including primary care, OB/GYN, behavioral health, specialist, hospital, pharmacy, pediatric dental, and additional discretionary provider types. The agency stated that time and distance standards were “a more accurate measure of the enrollee’s ability to have timely access to covered services than provider-to-enrollee ratios.”²⁵ In developing standards, CMS suggested that states look to standards established for the private insurance market, including standards set under the Medicare Advantage program, as well as historical utilization patterns for accessing services.

During the open comment period on the proposed rule, some stakeholders requested that states be required to implement more network adequacy measures in addition to time and distance, such as “enrollee ratios, appointment and office wait times, and beneficiary complaint tracking.”²⁶ However, CMS declined to do so, stating that “states are in the best position to set specific quantitative standards that reflect the scope of their programs, the populations served, and the unique demographics and characteristics of each state.”²⁷ **The agency, at the time, also opined that it would be inappropriate to import Medicare Advantage network adequacy requirements into Medicaid managed care because of the greater level of discretion granted to the states under Medicaid.**

State Monitoring Standards

The 2015 and 2016 rules strengthened state monitoring standards, requiring state Medicaid agencies to create access monitoring review plans²⁸ that considered beneficiary needs, the availability of care through enrolled providers in each geographic area by provider type and service, changes in utilization in each geographic area, the characteristics of the beneficiary population, and actual or estimated levels of provider payment from other payers.²⁹ States were required to develop the Access Monitoring Review Plan (AMRP) in consultation with the state’s Medical Care Advisory Committee (MCAC), were required to have the plan approved by CMS,

²² 2015 Final Rule at 67577.

²³ 2016 Final Rule at 27658.

²⁴ *Id.* at 27658.

²⁵ *Id.*

²⁶ *Id.* at 27661.

²⁷ *Id.* at 27515.

²⁸ 42 C.F.R. § 438.66.

²⁹ 2015 Final Rule at 67611.

and had to make the plan available for public review and comment at least 30 days prior to its finalization. Additionally, when access to care issues were identified through AMRPs, states were required to take remediation efforts, the specifics of which were left up to the state. This could include “modifying payment rates; improving outreach to providers; reducing barriers to provider enrollment; and improving care coordination,” among other strategies. States are required to review this access information for “primary care services,” which CMS specifies includes dental care.

The 2016 rule required states to use data collected from monitoring activities to improve managed care performance, and specified minimum activities that states must implement in conducting monitoring, including: enrollment and disenrollment trends in each MCO, PIHP, or PAHP; provider grievance and appeal logs; and an annual quality improvement plan for each MCO, PIHP, PAHP, or PCCM entity.³⁰ State monitoring programs were required to include minimum elements including: provider network management, including provider directory standards; quality improvement; and availability and accessibility of services, including network adequacy standards.

CMS also required states to provide an annual program assessment of managed care plans, including “[m]odifications to, and implementation of, MCO, PIHP, or PAHP benefits covered under the contract with the State,” and the “availability and accessibility of covered services . . . including network adequacy standards,” in addition to other requirements.³¹ The rule also required states to assess the “readiness” of each MCO, PIHP, PAHP, or PCCM it intends to contract with. Some commenters requested that states provide quarterly updates to providers, consumers, and stakeholder groups, however, CMS declined to do so, stating that this was “too prescriptive” and that the annual managed care program assessment was sufficient.³² Some commenters also requested that CMS require states to establish specific standards for monitoring program elements, including network adequacy standards, but CMS did not adopt this recommendation, emphasizing the importance of state flexibility.³³

Finally, related to network adequacy in Medicaid managed care, the 2016 final rule established a Medicaid managed care quality rating system (QRS)³⁴ “to increase transparency[,] . . . increase consumer and stakeholder engagement, and enable beneficiaries to consider quality when choosing a managed care plan.”³⁵

During this rule making process, CMS also published a Request for Information (RFI) seeking input regarding the future development of access standards in Medicaid.³⁶ CMS expressed interest in specifically developing “core access to care measures” that could be utilized across both FFS and managed care, setting national access to care thresholds, and creating a process for beneficiaries experiencing access issues to seek resolution.³⁷ CMS asked specific questions

³⁰ 2016 Final Rule at 27717.

³¹ *Id.* at 27717.

³² *Id.* at 27718-19.

³³ *Id.* at 27719.

³⁴ 42 C.F.R. § 438.334

³⁵ 2015 Final Rule at 27686.

³⁶ Medicaid Program; Request for Information (RFI)-Data Metrics and Alternative Processes for Access to Care in the Medicaid Program, 80 Fed. Reg. 67377 (Nov. 2, 2015).

³⁷ *Id.* at 67379.

pertaining to access to care data collection and methodology, processes for access concerns, access to care measures, measures for the availability of care and providers, measures for beneficiary reported access, measures regarding service utilization, and comparison of payments.³⁸ Of particular note, pertaining to beneficiary access, CMS asked for stakeholder comment on “unmet need for . . . dental . . . due to cost concerns” and pertaining to service utilization, asked for rates of utilization for dental services.³⁹ No further action was taken on this RFI.

2018-2020: Trump Administration Scales Back Obama-Era Network Adequacy Requirements

In 2018 and 2019, the Trump administration took a considerably different approach to network adequacy than the Obama administration, releasing two proposed rules^{40 41} that would have relaxed requirements pertaining to access monitoring review plans, but these rules were never finalized. The rules would have, among other things, provided a reporting exception for states that had a high managed care enrollment and an exception where the state engages in “nominal” payment rate changes below four percent. It also would have removed the requirement that states submit an analysis where there is a change in payment rates that affects access and instead would require an attestation of sufficient access.⁴² CMS reasoned that the current data being collected had “limited usefulness due to many uncertainties inherent to such analyses.”⁴³

In 2020, the Trump administration issued a new rule intended to allow states maximum discretion in establishing network adequacy requirements. CMS modified the Medicaid managed care network adequacy standards at 42 C.F.R. § 438.68, changing the standard from a “time and distance” requirement to a general “quantitative requirement,” as determined by each state. CMS stated that it believed it best not to be overly prescriptive in setting standards after receiving concerns from states that a uniform time and distance standard was not the most effective type of standard for determining network adequacy. Instead, the quantitative standard was intended to be a more flexible requirement.

Quantitative Standards

Examples of quantitative standards that states could use under the 2020 rule (but were not required to use) included: provider-to-enrollee ratios; travel time or distance; percentage of contracted providers accepting new patients; wait times; hours of operation; or a combination of such standards.⁴⁴ The agency also removed its discretionary ability to choose other providers that could become subject to network adequacy requirements, noting that “states

³⁸ *Id.* at 67379.

³⁹ *Id.* at 67379.

⁴⁰ Medicaid Program; Methods for Assuring Access to Covered Medicaid Services-Exemptions for States With High Managed Care Penetration Rates and Rate Reduction Threshold, 83 Fed. Reg. 12696 (Mar. 23, 2018).

⁴¹ Proposed Rule, Medicaid Program; Methods for Assuring Access to Covered Medicaid Services-Exemptions for States With High Managed Care Penetration Rates and Rate Reduction Threshold 83 Fed. Reg. 12696 (Mar. 23, 2018).

⁴² *Id.* at 12697.

⁴³ Medicaid Program; Methods for Assuring Access to Covered Medicaid Services-Rescission, 84 Fed. Reg. 33722 (July 15, 2019).

⁴⁴ Medicaid Program; Medicaid and Children's Health Insurance Program (CHIP) Managed Care, 85 Fed. Reg. 72754 (Nov. 13, 2020).

have expressed concern that . . . managed care plans may have to assess network adequacy and possibly build network capacity without sufficient time.”⁴⁵

Following release of the proposed rule, many stakeholders offered comments strongly encouraging additional guardrails be set for Medicaid network adequacy review, such as a combination of qualitative and quantitative standards; allowing separate standards for urban and rural areas in a given state; setting up routine monitoring requirements; setting restrictions on use of telehealth to satisfy network adequacy requirements; and other factors.⁴⁶

In the published final rule in 2020, the agency declined to establish further standards or guardrails. CMS repeatedly emphasized its deference to states in determining any specifics, reasoning that it “should defer to states and not set Federal standards as prescriptive as the commenters suggest.”⁴⁷ The agency acknowledged that flexibility could result in widely varied standards being set across states, but it justified such variations given the diversity and complexity of Medicaid managed care programs.⁴⁸

2022-2024: Biden Administration Seeks to Button Up Federal Oversight of Medicaid Network Adequacy; Focuses on Fee-for Service in Addition to MCOs

Beginning in 2022, the Biden administration began efforts to again amend the Medicaid managed care network adequacy provisions, steering standards in an entirely different direction and reversing course from the Trump administration’s decision to provide states broad general discretion over these standards.

In February of 2022, the Biden administration first signaled an interest in establishing more stringent federal oversight requirements of Medicaid network adequacy with its release of a RFI concerning *Access to Coverage and Care in Medicaid & CHIP*.⁴⁹ The stated goals of the RFI included: reaching people who are eligible under Medicaid and CHIP; providing consistent coverage; ensuring timely, high-quality, and appropriate care; improving access to data to “measure, monitor, and support improvement efforts related to access to services; and providing sufficient payment rates to enlist and retain providers. Questions pertaining to network adequacy in the RFI included:

- What priorities should be focused on if CMS develops minimum standards for Medicaid and CHIP programs related to access to services? Should standards be at the national level, state level, or both? How should standards differ by delivery system, value-based payment arrangements, geography, and program eligibility, etc.?
- How could CMS monitor states’ performance against any minimum standards?
- In what ways can CMS support states to increase and diversify the pool of available providers for Medicaid and CHIP?
- What should CMS consider when developing an access monitoring approach that is as similar as possible across Medicaid and CHIP delivery systems?

⁴⁵ *Id.* at 72802.

⁴⁶ *Id.* at 72803.

⁴⁷ *Id.* at 72803.

⁴⁸ *Id.* at 72803.

⁴⁹ Centers for Medicare and Medicaid Services. Request for Information: Access to Coverage and Care in Medicaid & CHIP (Feb. 2022), <https://www.medicaid.gov/medicaid/access-care/downloads/access-rfi-2022-questions.pdf>.

- What measures of potential access (care availability) should CMS consider as most important to directly monitor and encourage states to monitor (e.g., provider networks, appointment wait times, grievances and appeals, etc.)?

First Expansion of Regulations - Seeking to Modernize Network Adequacy Standards, Oversight and Enforcement

In May 2023, the Biden administration released two proposed rules, the *Ensuring Access to Medicaid Services Rule* (“Access” Rule)⁵⁰ and the *Managed Care Access, Finance and Quality Rule* (“Managed Care” Rule),⁵¹ responding to many of the recommendations offered by stakeholders through the RFI issued in 2022. Together, the rules aimed—for the first time—to address access to care in Medicaid across both FFS and MCO delivery systems and authorities. The Access Rule primarily addressed a couple relevant areas of interest to dental Medicaid network adequacy including: documentation of access to care and service payment rates and the establishment of new stakeholder and enrollee advisory committees. The Managed Care Rule primarily addressed many relevant regulatory areas of interest to dental Medicaid managed care: network adequacy; state directed payments; medical loss ratio standards; data and payment transparency; and beneficiary engagement.

Access Rule

New Medicaid Advisory Committee and Beneficiary Advisory Council⁵²

Medicaid regulations have long required states to operate “Medical Care Advisory Committees” (MCACs) to allow for stakeholder feedback on Medicaid operations and concerns. The Access Rule fundamentally changed the MCAC structure, renaming the Committee to the “Medicaid Advisory Committee” (MAC) and creating a second entity, the “Beneficiary Advisory Council” (BAC), to allow Medicaid beneficiaries to directly engage state Medicaid agencies, with overlap in membership between the two councils. The MAC membership must include: a consumer advocacy organization, a provider group, a managed care entity, and another relevant state agency (the state agency is in a non-voting role). The rule requires MACs and BACs to meet at least quarterly and the MAC to hold at least one public meeting each year. BACs can choose whether their meetings are public. Assessing Medicaid network adequacy in FFS and MCO plans is expected to be an area of focus for both councils.

Takes Effect: Stood up by July 9, 2025, allowing for membership in the MAC to be built out over three years (2028) to allow for sufficient beneficiary representation on the MAC.

Experience Surveys⁵³

Historically, state Medicaid agencies are to consider needed access improvements from agency or MCO surveys, but they have never been required to perform surveys. Under the new rules,

⁵⁰ Proposed Rule, Medicaid Program; Ensuring Access to Medicaid Services, 88 Fed. Reg. 27960, 27998 (May 3, 2023).

⁵¹ Proposed Rule, Medicaid Program; Medicaid and Children's Health Insurance Program (CHIP) Managed Care Access, Finance, and Quality, 88 Fed. Reg. 28092 (May 3, 2023) (“2023 Proposed Rule”) (“Managed Care Rule”).

⁵² 42 C.F.R. § 431.12.

⁵³ 42 C.F.R. §§ 438.66(b)(4) and (c)(5), 457.1230.

state Medicaid agencies must conduct an annual enrollee experience survey and act on its findings to make any recommended improvements. States can opt to have External Quality Review Organizations (EQROs) conduct these surveys.

The final rules state that survey results must also be included in the required Medicaid and CHIP Annual Program Report (MCPAR) that state Medicaid programs must submit to CMS annually.

Takes Effect: For contract rating periods beginning after July 9, 2027.

Managed Care Rule

Network Adequacy

*Provider Directories*⁵⁴

Federal law already required MCOs to make provider directories available to enrollees and to update the directories regularly; however, out of concern for “ghost networks,” listing providers no longer in network, Congress sought to codify protections,⁵⁵ and the final rule implements these protections and expands directory requirements. The final rule provides more explicit terms on what providers must be included, the information that must be in the directory, and the necessity of updating the directory to ensure its accuracy. The directory must provide information for the following types of providers: physicians, hospitals, pharmacies, behavioral health providers, and any additional providers the state has opted to include for its wait time standards (which could include dentists). In addition to the provider’s location information, the directories must also include whether the provider will accept new enrollees. Each MCO will be required to make its directory available in searchable electronic form; and indicate whether the provider offers covered services via telehealth. CMS issued a State Health Official Letter⁵⁶, explaining provider directory requirements.

Takes Effect: July 1, 2025 and must have provider directories on state websites beginning July 1, 2026.

*Wait Time Standards*⁵⁷

States are required to develop and enforce appointment wait time standards for four service types: adult and pediatric outpatient mental health and substance use disorder treatment; adult and pediatric primary care; obstetrics and gynecology; and an additional type of service to be determined by the state. While dental was not included in the first categories as a federal requirement, states have the discretion to include dental as the fourth category. CMS stated that the purpose of allowing discretion for the fourth category was to give states the opportunity to use an appointment wait time standard to address an access challenge being faced in their local market.

⁵⁴ 42 C.F.R. § 438.10(h).

⁵⁵ Consolidated Appropriations Act of 2023, H.R. 2617, 117th Cong. § 5123 (2023).

⁵⁶ Letter to State Health Official from CMS (July 16, 2024), <https://www.medicaid.gov/federal-policy-guidance/downloads/sho24003.pdf>.

⁵⁷ 42 C.F.R. §§ 438.68(e), 457.1218.

As prospective benchmarks for services, the rulemaking established a maximum national wait time of 15 days for routine primary care and OB/GYN care and 10 days for outpatient mental health and substance use disorder treatment.

Takes Effect: Contract rating periods beginning on or after July 9, 2027.

*Secret Shopper Surveys*⁵⁸

The rule requires a first-time federal requirement for “secret shopper” surveys for the purpose of assessing managed care plan compliance with the rules’ wait time requirement and the provider directory requirement. Managed care plans are required to demonstrate a 90 percent minimum compliance rate. States must contract with an independent entity not affiliated with the state Medicaid office or the MCO being surveyed. Surveys must include all areas of the state served by the MCO and must be statistically significant when assessing wait times. Survey results must be reported by the states to CMS and made available through the state Medicaid website 30 days after submission.

Takes Effect: Contract rating periods beginning on or after July 9, 2028.

*Remedy Plans*⁵⁹

Before this final rule (2024), CMS regulations required that state Medicaid agencies submit Corrective Action Plans (CAPs) to address the network adequacy/access deficiencies they identify in FFS programs, but there was no such corrective action requirement required for Medicaid MCOs. The 2024 rules recognize that to ensure MCO compliance with network adequacy standards, enforcement requirements are necessary. The Managed Care Rule establishes *remedy plans*. If a state Medicaid agency or CMS identifies an area where a MCO can improve access to care and meeting network adequacy requirements, the state Medicaid agency must submit a remedy plan to CMS for approval within 90 days of awareness of the issues of concern, outlining how the issues identified will be addressed within a period of 12 months. The state agency must submit quarterly updates on the progress of implementation to CMS. CMS can require the state to continue the plan for another 12 months, if problems persist.

Takes Effect: Contract rating periods beginning on or after July 9, 2028.

*State Directed Payments*⁶⁰

State Medicaid agencies are generally prohibited from directing how MCOs, PIHPs, and PAHPs, pay their network providers. However, CMS established a regulatory exception in 2016 to allow states some authority on how managed care plans pay providers. This exception is referred to as “State Directed Payments” (SDPs). Some states have used SDPs to require a minimum or maximum fee schedule, set a uniform payment increase for select providers, or use value-based purchasing, for example. Some states have used SDPs to support access to dental care.⁶¹

⁵⁸ 42 C.F.R. §§ 438.68(f), 457.1218.

⁵⁹ 42 C.F.R. §§ 438.207(f), 457.1230(b).

⁶⁰ 42 C.F.R. §§ 438.6, 438.7, 430.3.

⁶¹ MACPAC, Issue Brief: Directed Payments in Medicaid Managed Care (2023), <https://www.macpac.gov/wp-content/uploads/2023/06/Directed-Payments-in-Medicaid-Managed-Care.pdf>.

Under the final rule, states can require managed care plans to pay providers using Medicare rates. However, the new rule also increases oversight over SDP spending, and as of September 2024, requires states to include Medicare spending data in medical loss ratio (MLR) reporting. It's important to note, however, that this spending data is limited to medical data, as Medicare data does not include dental spending data. States will have to report provider-specific data annually through the Transformed Medicaid Statistical Information System (T-MSIS) and CMS will track which providers are receiving these funds and by what amounts. The rule allows some managed care SDP payments to go as high as the Average Commercial Rate (ACR). Some stakeholders expressed concern that ACR is typically well above Medicaid and Medicare rates, and that this allowance creates misalignment with FFS supplemental payments, which typically are no higher than Medicare payment levels.

Takes Effect: SDP reporting in MLR reports to begin September 9, 2024; SDP payments as high as ACR, contract rating periods beginning on or after July 9, 2024.

Medical Loss Ratio (MLR) Standards⁶²

MLR measures how much of a capitation payment to a plan goes toward providing Medicaid services and improving quality instead of plan costs and profit. Medicaid regulations in effect since 2017 require plans to submit annual MLR reports to states, and states must then submit MLR reports to CMS.⁶³ The new rule clarifies that MLR reports must be provided for each plan under contract with the state. MLR reporting must also be considered in state directed payment (SDP) spending, and provider incentive arrangements and bonus payments must now be considered in the MLR calculation.

Takes Effect: Plan MLR reporting and inclusion of SDPs in MLR reporting began September 9, 2024. Incorporation of provider incentive arrangements and bonus payments in MLR calculations is to begin during contract rating periods after July 9, 2025.

Payment Transparency

The Access and Managed Care Rules make important strides toward significantly improving payment rate transparency to providers/practitioners. States are required to post FFS payment rate schedules, compare Medicaid FFS payment rates to Medicare rates, and report aggregate provider payment rates under managed care compared to what the state would have paid under FFS, among other requirements. These changes, should they go into effect, will most certainly help to inform future payments for dentists and other health care providers.

FFS Rate Transparency⁶⁴

The Access Rule rescinds the state AMRP requirements (from 2015), implementing a new transparent regulatory framework, requiring states to post Medicaid FFS payment rates on a publicly available website, separating out payment rates for adults and children and including

⁶² 42 C.F.R. §§ 438.8, 438.3, 457.1203.

⁶³ See Medicaid and Children's Health Insurance Program (CHIP) Programs; Medicaid Managed Care, CHIP Delivered in Managed Care, and Revisions Related to Third Party Liability, 81 Fed. Reg. 27498 (May 6, 2016).

⁶⁴ 42 C.F.R. § 447.203(b)(1).

any geographic payment differences. Medicaid FFS payment rates must be organized and easily understood, allowing the public to determine the amount Medicaid would pay for a service.

Takes Effect: States no longer have to comply with AMRP rules as of July 9, 2024. States must post FFS payment rates by July 1, 2026.

Both the Access Rule and Managed Care Rule were finalized in 2024;^{65 66} taken together, the rules provide more tools than ever previously in place for holding states and Medicaid MCOs accountable for network adequacy and are intended to provide a new level of transparency to dentists and other practitioners on how the states are addressing network adequacy and access to dental and other services. The challenge, however, is that the rules have a lengthy timeline for implementation, with the regulatory requirements in the rules spread out for implementation from 2024 to 2030, making the rules fully vulnerable to the political whims and decisions of the Trump administration and future administrations, as of January 2025. There is a high likelihood that without advocacy efforts by the dental community and broader provider community, many of the rules could be temporarily or fully rescinded, delayed, and/or altered before the effective dates of the individual regulations.

Key Themes in Federal Network Adequacy Actions

Rulemaking Under Different Administrations Speaks to Different Philosophies About Medicaid Network Adequacy, Its Importance, and Its Oversight and Enforcement

The evolution of Medicaid network adequacy requirements across the last three presidential administrations reflects differences in philosophies and policy priorities when it comes to Medicaid network adequacy. The Obama administration prioritized standardization of Medicaid network adequacy, looking to establish requirements similar to Medicare Advantage and marketplace plans, and using those structures to inform new requirements for Medicaid Managed Care plans. While the Obama administration remained mostly deferential to state authority over Medicaid matters, it sought to establish a federal floor that required states to establish time and distance minimums to confirm efforts to meet federal Medicaid network adequacy statutory requirements.

The Trump I administration, consistent with its priorities of deregulation, dismantled the regulations put in place by the Obama administration to establish federal Medicaid minimum network adequacy requirements. The Trump administration's flexible "quantitative" standard allowed for states to implement Medicaid network adequacy standards that could encompass any measure, whether that be time and distance, provider-ratios, or other measures of adequacy.

The Biden administration then worked to return to and expand upon the work started by the Obama administration and go further to standardize measurement of Medicaid network adequacy in an effort to improve access to care. For the first time, the administration sought to equalize FFS and MCO payments and access, applying transparency requirements and addressing payments to providers. The components of the final rules issued by the administration merit

⁶⁵ Final Rule, Medicaid Program; Medicaid and Children's Health Insurance Program (CHIP) Managed Care Access, Finance, and Quality, 89 Fed. Reg. 41002, 41012 (May 10, 2024) ("2024 Final Rule") ("Managed Care Rule").

⁶⁶ *Id.*; Final Rule, Medicaid Program; Ensuring Access to Medicaid Services, 89 Fed. Reg. 40542, 40685 (May 10, 2024).

close review and consideration for how they can directly support improvements in dental Medicaid network adequacy.

The current Trump administration is expected to put a hold on these Biden rules and alter or eliminate them. The Administration has taken an even more aggressive stance toward deregulation during this Trump term, with an executive action that would require ten regulations to be rescinded for every new regulation.⁶⁷ It is likely that parts of the Biden regulations will be altered, delayed or rescinded consistent with the Trump administration's past (and current) state-centric position regarding Medicaid network adequacy.

What is the Responsibility of State Medicaid Agencies, CMS, and Other Entities for Meeting These Requirements?

Network Adequacy Enforcement Mechanisms

There are distinct differences in how Medicaid dental network adequacy is enforced within Medicaid managed care and Medicaid fee-for-service arrangements. Medicaid managed care plan violations of network adequacy requirements are typically contract-based. States often impose contractual penalties for managed care plan network deficiencies, such as financial sanctions through reductions or claw backs in capitation payments, mandatory out-of-network coverage at in-network cost sharing, and enrollment freezes for repeated violations. FFS programs do not typically have visible CAPs.

42 C.F.R. § 438.68: Network Adequacy Standards

42 C.F.R. § 438.68 is the primary regulation governing network adequacy for Medicaid managed care plans. These regulations provide greater clarity on what is required by states rather than by CMS to ensure the network adequacy requirements under section 1396a(a)(30)(A). Specifically, 42 C.F.R. § 438.68(b)(1) requires a state to develop a “quantitative network adequacy standard” for a defined provider list. This provider list includes “pediatric dental” providers.⁶⁸ States are required to publish their network adequacy standards on their websites.⁶⁹ States are required to comply with the following requirements in developing network adequacy standards:

Geographic Requirements

States are required to have network standards for “all geographic areas covered by the managed care program.” However, states have latitude to vary standards between geographic areas for a provider type.

Required Elements

Network adequacy standards must include, at a minimum, the following elements:

- (a) Anticipated Medicaid enrollment
- (b) Expected utilization of services

⁶⁷ Fact Sheet: President Donald J. Trump Launches Massive 10-to-1 Deregulation Initiative, The White House (Jan. 31, 2025), <https://www.whitehouse.gov/fact-sheets/2025/01/fact-sheet-president-donald-j-trump-launches-massive-10-to-1-deregulation-initiative>.

⁶⁸ 42 C.F.R. § 438(b)(1).

⁶⁹ 42 C.F.R. § 438(g).

- (c) Characteristics and health care needs of specific Medicaid populations covered
- (d) Numbers and types (in terms of training, experience, and specialization) of network providers required to furnish the contracted Medicaid services
- (e) The number of network providers who are not accepting new Medicaid patients
- (f) The geographic location of network providers and Medicaid enrollees, considering distance, travel time, the means of transportation ordinarily used by Medicaid enrollees
- (g) The ability of network providers to communicate with limited English proficient enrollees in their preferred language
- (h) The ability of network providers to ensure physical access, reasonable accommodations, culturally competent communications, and accessible equipment for Medicaid enrollees with physical or mental disabilities
- (i) The availability of triage lines or screening systems, as well as the use of telemedicine, e-visits, and/or other evolving and innovative technological solutions.

In developing network adequacy standards, states must also consider elements that would support an enrollee's choice of provider, strategies to ensure the health, welfare, and community integration of enrollees, and other considerations that are in the best interest of enrollees that require long-term services and support.

Wait Time Standards

States are required to establish and enforce wait time standards to ensure enrollees have access to timely care. Regulations specify specific wait time minimums that must be followed for certain "routine appointments" including outpatient mental health and substance use disorder services, primary care services, and obstetrics and gynecological services.⁷⁰ Such set minimums are not established for pediatric dental services. However, states have latitude to establish wait time standards for additional services of their choosing, so long as the standards are "chosen in an evidence-based manner."⁷¹ Additionally, CMS also has the authority to establish wait time services for additional services after "consulting with States and other interested parties" and offering opportunity for notice and comment.⁷²

Provider Directories

Plans are required to have provider directories for outpatient mental health and substance use disorder, primary care, and obstetrics and gynecology providers.⁷³ States must also have provider directories for any additional services that they have chosen to specify wait time standards for as described in the paragraph above. Plans are required to ensure that their provider directories are up to date. Plan provider directories must include the provider's active network status with the plan, the provider's street address and telephone number, and whether the provider is accepting new enrollees.⁷⁴

⁷⁰ 42 C.F.R. § 438(e)(1).

⁷¹ 42 C.F.R. § 438(e)(1).

⁷² 42 C.F.R. § 438(e)(3).

⁷³ 42 C.F.R. § 438(f)(1).

⁷⁴ 42 C.F.R. § 438(f)(1).

Secret Shopper Surveys

To ensure compliance with wait time standards and provider directory requirements, CMS requires states to conduct annual “secret shopper surveys,” which must be administered by an entity independent from the state Medicaid agency and its contracted health plans.⁷⁵ Survey results are then provided to states to facilitate any needed corrections by the plan. In accordance with CMS’s authority to establish wait time standards for additional services, CMS can also require secret shopper surveys to be completed for these additional services.

42 C.F.R. § 438.206: Availability of Services

42 C.F.R. § 438.206 pertains to the general availability of services. It requires states to ensure that “*all services covered under the state plan are available and accessible to all enrollees*” of (MCOs, PIHPs, and PAHPs in a timely manner.⁷⁶ Since the requirements of 42 C.F.R. § 438.206 pertain to “all services covered under the state plan,” these requirements would apply to pediatric dental services, since pediatric dental services are required to be covered under the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) federally-required benefit under Medicaid. Whether these same requirements apply to the adult population depends on the state’s individual coverage policies outside of the mandated EPSDT benefit. 42 C.F.R. § 438.206 requires states to ensure that the plans they contract with:

- (a) Maintain and monitor a network of appropriate providers “sufficient to provide adequate access to all services covered under the contract for all enrollees”
- (b) Provide female enrollees with access to a women’s health specialist
- (c) Allow for a second opinion from a network provider
- (d) Provide for adequate and timely coverage of out of network services when a provider network is unable to provide them
- (e) Ensure that network providers meet credentialing requirements
- (f) Ensure that networks have sufficient family planning services

The regulation also requires states to ensure plans have timely access standards that:

- (a) Comply with applicable state standards
- (b) Provide the same hours of operation as under fee-for-service Medicaid
- (c) Make medically necessary services available 24 hours a day, 7 days a week
- (d) Ensure providers comply with timeliness requirements, and monitor and take corrective action if necessary to assure compliance

42 C.F.R. § 438.207: Adequate Capacity

42 C.F.R. § 438.207 requires states to ensure that plans have “the capacity to serve the expected enrollment” in the area they serve. To ensure adequate capacity, plans must submit documentation to the state which demonstrates, in part, that the plan:

- (a) Offers an appropriate range of preventative, primary care, specialty care, and long-term care services for the number of enrollees

⁷⁵ 42 C.F.R. § 438(f).

⁷⁶ 42 C.F.R. § 206(a).

- (b) Maintains a provider network sufficient in number, mix, and geographic distribution
- (c) Provides a payment analysis to the state that demonstrates the amount paid for certain services including primary, obstetrical and gynecological, mental health, and substance use disorder care

“Primary care” is defined to include services provided by an “other licensed practitioner as authorized by the State Medicaid program.”⁷⁷ Therefore, this regulation would apply to dental care services to the extent that such services are covered under a particular state’s Medicaid program. As stated above, at a minimum, this would include pediatric dental services but could include adult dental services if covered by a state plan.

The state is required to review a plan’s provided documentation and certify compliance with CMS.⁷⁸

42 C.F.R. § 440.262: Cultural Competency

42 C.F.R. § 440.262 requires states to “promote access and delivery of services in a culturally competent manner to all beneficiaries.”⁷⁹ The regulation requires the state to have methods to ensure that all beneficiaries have access to services, regardless of English proficiency, background, disability, or sex.

Conclusion: An Evolving Regulatory Landscape

The regulation of Medicaid network adequacy has followed in the footsteps of requirements first established for Medicare Advantage and Marketplace plans. Federal Medicaid network adequacy standards currently apply primarily to managed care plans through explicit quantitative requirements under 42 CFR § 438.68.

While Medicaid fee-for-service network adequacy is subject to less federal oversight, the 2024 final rules have begun to introduce managed care-style oversight to fee-for-service programs through strategies such as access monitoring and payment transparency mandates. This regulatory convergence reflects CMS’s “comprehensive access strategy” as of 2024, aiming to create parity across delivery systems while respecting the diversity of fee-for-service state Medicaid programs. While the Biden administration expressed interest in continuing the integration of managed-care requirements into the FFS space, such efforts are likely to stall, or even be rescinded, under the Trump administration. The focus of network adequacy oversight at the regulatory level means requirements can be subject to frequent change to fit a given administration’s political priorities, messaging and goals. While the broad statutory directive to ensure that Medicaid beneficiaries are provided the same “care and services” that are available to the general population in a given geographic area, the specifics on how to implement this requirement is expected to continue evolving at both the federal and state levels.

⁷⁷ “Primary care” is defined as “all health care services and laboratory services customarily furnished by or through a general practitioner, family physician, internal medicine physician, obstetrician/gynecologist, pediatrician, or other licensed practitioner as authorized by the State Medicaid program, to the extent the furnishing of those services is legally authorized in the State in which the practitioner furnishes them.” 42 C.F.R. § 438.2.

⁷⁸ 42 C.F.R. § 207(d).

⁷⁹ 42 C.F.R. § 440.262.

II. A Comprehensive Survey of Medicaid Networks for Dental Services

It is important to understand the differences in states that operate their Medicaid programs primarily through fee-for-service vs. primarily through managed care. **The number of states that have a large portion of their beneficiaries in fee-for-service Medicaid has grown smaller over the years, and today, more than two-thirds of all Medicaid beneficiaries receive care through some kind of managed care arrangements.**⁸⁰ States that still rely heavily on fee-for-service for dental include: Alabama, Alaska, Arkansas, Connecticut, Hawaii, Maine, Montana, North Carolina, North Dakota, Vermont, and Wyoming. This represents significant diversity, both geographically and politically. Many states have 90 percent or more of their patients overall (for medical and dental) enrolled in Medicaid managed care. The following states operate dental through managed care arrangements, including PAHPs: Arizona, Florida, Illinois, Indiana, Iowa, Kentucky, Louisiana, Maryland, Michigan, Minnesota, Missouri, Nebraska, Oklahoma, and Tennessee.

Key Divergences in Application: Quantitative vs. Qualitative Standards

While managed care retains explicit numerical (quantitative) requirements that plans must meet, fee-for-service programs tend to adhere to more value-based metrics (qualitative standards). In managed care, plans are held to such standards such as the number of days within which appointments for certain services must be provided; a 90 percent minimum compliance rate for meeting appointment requests; correction of errors identified by secret shopper surveys within three business days; and public posting of results of secret shopper surveys within 30 days of submission to CMS.⁸¹ In FFS, the general statutory requirement states are held to include no such quantifiable minimums. Some states have looked at comparing dental provider participation in Medicaid FFS to that of commercial insurance markets or examining dental access based on secret shopper surveys. Ultimately, in the past absence of federal requirements, state Medicaid FFS programs have had discretion in choosing whether the Medicaid network adequacy standards they establish are qualitative or quantitative.

⁸⁰ *Medicaid Managed Care Tracker*, KFF, <https://www.kff.org/statedata/collection/medicaid-managed-care-tracker>.

⁸¹ 42 C.F.R. § 438.68.

Quantitative Network Adequacy Standards	Descriptors
Time and Distance	Establish an upper limit on how far or for how long enrollees should have to travel to access a provider in their network (measured in miles or average travel time).
Provider-to-Enrollee Ratio	Establishes a minimum ratio for the number of providers available to deliver services to enrollees in a given service area.
Appointment Wait Times	Establish a maximum amount of time an enrollee must be required to wait before accessing care.
Acceptance of New Patients	Establishes a minimum number or percentage of providers willing to accept new patients.

A study by the Medicaid and CHIP Payment and Access Commission (MACPAC) found that most states do not provide specific enforcement mechanisms for failure to meet access standards or report network data.⁸²

Some states with documented monitoring approaches include:

- North Carolina: Requires health plans to submit regular access plans and provider network data to demonstrate network adequacy.
- Texas: Analyzes provider network access for each managed care program quarterly, including conducting geospatial analysis annually to monitor distance standards and applying secret shopper methodology to evaluate timely access standards.
- Maryland and Minnesota: Require MCOs to submit provider network data as part of the contracting process or as a prerequisite to operating networks.

How States Monitor Dental Network Adequacy Compliance

State	Broad Consumer or Provider Surveys	Geo-Mapping	Secret Shopper Surveys
AK			
AL			
AR			
AZ	✓		✓
CA	✓	✓	✓
CO			
CT	✓		✓

⁸² Network Adequacy in Managed Care. MACPAC; July 2018.

DE			
FL			✓
GA			
HI			
IA			
ID	✓		
IL			✓
IN			
KS			✓
KY			✓
LA			✓
MA			✓
MD			✓
ME			✓
MI	✓		✓
MN			
MO		✓	✓
MS		✓	✓
MT			
NC			✓
ND			✓
NE	✓	✓	
NH			✓
NJ			
NM			✓
NV		✓	
NY			✓
OH		✓	✓
OK			
OR		✓	✓
PA			✓
RI			✓
SC			✓
SD			
TN			
TX			✓
UT			✓
VA			
VT		✓	
WA			
WI	✓	✓	
WV			✓
WY			

Which State Medicaid Fee-for-Service and Managed Care Networks Are Not Meeting the “Distance to Provider” Standards, the “Care and Services”⁸³ or Any Other Standards for Dental Services?

The latitude states have in establishing quantitative standards for evaluating network adequacy standards is clearly demonstrated when looking across states. Many states, presumably due to the original 2016 regulations, pursue a “distance to provider” approach, varying the requirements based on geography (e.g., longer distance standards for rural communities). While there are no formal “care and services” standards (see footnote description), states have consistently looked toward other standards, including minimum provider to patient ratios; whether there is access to specialists within the provider of focus (including dental specialists); minimum appointment wait times, which can vary by provider type; and consumer survey experience, which tend to be less objective or actionable.

State Dental Network Adequacy Standards

State	Time & Distance Requirements	Minimum Provider to Patient Ratios	Access to Specialists	Minimum Appointment Wait Times	Consumer Experience Surveys
AK					
AL					
AR					
AZ	✓			✓	
CA	✓	✓		✓	✓
CO	✓				
CT	✓	✓		✓	✓
DE					
FL	✓	✓	✓	✓	
GA	✓			✓	
HI					
IA	✓				
ID	✓			✓	
IL	✓	✓			
IN	✓				
KS	✓			✓	
KY	✓				
LA	✓				
MA	✓	✓		✓	
MD	✓		✓	✓	
ME	✓	✓			

⁸³ While the 2016 Medicaid Network Adequacy Regulations outline “time and distance (distance to provider) standards,” there is no foundational regulation for “care and services” standards. The reference to care and services is included in the broader Medicaid network adequacy statute but was not defined in Medicaid regulations. This report speaks instead to all quantitative standards recommended at the federal level or established at the state level via statute or regulations.

MI	✓	✓		✓	
MN	✓				
MO	✓			✓	
MS	✓			✓	
MT					
NC					
ND					
NE	✓			✓	
NH	✓	✓		✓	
NJ	✓			✓	
NM	✓			✓	
NV	✓				
NY		✓			
OH	✓	✓		✓	
OK					
OR	✓			✓	
PA	✓	✓			
RI	✓				
SC	✓				
SD					
TN	✓			✓	
TX	✓				
UT	✓			✓	
VA	✓			✓	
VT	✓	✓		✓	
WA	✓	✓			
WI	✓	✓		✓	
WV	✓				
WY					

Which State Medicaid Fee-For-Service or Managed Care Networks Have Pursued Improvements in Dental Network Adequacy or Made Strides Toward Compliance with 42 USC 1396a (30)A of the Medicaid Act?

States strive to increase dentist participation in Medicaid networks by implementing initiatives designed to entice participation, and therefore, improve access to oral health providers and services. Innovative strategies have been attempted by states, largely focused on: establishing financial incentives; directly raising Medicaid reimbursement rates; addressing workforce support needs (e.g., loan repayment programs); establishing tax credits; and other strategies.

Financial Incentives

Nearly all states identify low Medicaid reimbursement for dental services as a key barrier to provider participation in Medicaid dental networks. In the absence of adjusting fee schedule

payments across the board, some states have sought to offer incentive payments tied to specific goals and requirements. The following offers state examples of this approach.

- Between 2015-2021, California received a Section 1115 Medicaid Waiver from CMS to implement their “Dental Transformation Initiative (DTI)” with an aim to improve pediatric dental coverage and prevent dental decay. One of the primary components of this waiver was to implement financial incentives for providers to increase “categories of care:” (1) preventive dental services, (2) Caries Risk Assessment (CRA) and management, and (3) continuity of care.

Category 1 providers were paid on a semi-annual basis if they met or exceeded a predetermined increase in preventive services provided to Medi-Cal beneficiaries. The incentive amounts ranged from 37.5% or 75% above the current schedule for maximum allowances based on if the provider met or exceeded the benchmark for each preventive service for children. Category 2 providers were paid an incentive payment if they followed a CRA that was developed under the waiver. Category 3 providers were provided incentive payments if they continued providing dental examinations to enrolled Medi-Cal members for a continuous period.

Results from the waiver indicated improved pediatric preventive service utilization. As a result, California has continued to implement this program since 2022.⁸⁴

Reimbursement Increases

In response to continued calls for reimbursement increases, several states have passed legislation to increase dental reimbursement. In an effort to incentivize Maryland providers to participate in their Medicaid dental program, Healthy Smiles, Maryland approved a 9.4% reimbursement increase for preventative, diagnostic and restorative treatments.⁸⁵ In a similar effort, in 2023 Vermont increased their Medicaid dental provider rates to 75% of the general regional commercial dental rates, an approximate 50% increase in reimbursement to dentists.⁸⁶

Between 2018-2025, 28 states have implemented dentist rate increases at varying levels in Medicaid FFS (excluding MCO data) in an effort to incentivize provider participation in Medicaid: CO, CT, DE, GA, HI, ID, IL, KY, ME, MD, MS, MI, MO, MT, NE, NH, NJ, NY, ND, OK, OR, RI, SD, VT, VA, WA, WY.⁸⁷

Workforce Support - Loan Repayment Programs

Many states incentivize individual participation in Medicaid through state student loan repayment programs. Delaware offers \$100,000 in loan forgiveness to qualified dentists who

⁸⁴ California DHCS, California’s Med0Cal 2020 Demonstration (11-W-00103/9) (2021), <https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/ca-calaim-dental-transform-initiative-prgrm-final-rprt-01012021-12312021.pdf>

⁸⁵ Maryland Department of Health, 2023 Report on Dental Provider Participation in Maryland Healthy Smiles Dental Program (2024), [https://dlslibrary.state.md.us/publications/Exec/MDH/HB290Ch377\(3\)\(2023\).pdf](https://dlslibrary.state.md.us/publications/Exec/MDH/HB290Ch377(3)(2023).pdf)

⁸⁶ Summary of Improved Dental Benefits Effective July 1, 2023, Dep’t of Vermont Health Access, <https://dvha.vermont.gov/providers/dental/summary-improved-dental-benefits-effective-july-1-2023#:~:text=Effective%20July%201%2C%202023%2C%20the,provided%20to%20VT%20Medicaid%20members>

⁸⁷ States Reporting Provider Rate Increases, KFF (2023), <https://www.kff.org/medicaid/state-indicator/states-reporting-provider-rate-increases/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D>

commit a minimum of two consecutive years of full-time service in a health professional shortage area and agree to support a minimum of 20% of patients eligible for Medicaid or CHIP.⁸⁸

Florida's Reimbursement Assistance for Medical Education program awards a maximum of \$250,000 to dentists employed by any eligible public health program that serves Medicaid patients in a dental health professional shortage area or medically underserved community.⁸⁹

Delta Dental of Iowa sponsors a program that offers up to \$125,000 over a five-year period for dentists who work in a priority county, and up to \$200,000 over a five-year period for dentists who work in a high-priority county. In return, each selected dentist agrees to practice in one of Iowa's designated dental shortage areas and to allocate 35% of patient services to underserved populations, including a minimum of 15% Medicaid-insured patients.⁹⁰

Tax Credits

A few states offer income tax credits or bonuses for dentists agreeing to practice in underserved areas where network participation has been limited. The Louisiana Small Town Health Professional Tax Credit provides a nonrefundable tax credit for up to \$3,600 for five years to dentists who establish and maintain a primary office within a federally designated dental area of need that is also in a rural area as defined by the Louisiana Department of Health.⁹¹

Oregon's Rural Practitioner Tax Credit for Dentists Program grants up to \$5,000 in personal income tax credits for dentists working in designated frontier counties with populations less than 5,000 and accept 15% Medicaid patients.⁹²

South Dakota's Recruitment Assistance Program offers incentive payments to dentists that provide services in an eligible community serving Medicaid and CHIP patients for at least three consecutive years with a maximum payment of \$256,204.⁹³

In addition to a loan repayment program, North Carolina awards High Needs Service Bonuses to qualifying dentists without student loans who provide services in eligible facilities serving those with significant oral health care needs. The bonus maximum for a four-year commitment is \$100,000 for dentists and \$60,000 for dental hygienists.⁹⁴

⁸⁸ Delaware State Loan Repayment Program, Delaware.gov, <https://dhss.delaware.gov/dhcc/slrp.html>

⁸⁹ About FRAME, FRAMEworks Portal, <https://www.fdohframe.com/s/>

⁹⁰ FIND Project: Dental Education Loan Repayment, Delta Dental, <https://www.deltadentalia.com/foundation/find/>

⁹¹ WELL-AHEAD, Tax Year 2020: Louisiana Small Town Health Professional Tax Credit Application (2020), https://ldh.la.gov/assets/Wellahead/LA_Small_Town_Health_Professional_Tax_Credit_2020_FAQ.pdf

⁹² Oregon Rural Practitioner Tax Credit for Dentists, Oregon Office of Rural Health, <https://www.ohsu.edu/oregon-office-of-rural-health/oregon-rural-practitioner-tax-credit-dentists>

⁹³ Recruitment Assistance Program (RAP), South Dakota Dep't of Health, <https://doh.sd.gov/healthcare-professionals/rural-health/careers-and-recruiting/recruitment-assistance/rap/>

⁹⁴ Medical, Dental, and Behavioral Health Recruitment and Incentives, NCDHHS, <https://www.ncdhhs.gov/divisions/office-rural-health/office-rural-health-programs/provider-recruitment-and-placement/medical-dental-and-behavioral-health-recruitment-and-incentives>

Other Innovative Programs to Increase Access

Several states have implemented strategies to address dental access needs, focusing on teledentistry, mobile dentistry, and improving provider directories and patient outreach.

Teledentistry

California Medi-Cal implemented Virtual Dental Homes that uses teledentistry to provide dental care in community settings in 2016. Many states including Colorado, Oregon, Idaho, Iowa, Maine, Nevada, Texas, Florida, Minnesota, and New York implemented teledentistry programs, as well.⁹⁵

Provider Directories

Nevada offers an online provider directory and mobile app for Medicaid members to support finding available dentists, and the app includes information on teledentistry options.

Illinois developed an enhanced online provider directory with real-time updates and patient reviews to assist Medicaid members in finding dental care providers.⁹⁶

Appointment Availability Parameters

Several states, including MD, OH and GA now include maximum appointment wait times for dental appointments in their FFS and MCO contracts.

⁹⁵ Adam Lampe et al., Improving Oral Health Using Teledentistry and Virtual Dental Homes: Concepts and Progress, OpenSmiles Collaborative (Mar. 20, 2024), <https://opensmiles.ucsf.edu/news/improving-oral-health-using-teledentistry-and-virtual-dental-homes-concepts-and-progress>; Nevada Medicaid and Nevada Check Up Dental Program Member Handbook (2025), https://www.libertydentalplan.com/Resources/Documents/LDP_NV_Medicaid_Member_Handbook.pdf; <https://dental.metrostate.edu/teledentistry/>; https://www.chwsny.org/wp-content/uploads/2023/05/Theekshana-Teledentistry_6x3_Web.pdf.

⁹⁶ Provider Directory, Il. Dep't of Healthcare and Family Servs., <https://ext2.hfs.illinois.gov/hfsindprovdirectory/Main>

Examples of State Innovations to Improve Dental Medicaid Network Adequacy

State	Innovations
CO	Increased Reimbursement, allocating \$78 million toward Medicaid funding for fiscal year 2024-25 to increase reimbursement rates for dental providers and approving rate adjustments for specific dental codes.
MA	Transportation subsidies provided to support network adequacy.
MD	Telehealth permitted to support network adequacy.
MO	Increased Reimbursement for dental procedures, raising rates to 80% of the 50th percentile. Hired a dental Medicaid facilitator to assist dentists in applying to become providers, answer questions, and provide education about Medicaid.
NE	Increased dental reimbursement rates and removed the \$750 annual cap on dental services for adults enrolled in Medicaid to improve dental care access and allow providers to offer more comprehensive treatment.
NH	Mobile dentistry served 15,000 rural beneficiaries. Mobile dental units count toward network adequacy in counties with less than 50 dentists per 100,000 residents. State utilizes tiered reimbursements, with up to a 15% increase for dentists meeting annual visit thresholds.
NJ	Teledentistry coverage to support 12 rural counties.
VT	Reimbursement increases, benefit cap increases.
MO	Reimbursement rate increases, a dedicated dental Medicaid facilitator to support patient access to a dentist, targeted media campaigns on oral health access.

Financial Penalties

In Louisiana, the state issues \$40,000 penalties for plan failure to maintain adequate dental provider networks.⁹⁷

Other Corrective Actions

In Georgia, the state works extensively with MCOs to ensure plans are meeting network adequacy regulations and contractual obligations. In addition to CAPs, MCOs are required to contact providers practicing in the area and make a contract offer. The state monitors the process and ensures timely action. The state allows the MCO access to a database with all currently credentialed Medicaid dental providers. If MCO actions do not result in a sufficient network, the state requires the plan to include providers outside the network and arrange transportation and/or telehealth services when necessary.

⁹⁷ Louisiana issued sanctions on DentaQuest in 2023 for failure to maintain an adequate provider network.

Examples of State Corrective Action Plans to Address Dental Network Adequacy Requirements

State	Corrective Action Plans
GA	If access falls below the 90% threshold in any county, Care Management Organizations (CMOs) must provide a corrective action plan to address the deficiency. Corrective actions include recruiting additional providers where providers are available, contracting with providers in nearby counties to fill the gaps in access, or coordinating non-emergency transportation services, as necessary, to ensure that members receive care.
NJ	The state mandates quarterly Network Adequacy Reports from MCOs, and reports are reviewed during performance accountability meetings, with deficiencies triggering corrective action plans (CAPs).
MN	If a managed care or county-based purchasing plan has a dental utilization rate that is 10% or more below the performance benchmark, the commissioner requires the MCO to submit a corrective action plan describing how they intend to increase dental utilization.

States that Issued Penalties for Network Adequacy Violations (on any required service):

# of States	Issued Penalties in Past Three Years
10	California, Florida, Illinois, Indiana, Louisiana, Massachusetts, Maryland, Ohio, Oregon, Washington

SOURCE: Annual KFF survey of state Medicaid officials conducted by Health Management Associates, October 2023 and Powers Research. Penalties between 2019-2022.

III. Analysis of CMS and State Enforcement Activities – Dental Network Adequacy

What Activities Has CMS Undertaken to Ensure Full Compliance of the Standards Outlined in 42 USC 1396a (30)A of the Medicaid Act?

Required State Network Adequacy Plans

CMS requires that states demonstrate to them that the plans they contract with both meet the state's requirements for availability of services and provide an analysis that supports the state's certification of each plan's provider network adequacy. As of October 2022, states are required to use a CMS-required standard reporting template.⁹⁸ In its 2024 Final Rule, the Biden administration planned to have CMS make the state Network Adequacy and Access Assurances Reports publicly available on Medicaid.gov.

External Quality Reviews (EQRs)

CMS also requires that states that contract with managed care plans must have a qualified External Quality Review Organization (EQRO) perform an annual quality assessment⁹⁹ on each

⁹⁸ Centers for Medicare and Medicaid Services, Medicaid and CHIP Managed Care Reporting, <https://www.medicaid.gov/medicaid/managed-care/guidance/medicaid-and-chip-managed-care-reporting>.

⁹⁹ 42 C.F.R. § 438.310.

contracted plan to validate network adequacy, among other performance issues, and provide these reports on their website. In February 2023, CMS released updated EQR protocols,¹⁰⁰ mandating network adequacy validation activity and requiring that states and EQROs begin using the new network adequacy validation protocol by February 2024.

Essentially, EQRO's serve an audit role. The strength of that audit has not been seen or tested at this point, given states have only been using the new protocols established since early 2024, and we have a new administration that has not even begun to assess the reports. **When identifying how to potentially strengthen use of this kind of audit tool, however, one opportunity could be to implement a similar quality review/audit process in FFS states. 42 C.F.R. 447.203 provides that “To remedy an access deficiency, CMS may take a compliance action using the procedures described [in] ... this chapter.”¹⁰¹ For example, under the regulations, CMS may withhold payment to states for failure to comply with Federal requirements. This could be another avenue to request CMS to take action, although it would be their right to make that decision since the regulations say they “may” use this enforcement authority, which is not a requirement.**

Managed Care Program Annual Report (MCPAR)

Beginning December 2022, CMS required that states submit MCPARs and that these reports be provided for each Medicaid managed care program in the state and no later than 180 days after the end of a state's contract year.¹⁰² As a result of the differing contract year periods, MCPARs will be received by CMS in different tranches. These reports assess MCO-specific data on: grievances and appeals by type of service; state hearings information; evaluation of individual MCO performance on quality measures for primary care access and preventive care, maternal and perinatal health, behavioral health, and other types of services, often including dental; MLRs for each MCO; and any sanctions or corrective action plans imposed on each MCO and the reasons for each intervention. The Biden administration established a page on the Medicaid.gov website for the MCPARs to be publicly available following CMS' review and approval of the reports. The first reports posted were submitted by state Medicaid agencies for performance year 2023.

CMS uses these various methods to ensure that dental networks are adequate and accessible to enrollees across different types of health plans and programs.

There is a dearth of information on whether CMS has initiated enforcement actions against states for failures to address network adequacy for Medicaid dental services provided by MCOs. Our research did not find any record of CMS issuing an enforcement action against a state for failing to meet Medicaid dental network adequacy standards. If current reporting mechanisms continue under the Trump administration and thereafter, given the new transparency of the process, this may result in more direct engagement between CMS and the states on

¹⁰⁰ Ctrs. for Medicare & Medicaid Servs., CMS External Quality Review (EQR) Protocols (2023), <https://www.medicaid.gov/medicaid/quality-of-care/downloads/2023-eqr-protocols.pdf>.

¹⁰¹ 42 C.F.R. § 447.203

¹⁰² **Some states contract with MCOs on a January 1 through December 31 basis; others on a July 1 through June 30 basis. Other states start their contracts on April 1, September 1, or October 1.

whether state plans are meeting Medicaid network adequacy requirements, and if they are not, what the consequences may be from the federal government.

Documented Reports on Medicaid Network Adequacy (Including Dental Information)

*Click MCPAR Link for All Reports

*Click Checks for Accessible EQRO and State-Specific Reports

State	<u>MCPAR Report</u>	<u>EQRO Network Adequacy Report</u>	<u>Other State Network Adequacy Reports</u>
AK			
AL			
AR			
AZ	✓	<u>✓</u>	
CA	✓	<u>✓</u>	
CO	✓	<u>✓</u>	✓
CT		<u>✓</u>	
DE			
FL			
GA	✓		✓
HI		<u>✓</u>	
IA	✓		
ID	✓	<u>✓</u>	
IL	✓	<u>✓</u>	
IN	✓	<u>✓</u>	
KS	✓	<u>✓</u>	
KY	✓		✓
LA	✓		✓
MA	✓	<u>✓</u>	
MD			
ME			
MI	✓	<u>✓</u>	
MN	✓		
MO	✓		
MS	✓		✓
MT			
NC		<u>✓</u>	
ND			
NE	✓		<u>✓</u>
NH			
NJ	✓	<u>✓</u>	✓
NM	✓	<u>✓</u>	
NV	✓	<u>✓</u>	
NY		<u>✓</u>	
OH	✓	<u>✓</u>	
OK		<u>✓</u>	

State	<u>MCPAR Report</u>	<u>EQRO Network Adequacy Report</u>	<u>Other State Network Adequacy Reports</u>
OR	✓	✓	✓
PA		✓	
RI	✓	✓	
SC		✓	
SD			
TN	✓	✓	
TX	✓		✓
UT	✓	✓	
VA	✓		
VT		✓	
WA		✓	
WI	✓	✓	
WV	✓		
WY		✓	

*Reports captured from 2020-2025

What Activities Have States Undertaken to Ensure Full Compliance of the Standards Outlined in 42 USC 1396a (30)A of the Medicaid Act?

Several states require dental MCOs to provide their states' Medicaid, Health and Human Services, Insurance, or other similar agencies with network adequacy reports. For example, the District of Columbia requires carriers to submit network adequacy reports and access plans to identify and address any deficiencies in provider networks. Nevada requires quarterly network adequacy reports. Colorado requires contractors to provide an annual network adequacy report which details these and other facets of the network as well as a quarterly network report that details the changes in the makeup of the network over a quarter. Other states with more recently implemented reporting requirements include Idaho (requiring quarterly reports) and Kentucky, which developed a quarterly report to allow it to have a better idea of the existing gaps in its MCO network.

Other enforcement methods, which were not commonly reported among other states, include the following: Nebraska's quarterly sampling of provider availability; Ohio's quarterly review of provider rosters; Wisconsin's annual surveys, site visits, and handbook and contractual terms requirements; California's annual timely access surveys; and Utah's EQRO tableau dashboard.

When MCOs fall below a state's mandatory network adequacy standards, some states will issue CAPs, which lay out how the MCO is to address the gaps in network adequacy. Some states report use of CAPs to address deficiencies including: Georgia, Kentucky, and Texas.

While our research did not come across many states that issue monetary penalties for failures to maintain an adequate provider network, Louisiana is one exception. In Louisiana, a failure to maintain an adequate provider network can result in state issued sanctions of up to \$40,000 to a plan.

State Report Card- How States Are Doing in Meeting Medicaid Dental Network Adequacy Requirements

Standards Not Met	State has received penalties or a corrective action plan; CMS has raised concerns; there is low dentist participation in Medicaid networks
Needs Improvement	Struggling to address Medicaid dental network adequacy, but offering improvements
Innovating	Innovating to address Medicaid dental network adequacy

State	
AK	MT
AL	NC
AR	ND
AZ	NE
CA	NH
CO	NJ
CT	NM
DE	NV
FL	NY
GA	OH
HI	OK
IA	OR
ID	PA
IL	RI
IN	SC
KS	SD
KY	TN
LA	TX
MA	UT
MD	VA
ME	VT
MI	WA
MN	WI
MO	WV
MS	WY

Have Any States Been Granted Network Adequacy Exemptions?

Federal Framework for MCO Network Adequacy Exceptions to Be Authorized by States

Over the years, some state Medicaid plans have secured network adequacy exceptions through federal regulatory authorities¹⁰³, particularly for rural and other underserved locations facing provider workforce challenges. These exceptions have sought to enable flexibility in meeting quantitative standards, given the regulatory effort to ultimately provide states authority to determine standards that are most measurable and achievable for them.

Under federal regulations guiding network adequacy, states may evaluate and approve exceptions to network adequacy standards if:

1. The exception is specified in the MCO, PIHP, or PAHP contract.

¹⁰³ 42 CFR § 438.68.

2. Is based, at a minimum, on the number of providers in a specialty practicing in the MCO, PIHP, or PAHP service area.
3. Include consideration of the payment rates offered by the MCO, PIHP, or PAHP to the provider type or for the service type for which an exception is being requested.

States that grant an exception in accordance with an MCO, PIHP, or PAHP must monitor enrollee access to the provider type or service the exception was sought for on an ongoing basis and include the findings to CMS in the federally-required MCPAR.

Our research shows that while states must develop standards for all geographic areas of the state covered by a managed care program, states may permit plans to meet different standards in different parts of the state. A state could, for example, require plans to provide required services within 10 miles or 15 minutes in urban areas of the state, but within 30 miles or 45 minutes in rural areas.¹⁰⁴

We did not identify any recent state examples of such exceptions during our research, but view this as an area for further investigative research by reviewing all MCPAR reports submitted by states as states continue to issue these on an annual basis.

Creative Use of State Medicaid Waivers and State Plan Amendments to Improve Access to Care

Medicaid waivers¹⁰⁵ and Medicaid state plan amendments can also both be used to allow states to identify options to incentivize providers to participate in Medicaid networks. The flexibility of waivers allows states to creatively use Medicaid dollars to support Medicaid goals, including improving access and services.

Section 1115 Waivers

Through Section 1115 waivers, CMS can approve experimental, pilot, or demonstration projects aimed at serving the Medicaid populations. Our research shows a few examples of ways states have used 1115 waivers for network adequacy improvements. For example, California used the waiver process to provide incentive payments to practitioners in an effort to expand participation in Medicaid and the accepting of new patients. Some states have also utilized waivers in an effort to increase access to care for Medicaid-eligible individuals over the age of 21 who have disabilities by encouraging more practitioners to accept these patients.

1915(b) Waivers

The 1915(b) waiver is specifically used for managed care, allowing states to waive freedom of choice and require its Medicaid populations to enroll in a MCO. The 1915(b) waiver can also be used by states to offer certain benefits only to managed care enrollees and to limit the providers the state contracts with for these benefits. For example, Utah secured a 1915(b) managed care waiver to require contracted dental plans to ensure the delivery of dental benefits to specific populations, including children with disabilities.¹⁰⁶ The state requires contracted dental plans to

¹⁰⁴ Monitoring Managed Care Access, Medicaid and CHIP Payment and Access Commission, MACPAC, June 2022, <https://www.macpac.gov/subtopic/monitoring-managed-care-access>.

¹⁰⁵ Waivers available via Social Security Act sections 1915(b); 1915(c); and 1115. 42 U.S.C. §§ 1396n(b), (c), 1395.

¹⁰⁶ Choice of Dental Care Delivery Program (UT-0004), Medicaid.gov, <https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/83371>.

ensure direct access to specialists, to ensure that each enrollee has an ongoing source of primary dental care, and the state utilizes independent monitors to analyze demographic data to assess access needs for this population in the state.

Waiver approvals by CMS for state dental programs focused on expanding access can be grouped into two main categories:

1. Extending benefits to individuals in the state who are over age 21; and
2. Transitioning dental services from FFS to a PAHP overseen by a MCO. There are a few exceptions outside of these, which will be discussed further below.

Extending Benefits to Individuals Over the Age of 21

Using Section 1115 waivers, states have identified a number of opportunities to extend the Medicaid dental benefit to individuals over the age of 21. Commonly, requirements for meeting the threshold of coverage included: individuals who had a disability (including one state who specified individuals with diabetes alone for coverage); individuals who met dual eligibility criteria, and individuals who could continue to qualify for benefits through COVID-19 after a Medicaid beneficiary turned 21.

- Examples of States that Extended Dental Coverage Based on Disability
 - Delaware added adult dental benefits to its state plan through the state's managed care delivery system, which is authorized through the state's 1115 demonstration. Beneficiaries include elderly disabled individuals who meet the nursing facility level of care or are at risk for nursing facility care, those with HIV/AIDS, those who receive home and community-based services, disabled children with incomes at or below 250 percent of the SSI, and those in a residential treatment facility for substance use disorder.¹⁰⁷
 - New Hampshire began covering removable prosthodontics for nursing facility residents, age 21 and over in 2022 through 1115 and 1915(c) Home and Community Based Services amendments.¹⁰⁸
 - Tennessee began providing dental benefits for adults age 21 and over in Medicaid through an 1115 waiver for those who are medically needy and are aged, blind, or disabled individuals, or caretaker relatives.¹⁰⁹
- Examples of States that Extended Dental Coverage Due to COVID 19
 - Arizona received an amendment to their Section 1115 Demonstration Waiver in January 2021 under the Public Health Emergency (PHE) to allow them to cover EPSDT dental services authorized prior to a beneficiary turning age 21 for those

¹⁰⁷ Letter from CMS to Stephen M. Groff (Jan. 19, 2021), <https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/de-dshp-adult-dental-benefits-amend-appv1-01192021.pdf>.

¹⁰⁸ Print Application Selector for 1915(b) Waiver: NH.0002.R00.00, New Hampshire (2023), <https://www.medicaid.gov/medicaid/section-1915-demonstrations/downloads/nh-medicaid-care-mgt-dental-services-NH-02.pdf>.

¹⁰⁹ Letter from CMS to Stephen Smith (Dec. 27, 2022), <https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/tn-tenncare-iii-adult-dental-care-cms-ack-updated-12272022.pdf>.

beneficiaries who turned 21 on or after March 1, 2020, and through 60 days after the termination of the COVID-19 PHE who remained Medicaid eligible.¹¹⁰

- Examples of States that Extended Dental Coverage Due to Dual Eligibility (Medicare/Medicaid)
 - Maryland received an 1115 waiver amendment to cover basic dental benefits for dually eligible enrollees.¹¹¹

Transitioning Dental Services from FFS to a PAHP

In an effort to address rising Medicaid costs, states have sought to identify services that can be carved out from Medicaid FFS and provided through limited managed care plans. One option has included shifting service coverage to PAHPs, a non-comprehensive prepaid health plan that only covers limited services (including dental) and does not cover inpatient care. PAHPs are covered through a fixed per patient capitated payment, which allows for limited flexibility should costs change. CMS has approved two state-specific waivers to provide dental services through PAHPs in Louisiana and Utah.^{112 113}

Other State Waivers Affecting Medicaid Dental Access

There are few examples of states requesting waivers for other dental-related services that fall outside of the two most common categories explained above. The best example of this is the California 1115 Waiver for their DTI which ran from 2015-2021. The purpose of the DTI was to improve Medi-Cal dental service coverage and utilization of: (1) preventive dental services, (2) CRA and management, and (3) continuity of care. It also attempted to use Local Dental Pilot Programs to further improve dental service coverage. To improve Medicaid patient coverage of preventive dental service and to prevent caries, the waiver provided for incentive payments to dentists through the California Department of Health Care Services (DHCS) to dental service office locations that met or exceeded utilization benchmarks. Incentive payments for improving preventive dental care totaled \$307.5 million between 2015-2021.¹¹⁴ Due to the access and health improvements noticed through this program, DHCS expanded DTI through the California Advancing and Innovating Medi-Cal (CalAIM) program which began in 2022.

¹¹⁰ Letter from CMS to Director Carmen Heredia (Oct. 28, 2024), <https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/az-hccc-st-cms-approved-covid-epsdt-denyal-amndmnt-final-rpt.pdf>.

¹¹¹ Letter from CMS to Dennis R. Schrader (Apr. 5, 2019), <https://health.maryland.gov/mmcp/Documents/MD%20HealthChoice%20Amendment%20Approval%20%28update%20April%2025,%202019%29.pdf>.

¹¹² Print Application Selector For 1915(b) Waiver: LA.0005.R02.01, Louisiana (Jul. 1, 2022), https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/Downloads/LA_Dental-Benefit-Program_LA-05.pdf.

¹¹³ Print Application Selector For 1915(b) Waiver: UT.0004.R02.00, Utah (Jan. 1, 2024), <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/Downloads/UT-0004.pdf>.

¹¹⁴ California's Medi-Cal 2020 Demonstration (11-W-00103/9), DHCS (2020), <https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/ca-calaim-dental-transform-initiative-prgrm-final-rprt-01012021-12312021.pdf>.

State Plan Amendments

State approval of updates to dental coverage in the state can be covered by waivers, or the alternative is a state plan amendment. There are a few notable state plan amendments that impact dental coverage in the state, both of which impact payment and reimbursement rates for dental services.

In 2022, Maryland received state plan amendment approval from CMS Maryland Medical Assistance reimbursement rates for certain dental services, including preventative, diagnostic, emergency and treatment services by 9.4% beginning July 1, 2022.¹¹⁵

In 2011, South Carolina submitted a state plan amendment for reducing provider payments by 3%, including dentists. The state plan amendment was not approved for questions about the methodology to determine payment rates and reconciling actual and incurred costs with Medicaid reimbursement. Due to the failure to provide more detailed information about how this would impact beneficiaries the state plan amendment was not approved.¹¹⁶

Are There Opportunities for CMS to Engage in State-Level Enforcement and Monitoring Activities in Relation to the 42 USC 1396a (30)A of the Medicaid Act?

CMS State Letters

Another way that CMS can communicate to states that adjustments are needed to support Medicaid access generally, and Medicaid network adequacy specifically, is through state Medicaid director letters. This is less common, as such letters are usually only issued if a direct question is raised to CMS by a state official or Medicaid-providing entity that the agency believes they need to address directly.

Minnesota

There is notably one state letter identified that directly addressed concerns for dental network adequacy, which was sent to the state of Minnesota. In 2017, CMS issued a state director letter indicating that they were concerned that the state did not provide sufficient access to dental services for children enrolled in Medicaid, and that not enough dental providers participate in Minnesota Medicaid.¹¹⁷ After conducting a review, CMS determined that Minnesota Medicaid beneficiaries were not receiving the dental services called for in the state's dental periodicity schedule.

Following the letter, CMS held a call with Minnesota Medicaid and shared a range of suggestions for addressing the agency's concerns, including increasing Medicaid dental reimbursement rates to improve coverage. The state subsequently voted to increase the reimbursement rates.

¹¹⁵ Maryland, State Plan Amendment #22-0020, <https://www.medicaid.gov/medicaid/spa/downloads/MD-22-0020.pdf>.

¹¹⁶ Letter from CMS to Anthony E. Keck (June 23, 2011), <https://www.scdhhs.gov/internet/pdf/StatePlanApprovals/SC-11-005CompanionLetter.pdf>.

¹¹⁷ Letter from CMS to Marie Zimmerman (Apr. 6, 2017), <https://www.mndental.org/files/Letter-from-CMS-Director-Anne-Marie-Costello.pdf>.

Outside of the letter to Minnesota, there have been a couple state letters that provide examples of how CMS can investigate concerns, regarding Medicaid coverage; however, our research did not identify any additional CMS letters specific to dental Medicaid network adequacy.

CMS State Director Letter Examples

In 2024, CMS sent separate letters to Missouri and Texas detailing concerns with the significant processing times for Medicaid and CHIP applications.^{118 119} In the letters, CMS proposed to conduct a review of the application date, turn-around time, and proposed staffing updates. CMS proposed using the review to help the state identify mitigation efforts. This CMS strategy, like the one used in the Minnesota letter, can be used to correct state specific concerns about Medicaid not meeting federal requirements to ensure adequate coverage of services.

CMS Guidance to States

In addition to direct state outreach, CMS provides general guidance to states on how they should be implementing required components of Medicaid, including EPSDT and the Oral Health Initiative (OHI). These guidance documents provide suggestions for how states can improve dental coverage and services within the state.

OHI Bulletin

CMS, which launched OHI in 2010, releases guidance for how states can meet the goals of OHI to improve Medicaid enrolled children's use of appropriate dental and oral health services. In the guidance, CMS outlines state examples of best practices. In the 2020-2022 guidance CMS highlighted Pennsylvania's use of managed care contracts top quality improvement incentive program for plans and required plans to develop a pay-for-performance program for dental providers in order to increase access to preventive dental services for new and established patients.¹²⁰

EPSDT Best Practices

Periodically, CMS releases EPSDT best practices guidance. The guidance is intended to support states in ensuring that children on Medicaid and CHIP are receiving the full range of health services, including dental. The guidance provides specific state examples that other states can replicate. In the 2024 EPSDT best practice comprehensive guidance, CMS notes that "a different approach that has yielded an increase in available dental practitioners is to provide training, support, and enhanced payments to general dentists to increase their ability to serve younger children."¹²¹

¹¹⁸ *Id.*

¹¹⁹ Letter from CMS to Todd Richardson (May 22, 2024), https://www.documentcloud.org/documents/24762403-missouri_application_timeliness_review_letter_signed_52224.

¹²⁰ Letter from CMS to Calder Lynch (June 25, 2020), <https://www.medicaid.gov/federal-policy-guidance/downloads/cib062520.pdf>.

¹²¹ Letter from CMS to State Health Official (Sept. 26, 2024), <https://www.medicaid.gov/federal-policy-guidance/downloads/sho24005.pdf>.

IV. Suggested Remedial or Enforcement Actions to Ensure States are Meeting the Full Compliance Standard as Outlined in 42 USC 1396a (30)A of the Medicaid Act

With so much latitude in the interpretation and enforcement of Medicaid network adequacy laws, network adequacy standards across Medicaid managed care plans are highly variable. Dental plans within varied state Medicaid dental plan and MCO arrangements are permitted to self-regulate and self-report with minimal accountability. When reflecting on federal and state efforts over the last 10 years, it is clear that enforcement of network adequacy is extremely difficult, regardless of the terms of law or requirements outlined in federal and state laws and regulations.

CMS regulations governing Medicaid managed care contain standards for provider networks that can at best be characterized as ineffective. This can largely be attributed to the rollercoaster of Medicaid network requirements and taking away of those requirements between 2016-2020 in the policy arm wrestle between the Obama and Trump administrations. Trump successfully minimized initial federal network adequacy requirements that were put in place. Instead, states were encouraged to adopt any “quantitative standard” of their choosing for pediatric dental care along with other Medicaid required services. **No minimum federal quantitative standard was put in place, and there was no dedicated enforcement or oversight mechanism in place to ensure Medicaid MCOs formalized or complied with whatever “quantitative standards” the states determined should be in place.**

Conclusion

What Are Additional Suggested Remedial or Enforcement Actions that CMS Could Undertake to Strengthen Enforcement of 42 USC 1396a (30)A of the Medicaid Act?

Three specific recommendations can be made in consideration of how dental network adequacy might be improved through remedial actions within dental Medicaid/Medicaid Managed Care networks:

- **Ensure Any Willing Dental Provider Can Participate in Medicaid with Reasonable Contract Terms:** Model after Medicare statute and rules that seek to ensure convenient access standard requirements are in place and that payer contract terms for dentists are reasonable, including reasonable reimbursement. Provide data to demonstrate benchmarks for setting reasonable dental payment rates that can help to attract dentist network participation.
- **Encourage Rural Dental Residency and Other Incentive-Focused Programs to Address Dentist Deserts:** Explore whether programs that provide enhanced payments to other providers for serving in rural and underserved communities can serve as a model to enhance dental network adequacy.
- **Enforce Rewards and/or Penalties to Address MCO/PAHP Compliance/Noncompliance:** Support implementation of final 2024 federal rule requirements that establish remedy plans for MCOs. Encourage state legislation that sets

benchmarks for dental network participation and establishes rewards for plans that meet requirements and imposes fines on plans that are not compliant.

- **Adopt Transparent Metrics:** Encourage states to publish annual reports on provider participation and reimbursement rates as some states have begun to do and as 2024 federal rules envisioned. Such information should be reported by states and made available and accessible on the CMS website. Encourage a different standard for comparing FFS dental rates, given the lack of Medicare coverage and payment for dental services.

Any Willing Dental Provider – Reasonable Contract Terms

Quantitative plan measures for assessing dental network adequacy do not typically assess whether reimbursement rates for dental services provided within Medicaid are “reasonable.” Unlike terms that exist in other areas of federal law for other federal payors that are intended to ensure that “any willing provider” can participate in a plan network¹²² with assurance of reasonable contract terms (including reasonable reimbursement), Medicaid plans are not held to any such standard.

While many states have deliberated on and some have sought to adjust dentist Medicaid payment rates to improve network participation, ultimately contractual obligations required by Medicaid may be necessary to support such participation.

CMS’ 2024 final rules in many ways open the door to a new discussion about how to address provider payment rates in contracts, given the planned requirement for states to publicly report provider payment rates.¹²³ For example, the rules require states to submit *remedy plans* to address any areas where managed care plans need to improve access. Payment adequacy information was not included as a required focus for access improvements that would generate the need for a remedy plan evaluation and plan correction. States could choose to incorporate payment-related factors into their remedy plans.

Recommended Approach: Federal legislation (and/or state legislation) can be pursued to establish any willing dental provider participation requirements that seek to ensure that contractual terms are not prohibitive (e.g., underwater reimbursement; excessive audits, administrative challenges). Federal/state regulations could set the terms for what is considered “reasonable” but setting a standard (not rates) for evaluation of contract rates. Terms can be modeled after Medicare Part D standards seeking to ensure adequate pharmacy network participation in relation to convenient access and reasonable contract terms.

Encourage Rural Dental Residency and Other Incentive-Focused Programs

While federal network adequacy regulations and federal workforce programs meant to address provider shortages are not formally connected in the law or in regulations, many states, and even CMS, has sought to apply workforce program-type solutions to encourage provider participation and address network needs. Dentistry has a long history of advocating for dental workforce

¹²² 42 § C.F.R. 423.505(b)(18) (“any willing pharmacy” provision).

¹²³ 2024 Final Rule, 89 Fed. Reg. 41002, 41012, 41026 (May 10, 2024).

programs, recognizing the challenge of workforce needs in rural and other underserved communities. The profession, therefore, has workforce programs in place that could prove resourceful in addressing Medicaid network needs.

Recommended Approach: Review federal program efforts in Medicare that pay a 10% quarterly bonus to physicians who provide services in primary care HPSAs and psychiatrists practicing in mental health HPSAs.¹²⁴ See if the terms for a similar initiative would work for practicing dentists. This could initially be pursued as a regulatory pilot program to address rural shortage concerns in a specific region, for example.

Advocate for the 2016-established Medicaid network adequacy rules to be further amended through CMS rulemaking or guidelines to support a framework for states to analyze geographic distribution of dentists serving Medicaid in comparison to exchange markets and/or commercial populations to better assess and determine dental network challenges.

Enforce Rewards and/or Penalties to Address MCO/PAHP Compliance/Noncompliance

States and their contracted plans should be incentivized to address challenges within their dental networks, and penalized when they do not bother to address these challenges. Federal rules finalized in 2024 envisioned this strategy through the use of “remedy plans.” Strategies could be encouraged to address issues impacting dental network adequacy through teledentistry and allowing out-of-network participation by dentists, for example.

Recommended Approach: Establish model state legislation to set benchmarks for state dental network participation with rewards for plans that meet requirements and the imposition of fines on plans that are not compliant, generating revenue to support such a program.

Transparency and Sufficient Access to Care in Medicaid Networks

Providing reliable information to Medicaid beneficiaries about dentists who are accepting new Medicaid/Medicaid Managed Care patients could be instrumental in improving access and addressing network adequacy concerns. Allowing for resources such as real-time provider databases where dentists can directly update their participation status could eliminate state concerns over “ghost networks” and outdated plan directories.

States should also be encouraged to publish annual reports on dentist participation as well as reimbursement rates to dentists as 2024 federal rules envisioned.

Recommended Approach: The federal government must be encouraged to put into place state reporting requirements that are then accessible on the CMS website. Advocacy here will be important to ensure envisioned federal rules go into effect. Guidance from CMS to the states on how to effectively establish a standard for comparing FFS dental rates to plan rates will be necessary, and CMS will need this guidance from the dental community. The current CMS standard of relying on Medicare coverage and payment is not an appropriate benchmark for comparing dental data, given limited coverage and reimbursement for dental benefits under Medicare/Medicare Advantage.

¹²⁴ MLN Learning Network, Centers for Medicare and Medicaid Services; Health Professional Shortage Area Physician Bonus Program. February 2021.

Medicaid Reimbursement for Dental Care Services – 2024 data update

October 2024

Background

- We update data on reimbursement for dental care services within state Medicaid programs for 2024. Previous HPI report was for 2022. Data for 2022 and 2024 are not comparable to previous HPI data on Medicaid reimbursement.
- We use two main data sources:
 - State Medicaid program FFS reimbursement schedules collected from Medicaid websites through July 2024
 - FAIRHealth data on dentist charges in private dental insurance plans, aggregated to the state level for 2024
 - Fluent data on average maximum allowed payment rates in private dental insurance plans, aggregated to the state level for 2024
- We construct a weighted average index across 14 procedures and compare Medicaid FFS reimbursement amounts to average dentist charges and average maximum allowed payment rates. We conduct separate analysis for child dental care services and adult dental care services.
- The managed care ‘data void’ is still a major data limitation. We do not have access to any managed care data. Nor is there even an up-to-date classification of states according to how they administer their Medicaid dental programs. Use caution.
- Full details on data sources and methods are in the appendix.

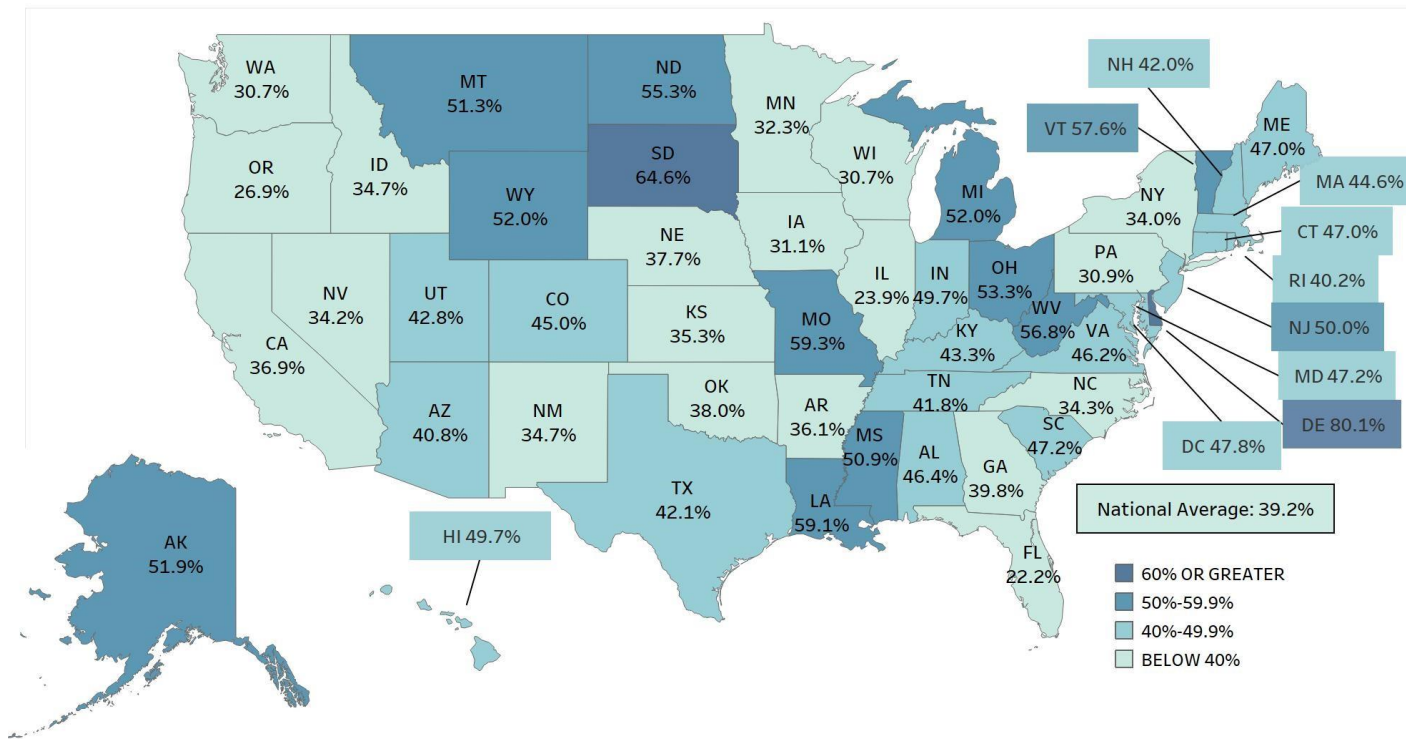
Results

	A	B	C	D	E	F	G
4							
5		State	Medicaid FFS Reimbursement as Percentage of Average Dentist Charges		Medicaid FFS Reimbursement as Percentage of Average Private Dental Insurance Payment Rates		
6			Child Dental Care Services	Adult Dental Care Services	Child Dental Care Services	Adult Dental Care Services	Adult Benefit Level
7		Alabama	46.4%		75.0%		None
8		Alaska	51.9%	44.5%	72.5%	59.1%	Enhanced
9		Arizona	40.8%		80.5%		Emergency
10		Arkansas	36.1%	31.2%	68.3%	58.8%	Limited
11		California	36.9%	41.4%	59.7%	68.3%	Enhanced
12		Colorado	45.0%	42.8%	78.5%	73.1%	Enhanced
13		Connecticut	47.0%	29.9%	79.6%	49.4%	Enhanced
14		Delaware	80.1%	78.0%	115.9%	111.1%	Limited
15		District of Columbia	47.8%	39.3%	86.3%	69.0%	Enhanced
16		Florida	22.2%		40.8%		Emergency
17		Georgia	39.8%		65.5%		Emergency
18		Hawaii	49.7%	44.1%	83.2%	79.7%	Enhanced
19		Idaho	34.7%	33.9%	52.4%	53.2%	Enhanced
20		Illinois	23.9%	26.6%	39.7%	43.2%	Enhanced
21		Indiana	49.7%	49.6%	78.7%	77.8%	Limited
22		Iowa	31.1%	29.9%	48.3%	45.5%	Enhanced
23		Kansas	35.3%	38.4%	59.8%	64.6%	Limited
24		Kentucky	43.3%	41.4%	75.3%	71.7%	Limited
25		Louisiana	59.1%	56.5%	89.9%	86.5%	Limited
26		Maine	47.0%	49.4%	64.6%	68.2%	Enhanced
27		Maryland	47.2%	45.5%	91.7%	87.3%	Enhanced
28		Massachusetts	44.6%	33.9%	88.3%	61.0%	Enhanced
29		Michigan	52.0%	51.7%	81.5%	82.3%	Enhanced
30		Minnesota	32.3%	33.1%	54.0%	51.6%	Enhanced
31		Mississippi	50.9%		82.2%		Emergency

	A	B
1	HPI	Health Policy Institute
2		
3		
4	ADA	American Dental Association®
5		
6		Medicaid Fee-For-Service Reimbursement as a Percentage of Dentist Charges and Private Dental Insurance Reimbursement, 2024
7		(Published October 2024)
8		
9		Table of Contents
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11		Data Table
12		Data Sources and Methods
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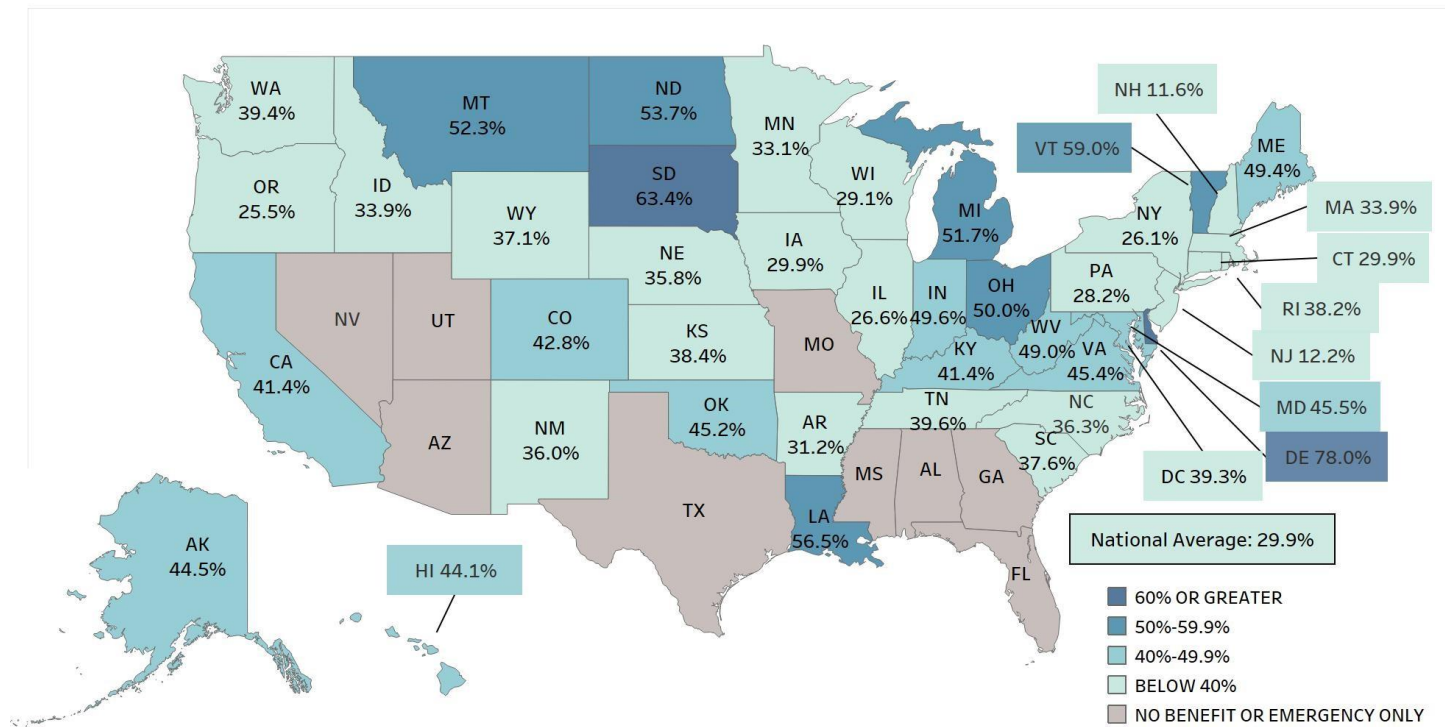
Results

Medicaid FFS Reimbursement as a Percent of Average Dentist Charges, Child Dental Services, 2024



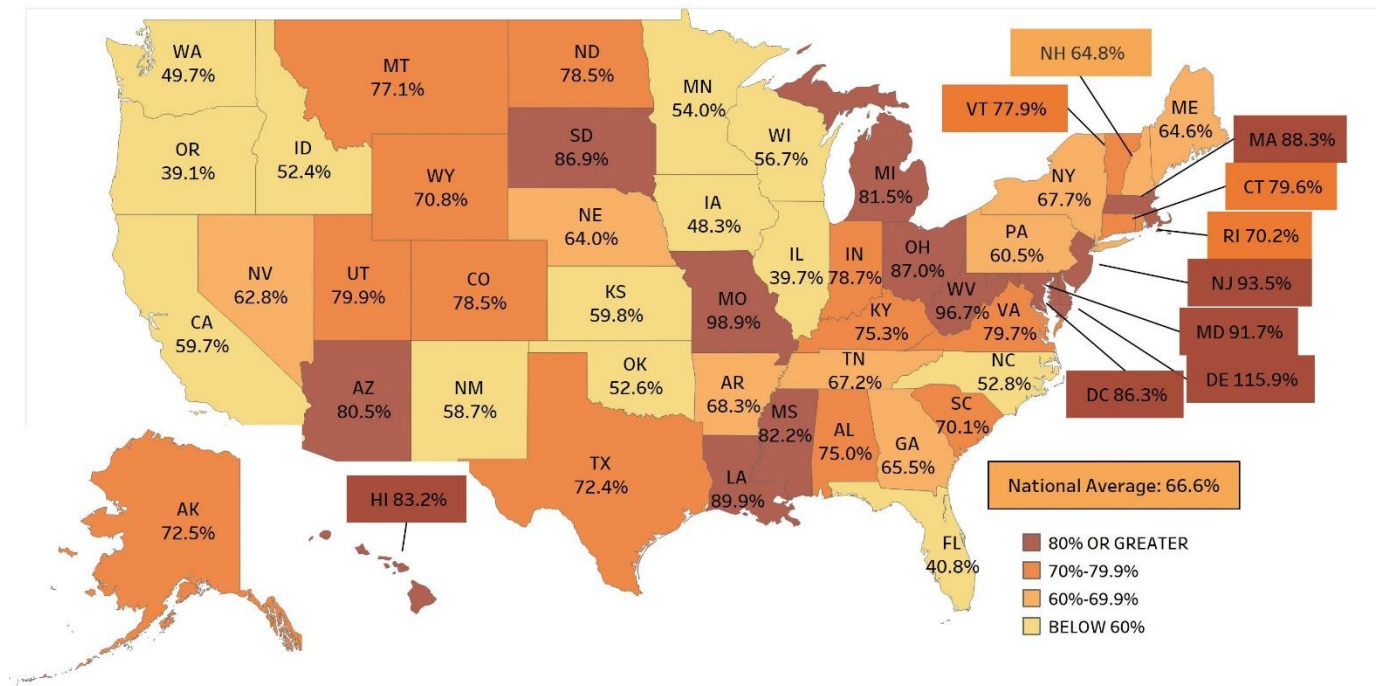
Results

Medicaid FFS Reimbursement as a Percent of Average Dentist Charges, Adult Dental Services, 2024



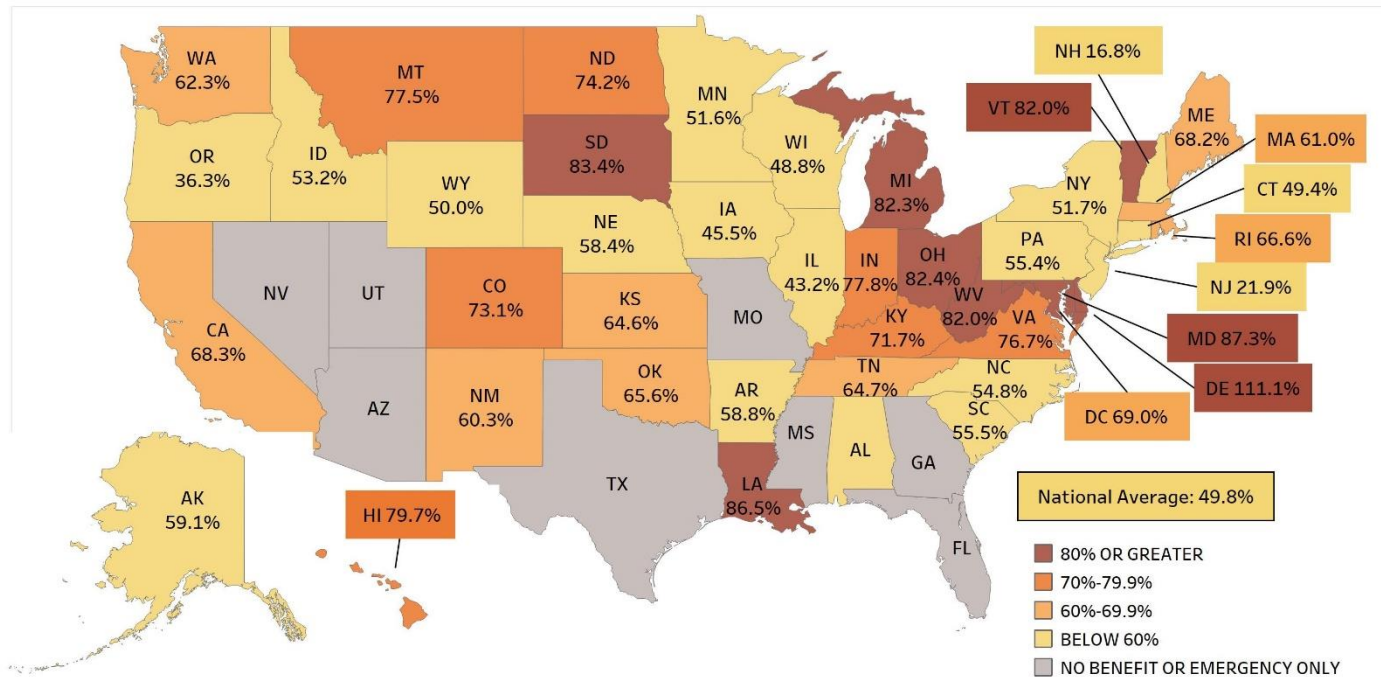
Results

Medicaid FFS Reimbursement as a Percent of Average Private Dental Insurance Payment Rates
Child Dental Services, 2024



Results

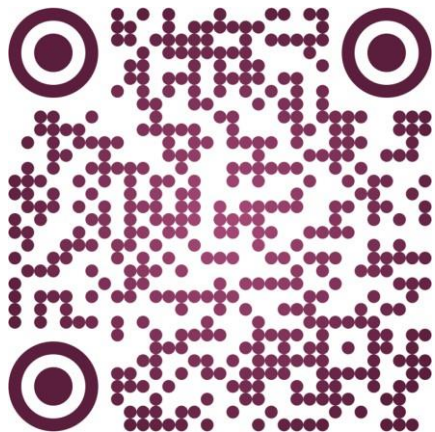
Medicaid FFS Reimbursement as a Percent of Average Private Dental Insurance Payment Rates
Adult Dental Services, 2024



Access the Data

- Download the data report here: [Medicaid Fee-For-Service Reimbursement as a Percentage of Dentist Charges and Private Dental Insurance Reimbursement, 2024 \(XLSX\)](#).
- This report along with the rest of HPI's research on Medicaid can also be found on HPI's [Coverage, Access and Outcomes page](#).

Thank You!



[ADA.org/HPI](https://ada.org/HPI)

hpi@ada.org



[@adahpi](https://twitter.com/adahpi)



Health
Policy
Institute

ADA American Dental Association®

Medicaid Fee-For-Service Reimbursement as a Percentage of Dentist Charges and Private Dental Insurance Reimbursement, 2024

(Published October 2024)

[Return to Table of Contents](#)

State	Medicaid FFS Reimbursement as Percentage of Average Dentist Charges		Medicaid FFS Reimbursement as Percentage of Average Private Dental Insurance Payment Rates		Adult Benefit Level
	Child Dental Care Services	Adult Dental Care Services	Child Dental Care Services	Adult Dental Care Services	
Alabama	46.4%		75.0%		None
Alaska	51.9%	44.5%	72.5%	59.1%	Enhanced
Arizona	40.8%		80.5%		Emergency
Arkansas	36.1%	31.2%	68.3%	58.8%	Limited
California	36.9%	41.4%	59.7%	68.3%	Enhanced
Colorado	45.0%	42.8%	78.5%	73.1%	Enhanced
Connecticut	47.0%	29.9%	79.6%	49.4%	Enhanced
Delaware	80.1%	78.0%	115.9%	111.1%	Limited
District of Columbia	47.8%	39.3%	86.3%	69.0%	Enhanced
Florida	22.2%		40.8%		Emergency
Georgia	39.8%		65.5%		Emergency
Hawaii	49.7%	44.1%	83.2%	79.7%	Enhanced
Idaho	34.7%	33.9%	52.4%	53.2%	Enhanced
Illinois	23.9%	26.6%	39.7%	43.2%	Enhanced
Indiana	49.7%	49.6%	78.7%	77.8%	Limited
Iowa	31.1%	29.9%	48.3%	45.5%	Enhanced
Kansas	35.3%	38.4%	59.8%	64.6%	Limited
Kentucky	43.3%	41.4%	75.3%	71.7%	Limited
Louisiana	59.1%	56.5%	89.9%	86.5%	Limited
Maine	47.0%	49.4%	64.6%	68.2%	Enhanced
Maryland	47.2%	45.5%	91.7%	87.3%	Enhanced
Massachusetts	44.6%	33.9%	88.3%	61.0%	Enhanced
Michigan	52.0%	51.7%	81.5%	82.3%	Enhanced
Minnesota	32.3%	33.1%	54.0%	51.6%	Enhanced
Mississippi	50.9%		82.2%		Emergency
Missouri	59.3%		98.9%		Emergency

Montana	51.3%	52.3%	77.1%	77.5%	Enhanced
Nebraska	37.7%	35.8%	64.0%	58.4%	Enhanced
Nevada	34.2%		62.8%		Emergency
New Hampshire	42.0%	11.6%	64.8%	16.8%	Enhanced
New Jersey	50.0%	12.2%	93.5%	21.9%	Enhanced
New Mexico	34.7%	36.0%	58.7%	60.3%	Enhanced
New York	34.0%	26.1%	67.7%	51.7%	Enhanced
North Carolina	34.3%	36.3%	52.8%	54.8%	Enhanced
North Dakota	55.3%	53.7%	78.5%	74.2%	Enhanced
Ohio	53.3%	50.0%	87.0%	82.4%	Enhanced
Oklahoma	38.0%	45.2%	52.6%	65.6%	Enhanced
Oregon	26.9%	25.5%	39.1%	36.3%	Enhanced
Pennsylvania	30.9%	28.2%	60.5%	55.4%	Enhanced
Rhode Island	40.2%	38.2%	70.2%	66.6%	Enhanced
South Carolina	47.2%	37.6%	70.1%	55.5%	Limited
South Dakota	64.6%	63.4%	86.9%	83.4%	Enhanced
Tennessee	41.8%	39.6%	67.2%	64.7%	Enhanced
Texas	42.1%		72.4%		Emergency
Utah	42.8%		79.9%		Emergency
Vermont	57.6%	59.0%	77.9%	82.0%	Enhanced
Virginia	46.2%	45.4%	79.7%	76.7%	Enhanced
Washington	30.7%	39.4%	49.7%	62.3%	Enhanced
West Virginia	56.8%	49.0%	96.7%	82.0%	Enhanced
Wisconsin	30.7%	29.1%	56.7%	48.8%	Enhanced
Wyoming	52.0%	37.1%	70.8%	50.0%	Limited
United States	39.2%	29.9%	66.6%	49.8%	

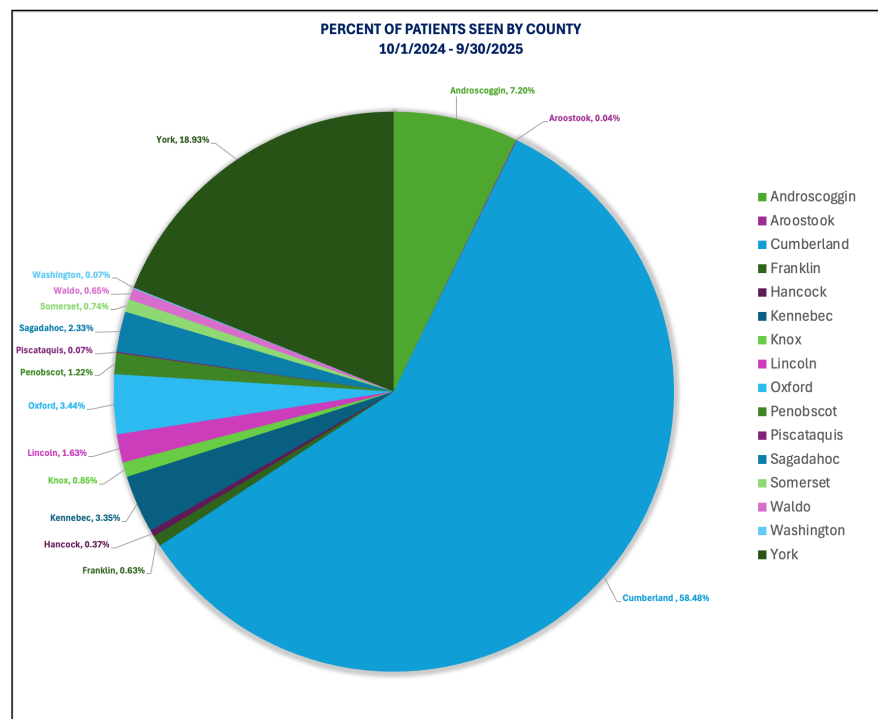
[For Data Sources and Methods, see next tab.](#)

The following responses are for the UNE CDM Oral Health Center clinic located in Portland. This does not include information from UNE's WCHP Coleman Dental Hygiene clinic which is a clinic for educational training of students in the dental hygiene program in the Westbrook College of Health Professions.

1. **How many people are served through the clinics annually (and Rep. Rana was especially interested in how many Mainers are served)? It seems that to the extent possible, info on where people come from for treatment along with any additional demographic data you may have (and can share) would be useful to Commission members.**

Response:

- Patients served from October 1, 2024 – September 20, 2025: 4,778
- Mainers served from October 1, 2024 – September 20, 2025: 4,595
- County breakdown for Mainers seen from October 1, 2024 – September 20, 2025:



- Age breakdown for Mainers seen from October 1, 2024 – September 20, 2025:
 - 0-17: 9%
 - 18-65: 63%
 - 66+: 28%
- Since the Oral Health Center opened, Mainers have received over 283,000 completed procedures. From October 1, 2024 – September 20, 2025 that number was 31,533.

2. Do you have to turn people away from the clinics? If so, do you have data on how many and the main reasons people are turned away?

Response:

Yes, we turn people away from our on-campus Oral Health Center clinic. The main reasons are due to appointment availability and the patient's needs not aligned with pre-doctoral student educational needs.

The demand for new patient appointments exceeds our availability. We currently have no available appointments for new patients and the soonest we anticipate having availability is the start of our spring semester in January. We do not track how many patients are turned away; however, a snapshot of the Oral Health Center email inbox over a 2-day period, revealed 14 new patient inquiries, but this does vary. I do not have any data about the number of phone inquiries. New patient inquiries are typically for general adult comprehensive care, pediatric care, and placement of implants. Patients are also looking for free care.

We are a pre-doctoral dental student training clinic and not all patient needs meet the educational needs of our students or the care they need may be too complex and require more experienced providers or specialists. All new patients are required to have a screening examination to determine if the patient can be accepted for comprehensive care at the Oral Health Center. I do not have counts, but the most common reasons that a patient is not accepted for comprehensive care include:

- Patient's dental needs are too complex for predoctoral students
- Patient is medically too complex for safe treatment in an educational setting
- Patient's expectations of timeline of treatment cannot be met in educational setting

3. Do the clinics have waiting lists for care? If so, what for (e.g. specific types of treatment)? Any data on average wait times?

Response:

We do not maintain waiting lists or average wait times. Because our clinic is a pre-doctoral dental student training clinic, intake of new patients is based on the current educational needs of our students and our academic calendar.

Question to DHHS, in response to Dr. Walawender's comment/request that the Rural Health Transformation Program include a pediatric dental residency program and an oral surgery residence program.

From Abby Stivers, Director of Governmental Affairs, DHHS:

"Here is what I got back from folks working on the RHT application:

The federal Rural Health Transformation Program (RHTP) funding is available to support a range of improvements, including workforce development efforts. Following review of multiple inputs, current needs, and public comments, Maine's RHTP proposal development team has proposed funding for a range of rural workforce development activities, including recruitment and retention activities; training and education efforts; and career advancement pathways across the continuum of care including Oral Health. Given the timeline, and with feedback from academic and clinical partners, adding new residency programs was not prioritized for the use of Maine's RHTP funding, but the Department would be open to exploring other ways to advance dental care in rural Maine, including through new rural rotations."

From Dr. Walawender in response to request for number of active dental providers (using active claims data):

Here is the requested information as of October 1st 2025 and as I said before, these are estimates but in my opinion are probably the most accurate we can get. I am not able to break it down further than this geographically or to add in specialists at this time.

Maine Dentists

854

New Hampshire Dentists

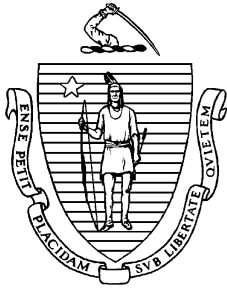
1025

Vermont

403

This also does not include mid level providers, denturists, or independent practice hygienists. It also does not include VA dentists, dentists working in the federal prison system, or any other provider type that would not bill insurance.

As we said before, those dentists are most likely a rounding error. For Maine we have currently 7 VA dentists (normally 8) and 2 residents. I don't know how many federal or state prison dentists there are and if they are full time vs practicing elsewhere and billing and counted already.



The Commonwealth of Massachusetts
Bureau of Health Professions Licensure
Board of Registration in Dentistry
250 Washington Street
Boston, MA 02108
(617) 973-0971
www.mass.gov/dph/dentalboard

INITIAL (FIRST-TIME) DENTAL INTERN LIMITED LICENSE APPLICATION INSTRUCTIONS

(See 234 CMR 4.05 Effective August 20, 2010)

A Dental Intern Limited License allows you to perform all the duties of a dentist but only in a specifically named prison, hospital, school, or public clinic under the supervision of a dentist registered in accordance with M.G.L. Chapter 112, Section 45. **Practice in a private office is not permitted. Dental Intern Limited Licenses are valid for one (1) year from date of issue**

Please Note: A licensee who has been initially issued a limited dental intern license by the Board pursuant to M. G. L. c. 112, § 45A may apply to the Board annually to renew his/her limited license(s) for a maximum of five one-year periods, except that said licensee may, upon permission of the Board, take the NERB Clinical Examination in Dentistry (CED) or successor examination required by the Board. A limited license dental intern who successfully completes and passes the NERB /CED may thereafter apply to the Board annually to renew his/her license to practice dentistry in the Commonwealth in settings specified in M.G. L. c.112, § 45A and in compliance with 234 CMR 8.02(2).

The Board may approve a limited license provided the following documentation is received.

- An accurate, complete, and signed application including CORI request form.
- Applicant must have secured employment before applying for the license.
- Payment of a non-refundable licensing fee
- Proof satisfactory to the Board that the applicant has received a diploma in dentistry. Graduates of non-CODA or foreign dental schools shall submit an original transcript, with college seal that indicates the date of issuance of a dental diploma from a reputable dental college. If the transcript is not in English, the applicant shall provide a certified translated copy of the original dental college transcript demonstrating the applicant received a dental degree from a reputable dental college.
- Documentation demonstrating current certification in American Red Cross Cardiopulmonary Resuscitation/Automated External Defibrillation for the Professional Rescuer (CPR/AED) or current certification in the American Heart Association Basic Life Support for Healthcare Providers (BLS).
- If the applicant has graduated from a dental school where the language of written or oral instruction (including textbooks) or both, is in a language other than English, the applicant shall submit documentation satisfactory to the Board that the applicant has achieved a minimum score on TOEFL or IELTS.

- A physician's statement that is the result of an examination, conducted within six months of the date of application, attesting to the health of the applicant and reporting impairments which may affect the applicant's ability to practice dentistry.
- Certified letters of standing from all jurisdictions in which the applicant has ever been issued a license to practice dentistry attesting to the standing of his/her license, including report of any past or pending disciplinary action, or any pending complaints against the applicant.
- A practice history, if applicable.
- An original report from the National Practitioner Data Bank (NPDB) Self-query.
- A statement disclosing any disciplinary action, civil and/or criminal action taken against the applicant at any time prior to the date of application, with supporting documentation as may be required by the Board.
- Proof satisfactory to the Board of good moral character.
- Successful completion of the Massachusetts Dental Ethics and Jurisprudence Examination. Email the Board at dentistry.admin@mass.gov to request a copy of the exam.
- Attach a passport-size photograph in color (2x2) to application where indicated. See http://travel.state.gov/passport/guide/composition/composition_874.html
- An affidavit, signed under pains and penalties of perjury, and witnessed by a Notary Public.

PLEASE NOTE:

- Incomplete applications will delay license processing.
- Please retain a copy of all application materials for your records.
- Upon board approval, a certificate and a license number will be issued in your name and sent to your supervising dentist. Confirmation of your license number will be available under "Online services/Check a License" on our website www.mass.gov/dph/dentalboard as soon as the Board approves the license.
- See other public health sites, clinics, faculty, and/or educational opportunities

Hospitals	www.mahospitalcareers.com
Community Health Centers	www.massleague.org
Massachusetts Department of Corrections	www.mass.gov/doc
Harvard University School of Dental Medicine	www.hsdm.harvard.edu
Boston University Goldman School of Dental Medicine	www.bu.edu/dental/
Tufts University School of Dental Medicine	www.tufts.edu/dental/



The Commonwealth of Massachusetts
Bureau of Health Professions Licensure
Board of Registration in Dentistry

250 Washington Street

Boston, MA 02108

(617) 973-0971

www.mass.gov/dph/dentalboard

BOARD USE ONLY

Receipt # _____

Fee : _____

Jurisprudence: Pass _____ Fail _____

APPLICATION

INITIAL(FIRST- TIME) DENTAL INTERN LIMITED LICENSE

1. APPLICANT NAME: _____
(Last) (First) (Middle)

2. MAIDEN NAME/OTHER NAME: _____

3. ADDRESS OF RECORD: _____
(No.) (Street) (Apt #) (City or Town) (State or Country) (Zip Code)

Note: The address of record may be home or business and is, by law, public information.

4. MOST RECENT PREVIOUS ADDRESS: _____

5. TELEPHONE NUMBER AND EMAIL ADDRESS: Day: _____ Cell: _____

Email Address: _____

6. _____ / _____ / _____ EYE COLOR: _____
Date of Birth (mm/dd/yyyy) Place of Birth (city/state/country)

HEIGHT: _____ Feet _____ Inches WEIGHT: _____ Lbs. MOTHER'S MAIDEN NAME: _____

7. SOCIAL SECURITY NUMBER (SSN) (disclosure is mandatory): _____ / _____ / _____

Pursuant to G.L. c. 30A, s. 13A and G.L. c. 62C, s. 47A, the Bureau of Health Professions Licensure is required to obtain your SSN and forward it to the Massachusetts Department of Revenue. The Department of Revenue will use your SSN to ascertain whether or not you are in compliance with Massachusetts tax laws (G.L. c. 62C, s. 47A) and child support laws (G.L. c. 119A, s.16).

EDUCATION

8. GRADUATE OF: _____
Name of Dental School

City State/Province Postal Code Country

9. DATE DENTAL DEGREE CONFERRED DATE _____ DEGREE _____
MM/DD/YYYY

ALL APPLICANTS MUST ATTACH:

AN OFFICIAL TRANSCRIPT OF ORIGINAL DEGREE OR LETTER FROM YOUR DENTAL SCHOOL INCLUDING DATE (MONTH, DAY, YEAR) OF GRADUATION AND DEGREE CONFERRED; AND,

IF APPLICABLE, AN ACADEMIC CREDENTIALS EVALUATION IN ENGLISH.

VERIFICATION OF OTHER LICENSES/BOARD REGISTRATIONS

10. LIST BELOW ALL PROFESSIONAL LICENSES OR REGISTRATIONS-- INCLUDING PROFESSIONS OTHER THAN DENTISTRY WHETHER OR NOT YOU HAVE PRACTICED UNDER THAT LICENSE OR REGISTRATION.

NOTE: Applicants must obtain official verification of each professional license or registration from each state or jurisdiction and submit it with this application.

☐ **I DO NOT CURRENTLY HOLD AND HAVE NEVER HELD A PROFESSIONAL LICENSE OR CERTIFICATION IN ANY STATE OR JURISDICTION**

☐ **I CURRENTLY HOLD AND HAVE A PROFESSIONAL LICENSE OR REGISTRATION AS FOLLOWS:**

<u>Issuing Jurisdiction</u>	<u>Profession</u>	<u>License/Certification Number</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____

PRACTICE LOCATION(S)

11. (A). NAME OF SPONSORING INSTITUTION/CLINIC _____

ADDRESS _____

PHONE# _____ PRACTICE TO BEGIN: _____
MM/DD/YYYY

SUPERVISING DENTIST NAME _____

MASSACHUSETTS DENTAL LICENSE #DN _____

***I CERTIFY, UNDER PAINS AND PENALTIES OF PERJURY, THAT THE INFORMATION I HAVE PROVIDED
PURSUANT TO THIS APPLICATION FOR LICENSURE IS TRUTHFUL AND ACCURATE.***

SUPERVISING DENTIST SIGNATURE _____

11. (B). OTHER AFFILIATED PRACTICE LOCATIONS _____

ADDRESS _____

PHONE# _____ PRACTICE TO BEGIN: _____
MM/DD/YYYY

SUPERVISING DENTIST NAME _____

MASSACHUSETTS DENTAL LICENSE #DN _____

***I CERTIFY, UNDER PAINS AND PENALTIES OF PERJURY, THAT THE INFORMATION I HAVE PROVIDED
PURSUANT TO THIS APPLICATION FOR LICENSURE IS TRUTHFUL AND ACCURATE.***

SUPERVISING DENTIST SIGNATURE _____

11. (C). OTHER AFFILIATED PRACTICE LOCATIONS _____

ADDRESS _____

PHONE# _____ PRACTICE TO BEGIN : _____
MM/DD/YYYY

SUPERVISING DENTIST NAME _____

MASSACHUSETTS DENTAL LICENSE #DN _____

***I CERTIFY, UNDER PAINS AND PENALTIES OF PERJURY, THAT THE INFORMATION I HAVE PROVIDED
PURSUANT TO THIS APPLICATION FOR LICENSURE IS TRUTHFUL AND ACCURATE.***

SUPERVISING DENTIST SIGNATURE _____

ATTESTATION OF COMPLIANCE WITH 234 CMR 4.05 (5) EDUCATION REQUIREMENTS

12. CHECK THE APPLICABLE BOX BELOW. THEN SIGN TO INDICATE YOUR CERTIFICATION OF THE CHECKED STATEMENT. THE SIGNATURE OF THE SUPERVISING DENTIST IS ALSO REQUIRED ON THIS PAGE.

☐ I certify, under pains and penalties of perjury that I have completed or shall complete, within one year of the date of initial licensure, all of the following continuing education units (CEUs):

- A minimum of 3 CEUs in *CDC Guidelines*;
- A minimum of 3 CEUs in OSHA Standards at 29 CFR;
- A minimum of 6 CEUs in treatment planning and diagnosis;
- A minimum of 3 CEUs in record-keeping;
- A minimum of 2 CEUs in risk management; and
- A minimum of 3 CEUs in pharmacology with emphasis on prescription writing;

OR

☐ I certify, under pains and penalties of perjury that I am enrolled in a CODA-accredited dental school academic program that includes all areas of study listed above.

NAME OF SCHOOL

GRADUATION YEAR

REQUIRED SIGNATURES:

SIGNATURE OF APPLICANT

SIGNATURE OF SUPERVISING DENTIST AS WITNESS TO APPLICANT'S ATTESTATION

GOOD MORAL CHARACTER QUESTIONS

IF YOU ANSWER "YES" TO ANY OF THE FOLLOWING QUESTIONS PLEASE ATTACH A SEPARATE SHEET EXPLAINING THE CIRCUMSTANCES. ALSO PROVIDE ALL RELEVANT CERTIFIED DOCUMENTATION (POLICE REPORTS, COURT RECORDS, DISCIPLINARY ACTION REPORTS, ETC.) INCLUDING FINAL DISPOSITION OF THE MATTER.

NOTE: An applicant for employment or for housing or an occupational or professional license with a sealed record on file with the commissioner of probation may answer 'no record' with respect to an inquiry herein relative to prior arrests, criminal court appearances or convictions. An applicant for employment or for housing or an occupational or professional license with a sealed record on file with the commissioner of probation may answer 'no record' to an inquiry herein relative to prior arrests or criminal court appearances. In addition, any applicant for employment or for housing or an occupational or professional license may answer 'no record' with respect to any inquiry relative to prior arrests, court appearances and adjudications in all cases of delinquency or as a child in need of services which did not result in a complaint transferred to the superior court for criminal prosecution.

13. Have you ever applied for and been denied a professional license in the United States or any country or foreign jurisdiction?

Yes ☐ No ☐

14. Has any licensing or certification board, government authority, hospital or health care facility or professional medical association located in the United States or any country or foreign jurisdiction taken any disciplinary action against you?

Yes ☐ No ☐

15. Are you the subject of pending disciplinary actions by any licensing or certification board, government authority, hospital or health care facility or professional medical association located in the United States or any country or foreign jurisdiction?

Yes ☐ No ☐

16. Have you ever voluntarily surrendered any professional license or board certification in the United States or any country or foreign jurisdiction?

Yes ☐ No ☐

17. Have you ever been arrested, charged, arraigned, indicted, prosecuted, convicted or been the subject of any criminal investigation or any court proceeding in relation to any criminal violation? Do not report minor violations for which a fine of \$100 or less was imposed.

Yes ☐ No ☐ No Record ☐

RELEASE

I hereby authorize all hospitals, institutions, credentialing agencies, organizations, personal physicians, employers (past and present), business and dental associates (past and present), and all government agencies and entities (local, state, federal, or foreign) to release to the Board of Registration in Dentistry any information, files or records requested by the Board in connection with the processing of my application. I further authorize the Board of Registration in Dentistry to release information contained in this application in association with its processing.

AFFIDAVIT OF APPLICANT

To the best of my knowledge and belief, I have filed all state tax returns and paid all state taxes required by state law and do not owe child support. I am aware of my professional obligations under M.G.L. c. 119 s. 51A, the reporting of suspected child abuse.

I understand that the Board is certified by the Massachusetts Criminal History Systems Board for access to Criminal Offender Record Information (CORI), including conviction and pending criminal case data. As an applicant for a license to practice as a limited licensed dentist I understand that a CORI check may be conducted by the Board for conviction and pending criminal case information only and that the CORI results will not necessarily disqualify me.

I understand that I am responsible for reading and understanding the laws and regulations governing practice as a limited licensed dentist in Massachusetts and I hereby agree to comply with such laws and regulations.

I understand that this application for licensure shall be deemed no longer valid if requirements for licensure as a limited licensed dentist are not met within one (1) year from the date of Board receipt. I also understand that fees are non-refundable and non-transferable.

I certify, under the pains and penalties of perjury, that the information I have provided pursuant to this application for licensure is truthful and accurate. I understand that any failure to provide truthful and accurate information in connection with this application for licensure may be grounds for the Board of Registration in Dentistry to deny issuance of a license; to suspend or revoke a license issued to me; and to deny renewal of a license issued to me, all in accordance with Massachusetts law.

To be completed, signed and witnessed by the applicant and a Notary Public.

APPLICANT SIGNATURE _____ DATE _____

PRINT NAME _____

**Attach a recent color
2"x 2" passport-sized
Photo**

NOTARY PUBLIC NAME: _____

NOTARY PUBLIC COMMISSION EXPIRES: _____

[Seal or Stamp]

SUBMIT A NONREFUNDABLE AND NONTRANSFERABLE FEE FOR \$90 (CHECK OR MONEY ORDER) PAYABLE TO THE COMMONWEALTH OF MASSACHUSETTS

The Commonwealth of Massachusetts
Executive Office of Health and Human Services
Department of Public Health
Bureau of Health Professions Licensure
Board of Registration in Dentistry
250 Washington Street, Boston, MA 02108

CHARLES D. BAKER
Governor

KARYN E. POLITO
Lieutenant Governor

Tel: 617-973-0971

Fax: 617-973-0982

www.mass.gov/dph/dentalboard

MARYLOU SUDDERS
Secretary

MARGRET R. COOKE
Commissioner

CRIMINAL OFFENDER RECORD INFORMATION (CORI)
ACKNOWLEDGEMENT FORM

TO BE USED BY ORGANIZATIONS CONDUCTING CORI CHECKS FOR
EMPLOYMENT, VOLUNTEER, SUBCONTRACTOR, LICENSING, AND HOUSING
PURPOSES.

The Board of Registration in Dentistry is registered under the provisions of M.G.L. c. 6, § 172 to receive CORI for the purpose of screening current and otherwise qualified license applicants and current licensees.

As a prospective or current license applicant or current licensee, I understand that a CORI check will be submitted for my personal information to the Department of Criminal Justice Information Systems (DCJIS). I hereby acknowledge and provide permission to the Board of Registration in Dentistry to submit a CORI check for my information to the DCJIS. This authorization is valid for one year from the date of my signature. I may withdraw this authorization at any time by providing written notice of my intent to withdraw consent to a CORI check.

FOR EMPLOYMENT, VOLUNTEER, AND LICENSING PURPOSES ONLY:

The Board of Registration in Dentistry may conduct subsequent CORI checks within one year of the date this Form was signed by me provided, however, that Board of Registration in Dentistry must first provide me with written notice of this check.

By signing below, I provide my consent to a CORI check and acknowledge that the information provided on Page 2 of this Acknowledgement Form is true and accurate.

SIGNATURE

DATE

NOTE: The Board of Registration in Dentistry cannot accept this form unless it is either (1) signed in person at the Board's offices in the presence of a BHPL employee who has verified the applicant's identity through acceptable identification, or (2) signed in the presence of a notary public who has likewise verified identity and then mailed or hand-delivered to the Board's offices at the address set forth above.

**CRIMINAL OFFENDER RECORD INFORMATION (CORI)
ACKNOWLEDGEMENT FORM**

SUBJECT INFORMATION: (An asterisk (*) denotes a required field)

*Last Name *First Name Middle Name Suffix

Maiden Name (or other name(s) by which you have been known)

Date of Birth Place of Birth

Last Six Digits of Your Social Security Number: _____ - _____

Sex: ____ Height: ____ ft. ____ in. Eye Color: _____ Race: _____

Driver's License or ID Number: _____ State of Issue: _____

Mother's Full Name (Mother's Maiden Name) Father's Full Name

Current and Former Addresses:

Street Number & Name City/Town State Zip

Street Number & Name City/Town State Zip

The identity of the subject of this acknowledgement form was verified by reviewing the following form(s) of government-issued identification:

VERIFIED BY: _____ ON _____
Name of Verifying BHPL Employee or Notary Public (Please Print) Date

Signature of Verifying BHPL Employee or Notary Public

NOTARY NAME: _____

COMMISSION EXPIRES: _____

[Seal or stamp]

ATTACHMENT CHECKLIST

Your application cannot be processed without all of the following:

- ☐ **Attachment 1: Licensing Fee** - Personal or business check or money order made payable to the Commonwealth of Massachusetts for \$90.00. Cash is not accepted. All fees are non-refundable and non-transferable. Do not staple check or money order to the application.
- ☐ **Attachment 2: Proof of Graduation from a Dental School** - Provide an official transcript or letter from your dental school including date of graduation and degree conferred, and translated into English, if necessary. Photocopies will not be accepted. Diplomas will not be accepted.
- ☐ **Attachment 3: English Language Proficiency** - If your dental degree is from a school where instruction (written or oral) was in a language other than English, documentation of a minimum score on the TOEFL or the academic format IELTS must be attached.

Test of English as a Foreign Language (TOEFL)

90 (internet-based) **OR 577** (paper-based)

OR

Academic Format International English Language Testing System (IELTS) 7.0

- ☐ **Attachment 4: Physician's Statement** - Signed statement on physician's stationery certifying that the candidate has been examined within 6 months prior to the date of application and is deemed fit to practice dentistry.
- ☐ **Attachment 5: Documentation of Current CPR/AED for the Professional Rescuer or Current BLS Certification**
- ☐ **Attachment 6: Massachusetts Dental Ethics and Jurisprudence Exam—Answer sheet only.**

IF APPLICABLE

- ☐ **Attachment 7: Letters of Standing** – Verification of Professional Licensure from each state or jurisdiction in which you hold or have ever held a license must be included in the application. The letter of verification of licensure must include the current status of the license, license number, the official seal of the jurisdiction's licensing Board, and any disciplinary actions taken. A photocopy of a license is not acceptable.
- ☐ **Attachment 8: Practice History** - If you have ever practiced dentistry in another jurisdiction or state, please include an up-to-date resume or practice history, including employers' contact information and dates of employment.
- ☐ **Attachment 9: National Practitioner Data Bank Self-Query Report** – (If you have ever held a professional healthcare license in the United States) To request a self-query report, please contact the Data Bank at 1-800-767-6732 or www.npdb-hipdb.hrsa.gov. The Data Bank will mail the report to you. Only an original report from NPDB will be accepted for this application.

MaineCare's Dental Benefit

**Commission to Expand Access to Oral Health
Care by Studying Alternative Pathways for
Obtaining a License to Practice Dentistry**

Courtney Pladsen, DNP, FNP, FAANP

MaineCare Medical Director

October 22, 2025



Dental Community Engagement

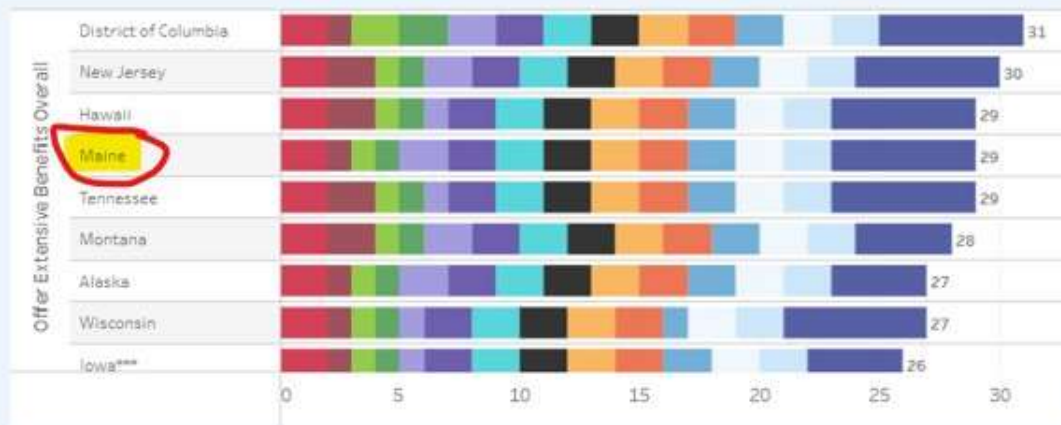
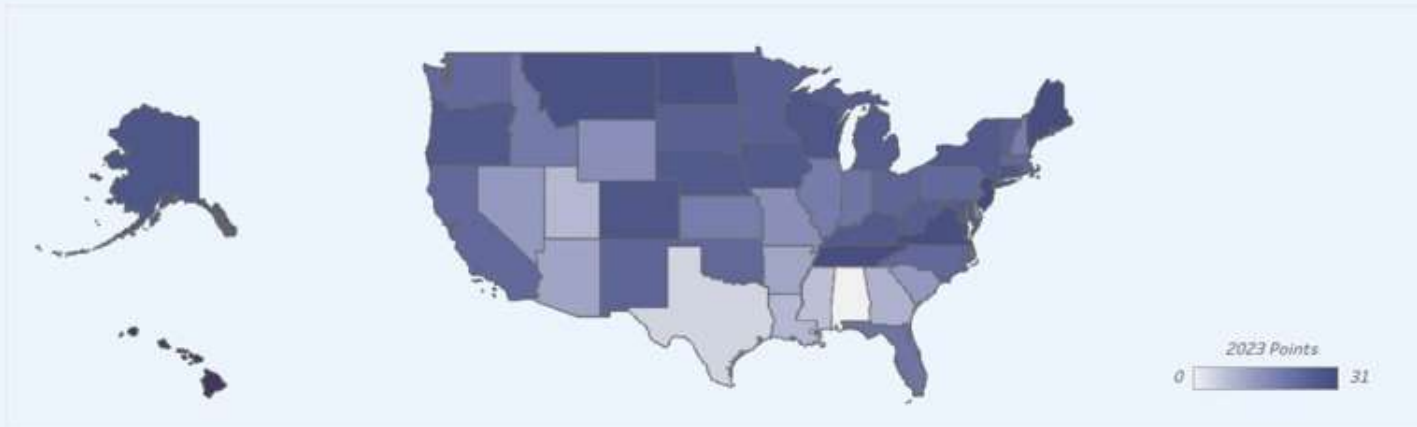
Engagement

- OMS Engages with Dental Providers possibly more than any other provider type
- Dental Sub-MaineCare Advisory Committee
- OMS is represented at every major dental event in Maine
- Held public forums to clarify dental policy
- Provide support to providers experiencing clearinghouse challenges

Recruitment

- Develop materials specific to MaineCare enrollment for dental providers
- Attend and table at conferences
- Applied and was one of eleven states chosen to the CHCS national learning collaborative – Medicaid Oral Health Workforce Implementation. Our proposal was to develop a state-wide strategy. COHN, MDA, and IDH organizations, in partnership with DHHS are on the team

2023 Medicaid Adult Dental Coverage Checker



Select below to view individual measures

(All)

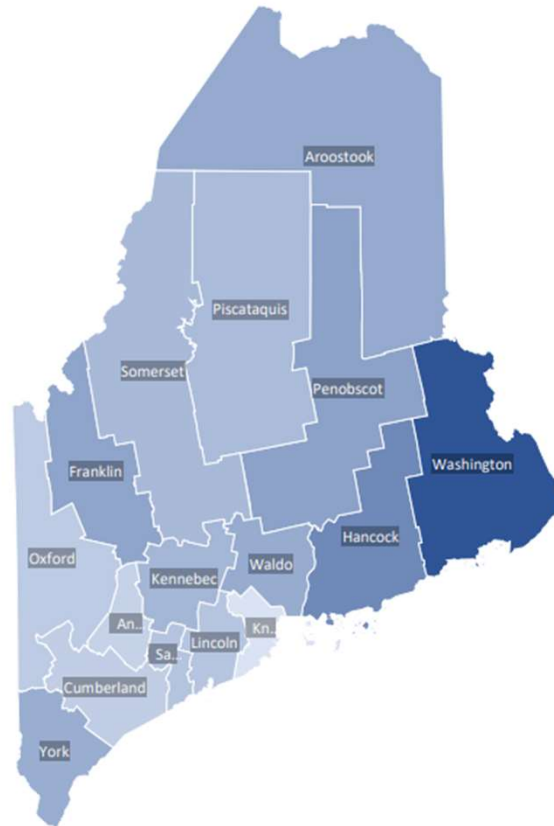
- Annual Benefit Max 1
- Diagnostic 2A (periodic ...
- Diagnostic 2B (limited o...
- Preventive 3A (prophyla...
- Preventive 3B (applicati...
- Restorative 4A (fillings)
- Restorative 4B (crowns)
- Endodontic 5A (anterior ...
- Endodontic 5B (posterior...
- Periodontal 6 (scaling a...
- Prosthodontic 7A (remot...

MaineCare Dental Metrics

- The FY22-FY23 biennial budget allocated funds to establish a new Adult Dental Benefit in MaineCare effective July 1, 2022. Adults aged 21 and over now have access to a comprehensive benefit, including coverage of full and partial dentures, preventive services, diagnostic services, and restorative services.
- Per Section CCC-3 of the budget, MaineCare must produce:
 - Dental Metrics Legislation Metrics to measure outcomes of the expansion of dental services to adults 21 years of age and over, including measures of provider participation, the use of those services by adults over 21 years of age and over and oral health outcomes for adults 21 years of age and over, in the aggregate and, in order to identify and address potential disparities in access to and outcomes of such services, by race, ethnicity and geography.
- Link [Dental Metrics Report June 2025.pdf](#)

Adult Member Use of Any Dental Services

Member Use of Services, Any Service, Adults 21+ by Member County of Residence



For the Year Ending 6/30/2025

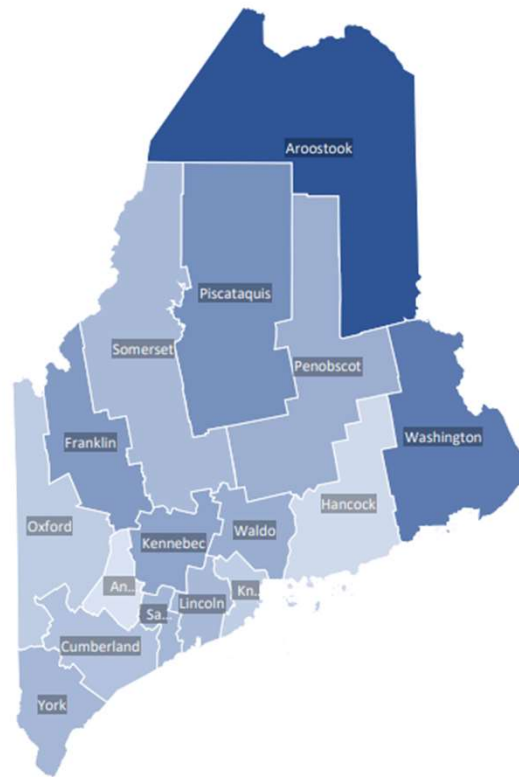
County	Adult Members 21+ w/ Any Dental Svc
Androscoggin	11.61%
Aroostook	14.19%
Cumberland	11.87%
Franklin	14.48%
Hancock	16.22%
Kennebec	13.34%
Knox	10.53%
Lincoln	12.43%
Oxford	12.05%
Penobscot	14.66%
Piscataquis	13.00%
Sagadahoc	12.52%
Somerset	13.13%
Waldo	14.02%
Washington	19.59%
York	13.92%

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Office of MaineCare Services, Data Analytics - Dental Measures

Child Member Use of Dental Services

Member Use of Services, Any Service, Children Under 21 by County of Residence



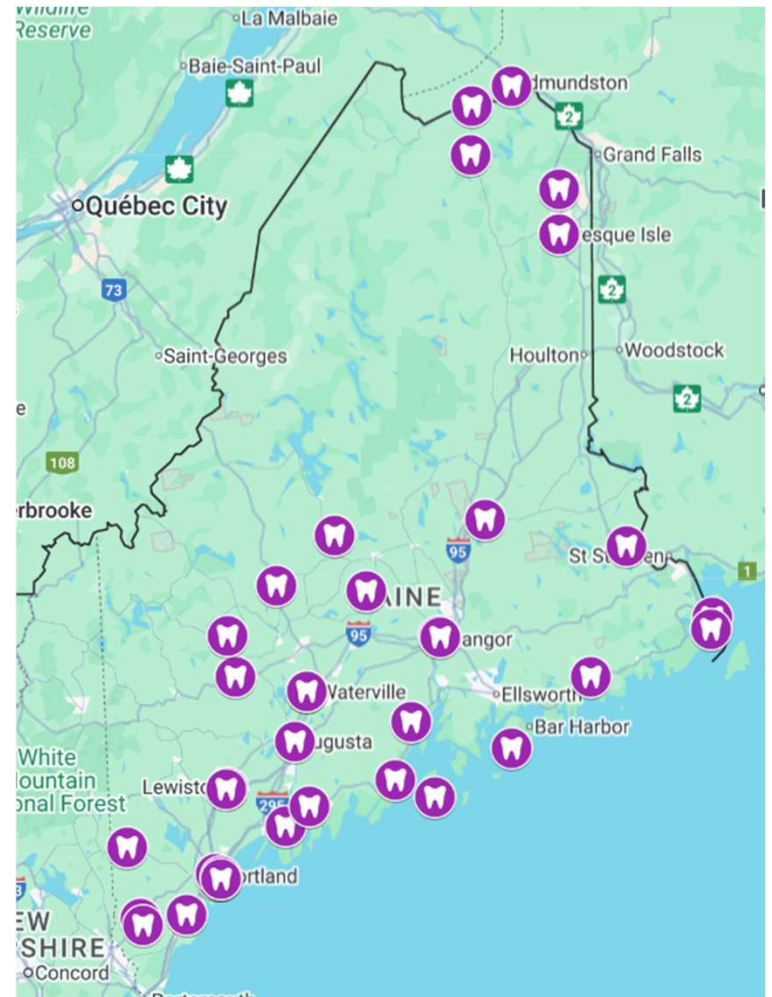
For the Year Ending 6/30/2025

County	Children Under 21 w/ Any Dental Svc
Androscoggin	41.13%
Aroostook	61.21%
Cumberland	45.74%
Franklin	51.30%
Hancock	42.34%
Kennebec	49.86%
Knox	44.03%
Lincoln	46.89%
Oxford	44.42%
Penobscot	48.46%
Piscataquis	52.77%
Sagadahoc	47.34%
Somerset	46.89%
Waldo	48.61%
Washington	55.82%
York	47.29%

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Office of MaineCare Services, Data Analytics - Dental Measures

Maine Dental Access Map



Oral Health Specialists

Type of Specialist	# with any dental claims Oct 2022-Sept 2023	# currently* taking referrals for MaineCare members	Locations / restrictions / Wait-times for those currently taking referrals
Pediatric dentistry	13	5	4 of the 5 are in York or Cumberland County 4 of the 5 are only taking kids from their county and/or certain ages. Only 1 is booking new patients out less than 6 months. Wait-times for kids who need to be seen in an operating room with general anesthesia are much longer, managed on a case-by-case basis based on OR availability
Orthodontics	7	2	1 in York Cty, booking consults 2 months out 1 in Cumberland Cty (age 10-21 only) booking consults 9 months out.
Oral Surgery	6	4	2 in York Cty, booking 4-6 months out 1 in Androscoggin Cty (local referrals only) booking out 9 months Plus 1 in Cumberland Cty that can be called daily in case appt opens up and 1 in Aroostook Cty where could only leave a
Anesthesia	1	n/a	
Endodontist		0	
Periodontist	Unkn own	1	Bangor – Penobscot Community Health Center

FQHCs & Dental Services

Unique Characteristics:

- FQHCs see patients regardless of the ability to pay. They are required to have a sliding scale fee for all services.
- Of those who provide dental care, they offer low-barrier access

Providers

- There are about 210 non-FQHC billing dental providers and about 50 FQHC dental providers
- FQHCs are disproportionately in rural communities

Rates

- FQHCs utilize an alternate payment model, which equates to a flat rate per visit.
- Each FQHC has a different rate based on the scope of services the health center provides and is calculated based on all visit costs.
 - Exception: Dentures and crowns are paid off the fee schedule

Rate Determination

- 22 M.R.S. § 3173-J Process for Section 25
 - 1. Public Forums: Nov 29, 2023, April 12, 2024 Draft Rates and Benchmarking
 - 2. Official written comment period
 - 3. Department review and response to comments
 - 4. Target 7/1/24 effective date
- Existing methodology would result in an estimated \$2.2M reduction in reimbursement for dental services. Amended the rule to prevent rate benchmark updates from reducing overall reimbursement to providers. Cost of Living Adjustment (COLA)
- Due to ongoing dental access issues, it is our goal to conduct a full rate determination for all Dental Services in CY 2026, one year ahead of the five-year timetable.
- If a rate study results in a recommendation for increased rates, that would need to be appropriated by the Maine Legislature.

Final Thoughts

- MaineCare is regulated by federal laws and regulations. This creates an administrative burden in our processes. Our team is committed to decreasing the burden to the maximum extent possible while also meeting regulations and being fiscally responsible.
- Dental therapists are included as a covered provider within MaineCare
- To improve access, we need to use every tool and avenue possible, including:
 - Tele-dentistry
 - School-based health centers
 - Silver Diamine Fluoride expansion in primary care
 - Mobile dental vans
- The MaineCare team is committed to working with community partners, professional organizations, and the state legislature to improve access to dental care.

Thank you!

Courtney Pladsen

courtney.pladsen@maine.gov





Barriers to Licensure for Foreign Trained Dentists in the US

Dr. Riddhi Badamia

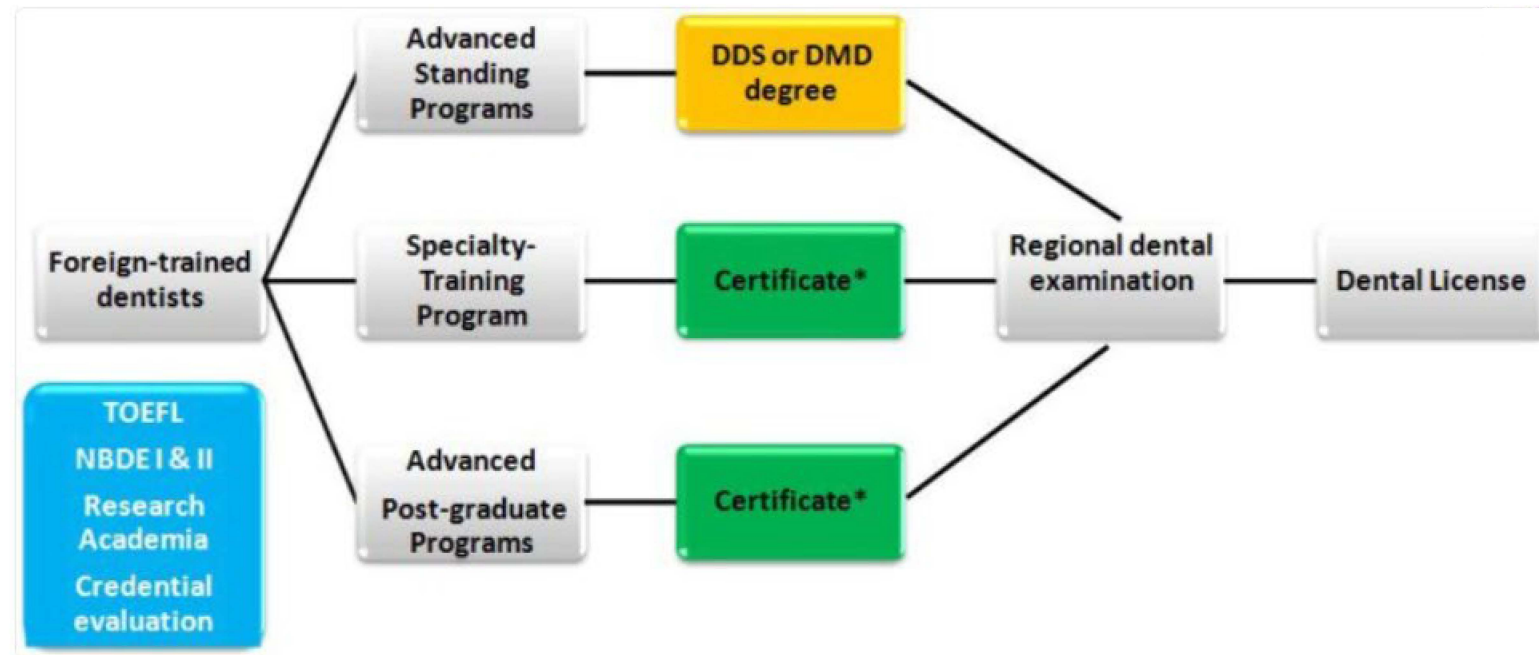
BDS, MSD, MPH, EMBA, FICOI

Diplomate – American Board of Dental Public Health

[View full-text article in PMC](#)

► *Dent J (Basel)*. 2018 Jul 1;6(3):26. doi: [10.3390/dj6030026](https://doi.org/10.3390/dj6030026) [↗](#)

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Pathways to licensing for foreign-trained dentists in the United States. * Recognized by a limited number of States.

Poorly Regulated Regulations

- Most glaring issues exacerbating the dental crisis in the U.S. are the licensure barriers preventing highly educated, skilled, foreign-trained dentists from practicing.
- 95% of the foreign-trained dentists currently residing in the U.S. are prevented from entering the workforce due to outdated licensure regulations.

This system forces these highly qualified professionals into:

- 1) Unnecessary debts
- 2) Redundant education
- 3) Perpetuating a counterproductive policy
- 4) Solutions to the dental care shortage exist within underserved communities.



The False Dichotomy—‘Licensed-Qualified’ vs. ‘Skill-Qualified’

- Some states’ license regulations rest on the flawed assumption that foreign dental degrees are inferior.
- Even if a foreign-trained professional with significant US education from CODA-accredited post-graduate specialty programs has more academic training and clinical experience than their US counterparts.
- For example, a graduate Certificate or a Master degree from one of the 12 CODA-accredited Dental Specialties recognized by the national commission.



A Glaring Contradiction—Foreign-Trained Dentists vs. Dental Therapists

- Stark contradictions in the current U.S. dental system are the comparison between foreign-trained dentists and dental therapists.
- In the U.S., dental hygienists can now become dental therapists, licensed to perform various procedures, including administering anesthesia, providing restorative care, and even extracting teeth.
- In contrast, foreign-trained dentists—with significantly more clinical training—are barred from performing the same tasks.



A Path Forward – Work Force Integration

1. **Systemic reforms to expand oral health access** - Provide immediate relief to chronic issues of access for the underserved communities and reduce the burden of oral diseases, simultaneously reducing significant state health expenditure.
2. **Improve QALYs of life** via ‘Skilled qualification measures’ rather than ‘Licensed only measures of qualification’.
3. **Have standards** - Reducing the barriers for licensing while strongly upholding the standards of education and the standards of care in dentistry via mandatory requirements of national board exams, specialty trainings, licensing exams, and board certifications.



Thank you!

DENTAL CENTERS

provider capacity



LOCATION	OPERATORIES	CURRENT PROVIDERS	ADDITIONAL PROVIDER CAPACITY	ESTIMATED ADDITIONAL ANNUAL ENCOUNTERS
Bangor Dental Center	40	4 dentists 4 hygienists 1 periodontist (1 day/month) 1 orthodontist (6 days/month)	8 dentists 8 hygienists	37,800
School-Based Health Centers*	2	1 dentist 1 hygienist	2 dentists	2,124
Belfast Dental Center (opening April 2026)	8	--	2 dentists 4 hygienists	12,950
*Two of PCHC's School-Based Health Centers have dental clinics with shared providers: Downeast School (Bangor) & Brewer Community School			12 DENTISTS 12 HYGIENISTS	52,874

KEY TAKEAWAYS

- PCHC currently operates 50 operatories across its dental network but lacks sufficient providers to meet patient demand.
- 22 additional providers would enable the network to operate at full capacity, generating roughly 53,000 more patient encounters annually.
- Increasing staffing to full capacity would significantly expand access to care.

Additional annual encounters methodology

Bangor & Belfast Dental Centers

- 208 working days minus 13 holidays and 5 weeks of vacation = 175 days
- Annual **Dentist** Encounters:
 - Per Dentist: 17 daily encounters
 - **2,975 encounters a year**
- Annual **Hygienist** Encounters:
 - Per Hygienist: 10 daily encounters
 - **1,750 encounters a year**

Bangor Downeast School SBHC Dental Clinic

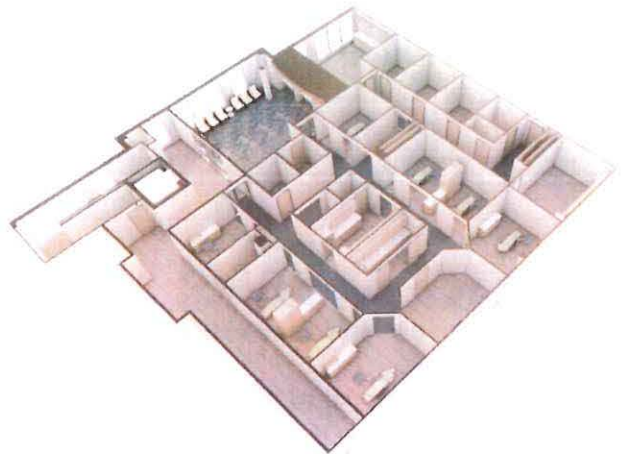
- 260 working days minus 13 holidays, 18 weeks summer vacation and 5 weeks of vacation = 132 days
- Annual **Dentist** Encounters:
 - Per Dentist: 6 daily encounters
 - **792 encounters a year**

Brewer Community School SBHC Dental Clinic

- 260 working days minus 13 holidays and 5 weeks of vacation = 222 days
- Annual **Dentist** Encounters:
 - Per Dentist: 6 daily encounters
 - **1,332 encounters a year**



Bangor Dental Center



Belfast Dental Center
(opening April 2026)