# Impact of Medicaid Dental Policy Reforms on Pediatric Dental Access

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## ABSTRACT

**Purpose:** Medicaid's EPSDT benefit guarantees dental coverage for children, yet caries prevalence and unmet needs remain disproportionately high among low-income populations. Recent state revisions to benefit scope, reimbursement levels, and administrative requirements may influence provider participation and pediatric utilization of preventive and operative dental services.

**Methods:** This review synthesized peer-reviewed literature, national policy analyses, and state plan documents. The evaluation focused on benefit scope, including minimally invasive services such as silver diamine fluoride (SDF) and anesthesia, reimbursement adequacy, provider participation, and trends in preventive visits and emergency department (ED) utilization. Four states (NY, PA, CA, TX) were selected as case examples to illustrate contemporary policy approaches and implementation details.

**Results:** States that reimburse minimally invasive pediatric services, clarify clinical criteria, and maintain consistent payment policies generally demonstrate increased preventive dental utilization. ED use varies depending on program design and availability of community-based alternatives. Provider participation is sensitive to reimbursement rates and administrative complexity. SDF policies increasingly specify frequency limits, lifetime caps, and documentation requirements, supporting broader adoption of conservative care.

**Conclusions:** Aligning reimbursement with chair time and procedural complexity, standardizing core pediatric dental benefits, including SDF and medically necessary anesthesia, and promoting incentives tied to minimally invasive, quality-linked metrics may improve access and utilization. Targeted policies addressing children with special health care needs and rural populations can reduce disparities. Long-term sustainability is achievable when benefit design reduces avoidable ED visits and lowers reliance on high-intensity operative care.

## INTRODUCTION

Dental caries remain the most prevalent chronic disease of childhood in the United States, disproportionately burdening children from low-income and minoritized communities. Although Medicaid's Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit guarantees comprehensive pediatric dental coverage, substantial gaps in access and utilization persist. Preventive visit rates remain uneven across states, and unmet oral health needs continue to drive avoidable emergency department (ED) use.

In recent years, states have implemented notable Medicaid dental policy changes including expanded coverage of minimally invasive treatments such as silver diamine fluoride (SDF), revisions to anesthesia and sedation criteria, adjustments to reimbursement, and efforts to streamline administrative requirements. These changes aim to improve provider participation and promote preventive, conservative care, yet their real-world implications for pediatric access remain incompletely understood.

This project examines how recent Medicaid pediatric dental policy changes affect access to care, provider participation, and utilization patterns. Focusing on benefit scope, reimbursement adequacy, and implementation details, we synthesize national evidence and highlight policy variation across four illustrative states—New York, Pennsylvania, California, and Texas—to identify emerging best practices and remaining barriers to equitable pediatric oral health care.

## METHODOLOGY

Study Design
We conducted a policy-focused evidence synthesis examining how recent Medicaid pediatric dental policy changes affect access to care, provider participation, and utilization. The analysis integrates policy review, secondary literature synthesis, and cross-state case comparison.

Data Sources
- Peer-reviewed literature on Medicaid dental reimbursement, provider participation, preventive utilization, and emergency department (ED) use
- National policy and data sources, including:
  - American Academy of Pediatric Dentistry (AAPD) Research & Policy Center mappings (2021–2023)
  - American Dental Association Health Policy Institute (ADA HPI) state-level Medicaid data (2024–2025)
  - CMS Child and Adult Core Set oral health measure documentation
- State and managed care plan documents, including Medicaid Updates, provider manuals, plan bulletins, and clinical policy criteria

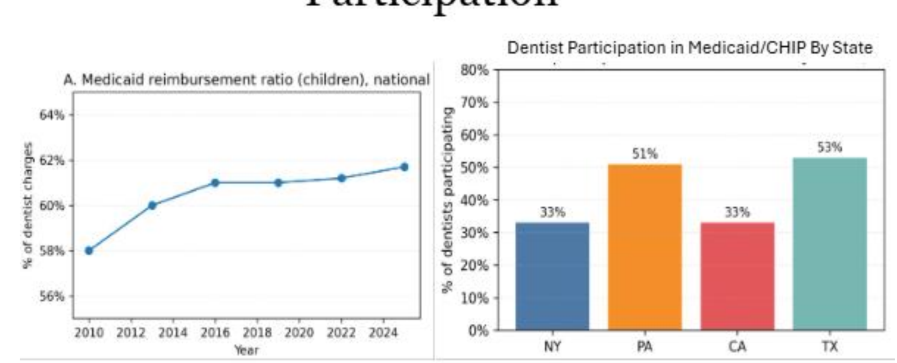
Policy Domains Analyzed
We systematically reviewed policies across four domains:
- Benefit Scope – coverage of preventive and minimally invasive services (e.g., silver diamine fluoride [SDF]), behavior guidance, and medically necessary anesthesia/sedation
- Reimbursement – recognition of CDT/CPT codes, payment levels, and stability over time
- Administrative Requirements – prior authorization, documentation criteria, and plan variation
- Access & Utilization Indicators – preventive visit trends, provider participation, and ED use

State Case Studies
Four states—New York (NY), Pennsylvania (PA), California (CA), and Texas (TX)—were selected to illustrate contemporary variation in:
- Pediatric SDF policies (frequency limits, lifetime caps, visit limits)
- Anesthesia/sedation criteria and authorization processes
- Implementation across fee-for-service and managed care delivery systems

Analytic Approach
- Policies were abstracted into a standardized comparison matrix
- State-specific SDF limits were summarized
- Findings were interpreted alongside national trends in reimbursement and dentist participation

Outcomes of Interest
- Alignment of benefit design with preventive, minimally invasive care
- Signals of access improvement (preventive utilization, provider participation)
- Implications for equity, administrative burden, and program sustainability

Reimbursement Trend and State Participation




Note: Adapted from Dental Care in Medicaid Programs. Health Policy Institute. December 2025

## RESULTS

**Policy and Recent Changes**
Core pediatric dental benefits include preventive services, caries-arresting medicaments (notably SDF), behavior guidance, and medically necessary anesthesia/sedation

State Updates and Policies Regarding SDF:
- New York: All ages; 2x/tooth/year, 4x lifetime, 5 teeth/DOS, documentation required; effective January 1, 2025
- California: Ages 0-20, 2x/year baseline (4x/year if high risk), 5 teeth per arch/DOS, $5/tooth; no prior authorization
- Pennsylvania: Ages 0-6 and specified populations; two visits/year, 10 teeth/visit, 4x lifetime per tooth, $12/tooth
- Texas: Ages 6 months-6 years (value-added), 2x lifetime per tooth, $14.12/tooth, per visit count not specified in cited plan letter

State Policies Regarding Anesthesia and Provider Challenges
- New York: prior authorization per eMedNY manual; facility fees and medical benefits apply when anesthesia is physician administered in hospital/ASC or eligible dental office.

Overall: can be complex due to needed compliance with office-based surgery safety rules
- California: requires managed care plans (private insurance company to manage Medicaid) to cover IV moderate sedation (D9293/D9243) and deep sedation/GA (D9222/D9223) associated with dental services, with standardized prior authorization criteria across standards

Overall: strict criteria/checklist for approval
- Pennsylvania: clinical policy defines indications for IV moderate/deep sedation or GA; prior authorization and documentation required depending on plan; provider setting must meet licensing and monitoring standards

Overall: Need clear clinical justification and greater documentation to justify
- Texas: required narratives, radiographs, and behavior assessments; codes D9222/D9223 typically require prior authorization and linkage to approve dental treatment plans

Overall: Provider attestation required which increases perceived liability

The stricter the medical necessity rules and the higher the documentation/administrative burden, the more likely the provider is to limit sedation cases, refer out complex patients or reduce Medicaid participation.

**Access, Utilization, and Outcomes**
- Expanding reimbursement for pediatric preventive services is associated with higher preventive visit rates. This is the case especially when programs coordinate with well-child visits (Tiwari, 2021).
- Reimbursement rates influence dentist participation and children's utilization. Analyses demonstrate a positive relationship between higher fees and utilization/participation, although effects can be context dependent (Buchmueller, 2013).
- Evidence on ED outcomes is mixed. Baker et al evaluated Florida's adoption of managed dental care and pediatric ED visits and found that managed dental care coincided with increased pediatric ED visits for nontraumatic dental injuries. Whereas Giannouchos et al found that Medicaid expansion with dental benefits was linked to reduced adult dental ED use.

## DISCUSSION

Recent Medicaid pediatric dental policy changes show promise for improving access to preventive and minimally invasive care, particularly when states explicitly recognize and reimburse services such as silver diamine fluoride (SDF) and medically necessary anesthesia. Across illustrative states, clearer benefit definitions, standardized clinical criteria, and stable payment policies are associated with higher preventive utilization and improved alignment with conservative care models.

However, gains in coverage do not uniformly translate into access. Provider participation remains sensitive to reimbursement adequacy and administrative burden, with persistent variation across states and delivery systems. While some policies are designed to reduce operative intensity and avert costly emergency department (ED) visits, ED utilization patterns remain mixed, suggesting that benefit expansion alone is insufficient without accompanying workforce and implementation supports.

Importantly, policy design choices such as frequency limits, documentation requirements, and prior authorization thresholds shape clinical adoption. States that balance program integrity with administrative simplicity may be better positioned to support equitable access, particularly for children with special health care needs and those in rural areas.

Overall, the findings underscore that **pediatric dental access under Medicaid depends not only on statutory coverage, but on how benefits are operationalized**. Continued alignment of reimbursement, quality incentives, and minimally invasive care strategies is critical to advancing equity and sustainability in pediatric oral health.

## CONCLUSION

States that reimburse minimally invasive pediatric services, clarify clinical criteria, and maintain consistent payment policies generally demonstrate increased preventive dental utilization. SDF policies increasingly specify frequency limits, lifetime caps, and documentation requirements. Aligning reimbursement with chair time and procedural complexity, standardizing core pediatric dental benefits, including SDF and medically necessary anesthesia, and promoting incentives tied to minimally invasive care may improve Medicaid pediatric dental access and utilization of benefits.
Long-term sustainability is achievable when benefit design allows improved access to dental care, and this in turn may reduce avoidable emergency department visits and lower reliance on more complex operative treatment.

Recommendations:
Standardize core pediatric dental benefits across states including coverage for caries risk assessment, SDF, interim therapeutic restorations, behavior guidance, medically necessary anesthesia/sedation, and SHCN accommodations following AAPD policies.

Adjust reimbursement to time and complexity to reflex chair time requirements and to encourage preventive and minimally invasive care.
Reduce administrative burden by streamlining prior authorization and documentation standards across managed plans, as well as simplifying fee schedule navigation.

## REFERENCES

1. AAPD. Management of Dental Patients with Special Health Care Needs (Ref. Manual 2025–2026; latest revision 2021). https://www.aapd.org/research/oral-health-policies--recommendations/management-of-dental-patients-with-special-health-care-needs/
2. AAPD Research & Policy Center. Reimbursement for Dental Services for Children Covered by Medicaid (Jan 2024; rev Apr 2024). https://www.aapd.org/globalassets/reimbursement-medicaid-childrens-dental_aapd-rpc_2024.pdf
3. American Academy of Pediatric Dentistry. State Dental Periodicity Schedules. Updated October 2024. https://www.aapd.org/research/policy-center/state-dental-periodicity-schedules/
4. American Dental Association Health Policy Institute (ADA HPI). Health Policy Institute—Coverage, Access & Outcomes (state-level data tools). https://www.ada.org/resources/research/health-policy-institute
5. American Dental Association. Dental Care in Medicaid Programs. Health Policy Institute. December 2025. https://www.ada.org/-/media/project/ada-organization/ada/ada- org/files/resources/research/hpi/dental_care_in_Medicaid_programs.pdf
6. Baker, L., Munnich, E. L., & Kranz, A. M. (2024). Medicaid Managed Care and Pediatric Dental Emergency Department Visits. *JAMA health forum*, *5*(6), e241472. https://doi.org/10.1001/jamahealthforum.2024.1472
7. Becker's Dental Review. Dentist Medicaid participation in every state (2024) (Dec 19, 2025; citing ADA HPI). https://www.beckersdental.com/benchmarking/the-percentage-of-dentist-medicaid-participation-in-every-state/
8. Buchmueller TC, Orzol S, Shore-Sheppard LD. The Effect of Medicaid Payment Rates on Access to Dental Care Among Children. NBER Working Paper No. 19218; 2013. https://www.nber.org/system/files/working_papers/w19218/w19218.pdf
9. California Department of Health Care Services (DHCS). Silver Diamine Fluoride—CalAIM Dental. https://www.dhcs.ca.gov/services/Pages/silver-diamine-fluoride.aspx
10. Centers for Disease Control and Prevention. (2024, October 9). *2024 Oral Health Surveillance Report: Selected Findings*. Centers for Disease Control and Prevention. https://www.cdc.gov/oral-health/php/2024-oral-health-surveillance-report/selected-findings.html
11. Centers for Medicare & Medicaid Services (CMS). Dental and Oral Health Services Measures in the 2025 Core Sets (March 2025 TA Resource). https://www.medicaid.gov/medicaid/quality-of-care/downloads/dentaloralhealth-ta-resource.pdf
12. Commonwealth Fund. How State Budget Shortfalls Could Put Medicaid Dental Coverage at Risk(June 12, 2025). https://www.commonwealthfund.org/publications/explainer/2025/jun/how-state-budget-shortfalls-put-medicaid-dental-coverage-risk
13. DentaQuest (TX). Provider Letter—Silver Diamine Fluoride (D1354) Value-Added Service (July 24, 2020; effective Sept 1, 2020). https://www.dentaquest.com/content/dam/dentaquest/en/providers/texas/tx-silver-diamine-fluoride-provider-letter-july-2020.pdf.coredownload.inline.pdf
14. DHCS. All Plan Letter 23-028: Dental Services—IV Moderate Sedation & Deep Sedation/General Anesthesia Coverage (Oct 3, 2023). https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2023/APL23-028.pdf
15. EmblemHealth. Medicaid Dental Coverage for D1354—Interim Caries Arresting Medicament (SDF)(effective Jan 1, 2025). https://www.emblemhealth.com/providers/resources/State-Sponsored-Programs/medicaid-dental-coverage-for-d1354--interim-caries-arresting-med
16. eMedNY. New York State Medicaid: Dental Policy and Procedure Code Manual (2025/2026). https://www.emedny.org/ProviderManuals/Dental/PDFS/Dental_Policy_and_Procedure_Manual.pdf
17. Giannouchos TV, Reynolds J, Damiano P, Wright B. Medicaid expansion and dental ED visits by benefit generosity. *BMC Health Serv Res.* 2023;23:625
18. Keystone First (PA). Silver Diamine Fluoride flyer (coverage/limits). https://www.keystonefirstpa.com/content/dam/keystone-first/keystone-first-pa/pdf/provider/resources/dental/silver-diamine-fluoride.pdf.coredownload.inline.pdf
19. National Conference of State Legislatures (NCSL). Meeting Children Where They Are: State Strategies to Increase Preventive Oral Health (May 8, 2025). https://www.ncsl.org/health/meeting-children-where-they-are-state-strategies-to-increase-preventive-oral-health
20. New York State Department of Health. Medicaid Update (Nov 2024): Dental Benefit—SDF (D1354) expansion. https://www.health.ny.gov/health_care/medicaid/program/update/2024/docs/mu_no12_nov24_pr.pdf
21. PA Health & Wellness (Centene). Clinical Policy: IV Moderate Sedation, IV Deep Sedation, and General Anesthesia (Dental) (Sept 2023; rev 2024). https://www.pahealthwellness.com/content/dam/centene/Pennsylvania/policies/clinical-policies/PA.CP.MP.61%20IV%20Moderate%20Sedation,%20IV%20Deep%20Sedation-General%20Anesthesia%20Dental%20Procedures_REV_AUGUST_2024.pdf
22. Serban N, Anderson A, Oberst G, et al. Dentists' Participation in Public Insurance Programs for Children. *JAMA Netw Open.* 2022;5(7):e2221444. https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2794118
23. Spetz J, Rose J, Kahn JG, et al. Cost-effectiveness analysis design for interventions to prevent children's oral disease. *Front Oral Health.* 2024;5:1428638. https://www.frontiersin.org/journals/oral-health/articles/10.3389/froh.2024.1428638/full
24. Texas Medicaid & Healthcare Partnership (TMHP). Texas Medicaid Provider Procedures Manual (TMPPM) (last updated Dec 31, 2025). https://www.tmhp.com/resources/provider-manuals/tmppm
25. Tiwari T, Marinucci J, Tranby EP, Frantsve-Hawley J. Effect of Well-Child Visit Location on Preventive Dental Visit. *Children.* 2021;8(3):191. https://www.mdpi.com/2227-9067/8/3/191
26. Wellpoint (TX). Clinical Criteria Update for Moderate to Deep Anesthesia for Dental Surgery Ages 0–20 (Feb 19, 2025). https://providernews.wellpoint.com/tx/articles/clinical-criteria-update-for-moderate-to-deep-anesthesia-for-24164
27. UnitedHealthcare Dental (TX). Criteria for Dental Therapy Under General Anesthesia—PA Form(June 11, 2024). https://dentaltx.uhc.com/content/dam/texas-medicaid/PDF/ProviderForms/UHC%20Dental%20TX%20Criteria%20for%20Dental%20Therapy%20Under%20General%20Anesthesia%202024-06-11.pdf

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