EXPLORING THE IMPACT OF DENTAL PROVIDER REIMBURSEMENT RATES ON PROVIDER PARTICIPATION IN MEDICAIDFEE-FOR-SERVICE AND MANAGED CARE

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Date: June 2025

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Background

Access to dental care remains a persistent challenge for Medicaid beneficiaries across the United States, despite the legal mandate for coverage and evidence of the importance of oral health in overall well-being. Medicaid serves as a vital safety net for millions of low-income individuals, but numerous analyses over the past two decades have consistently identified low provider participation as a critical bottleneck limiting access. Among the most frequently cited factors influencing provider participation are low reimbursement rates. This white paper presents data from representative state Medicaid programs and health plans, along with the perspectives of Medicaid dental program administrators, to examine how increased reimbursement rates influence overall dental provider participation and the volume of significant providers—defined as those submitting ≥ $20,000 in annual claims.

Introduction

Medicaid Reimbursement Trends and Their Implications

Reimbursement rates for dental services in Medicaid have historically lagged significantly behind those in the private sector. In 2011, the average Medicaid fee-for-service (FFS) reimbursement for dental services was only 52% of the typical dentist charge, revealing a persistent undervaluation of Medicaid dental services across the country.[1] This finding underscores how far below market-rate Medicaid reimbursement often falls, creating a structural disincentive for providers to participate—especially in competitive urban markets where operational costs are high. More recent data from the American Dental Association Health Policy Institute (ADA-HPI) in 2022 showed similarly low reimbursement ratios: 61.2% of dentist charges for children's services and 53.3% for adult services.[2] In 2024, these figures remained virtually unchanged, with average Medicaid fee-for-service reimbursement at 61.7% for children and 52.7% for adults.[3] Despite incremental improvements in some states—particularly in pediatric dental reimbursement—the gap between Medicaid and private dental insurance payments remains substantial and uneven across states. These quantitative analyses underscore a central concern: the alignment between Medicaid reimbursement and the actual cost of care delivery remains tenuous, and for many providers, participation in Medicaid is financially unsustainable. Understanding how administrators perceive and respond to this tension is essential for designing effective policy reforms.

The expansion of Medicaid enrollment in recent years has led many states to adopt commercial managed care organizations (MCOs) to manage costs and improve service coordination. While some states have achieved cost savings through these models, outcomes have been mixed. Traditional managed care principles based on financial risk-sharing may not fully apply to Medicaid populations, which can limit the effectiveness of such models in certain contexts.[4]

Comparative analyses have also identified differences in care delivery between managed care and fee-for-service (FFS) models. Patterns of ambulatory care under managed care tend to be more fragmented, with beneficiaries often seeing a larger number of providers across fewer visits.[5] In the context of dental care, transitioning from FFS to managed care has been associated with modest declines in utilization, particularly when compared to states that retained FFS delivery systems. [6] These findings suggest that while managed care can support cost containment and administrative efficiency, thoughtful implementation is necessary to maintain access and care continuity, especially in dental services

Structural Factors Affecting Medicaid Dental Access

Beyond reimbursement levels and delivery models, analyses have highlighted a range of administrative and systemic barriers that influence provider willingness to participate in state Medicaid programs. In one state analysis, despite Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) requirements, only 30.5% of children received preventive dental services and fewer than 18% received treatment services, with administrative burden, delays in payment, and insufficient care coordination identified as major deterrents to provider participation.[7] Similar themes emerged in a multi-population policy analysis examining Medicaid programs designed to improve dental access for young children, pregnant women, individuals with developmental disabilities, and rural residents.[8] Across all groups, participation was constrained not only by low reimbursement rates but also by insufficient provider training, lack of administrative infrastructure, and geographic or logistical barriers. Even in rural areas supported by dedicated funding, challenges related to infrastructure and workforce incentives hindered efforts to recruit and retain dentists. Furthermore, in states where Medicaid dental services were subcontracted to managed care plans, administrative fragmentation contributed to longer wait times and increased difficulty with prior authorization processes.[7] Conversely, health plans that directly managed their dental networks experienced higher utilization, suggesting that simplified administration and more active provider engagement can serve as effective strategies for improving access.

Efforts to Integrate Social Risk Mitigation and Reimbursement Innovation

A growing number of states are exploring innovative Medicaid strategies that extend beyond clinical care to address broader social determinants of health. One recent report offers a range of research-based options aimed at meeting the goals of Senate Joint Resolution (SJR) 54, while also highlighting a broader array of programmatic and payment approaches that states are adopting to reduce healthcare disparities and respond to unmet social needs.[9] These strategies include leveraging Section 1115 waivers, value-based payment models, and in-lieu-of services to integrate non-clinical supports—such as housing, nutrition, and care coordination—into the Medicaid framework. While these reforms primarily target medical and behavioral health services, their principles are increasingly relevant to dental care, particularly as states look for ways to build more equitable and holistic care delivery systems.

Purpose of This Analysis

Ensuring network adequacy is a fundamental component of effective Medicaid dental program administration. However, in recent years, provider networks have come under growing strain due to economic pressures, dental workforce shortages, and ongoing barriers to access. In response to increasing concerns about these challenges—particularly the difficulty states face in maintaining sufficient numbers of participating dental providers—this study was conducted under the auspices of the Medicaid Medicare CHIP Services Dental Association (MSDA) to examine how reimbursement rates may influence dentist participation in Medicaid programs. The purpose of this study is twofold: (1) To advance the scientific evidence regarding reimbursement factors that influence dental provider participation in Medicaid programs; and 2) To provide examples of Promising Practices that states may consider to recruit and retain an adequate Medicaid dental provider network. By capturing the firsthand insights of those responsible for Medicaid dental program design and implementation, this study aims to contribute actionable knowledge that can help states and health plans strengthen network adequacy and improve access to care for low-income populations.

Methodology

MSDA convened a Program Advisory Committee (PAC), made up of representatives from state Medicaid dental programs, participating health plans and other key stakeholders to gain insight and guidance throughout the project period. The PAC met monthly to assist in project development and offered suggestions for data collection and analysis. This qualitative study was designed to collect data on the relationship between reimbursement rates and dental provider participation. State Medicaid dental program administrators and Medicaid managed care organizations (health plans) were invited to participate in this study. Each program report highlights program types Early and Periodic, Screening, Diagnostic and Treatment (EPSDT) or adult Medicaid dental programs.

The study employed a quantitative data collection tool as well as qualitative interviews composed of open- and close-ended questions to capture detailed insights across diverse programs. The data collection tool consisted of structured questions addressing changes in reimbursement rates, provider enrollment trends, and participation dynamics. The tool measured two key indicators: (1) the number of dentists submitting one or more claims (defined as “providers”), and (2) the number of dentists reimbursed at least $20,000 in a single year (defined as “significant providers”). Note that one state only had data by practice, rather than provider, and defined a significant practice as reimbursed at least $50,000 biannually. Respondents provided responses based on their program’s administrative records, policy changes, and experiential insights.

We employed a purposive sampling strategy targeting key informants—namely, those with oversight responsibility for dental reimbursement and provider management in their respective Medicaid programs. Each participating program was asked to designate a single knowledgeable respondent to complete the data collection instrument. Administrators were given approximately six weeks to respond.

All program responses were de-identified to preserve confidentiality. Descriptive statistics were conducted on the quantitative data, including changes in provider enrollment and significant providers. Narrative responses and interview transcripts were analyzed inductively to identify

recurring patterns, explanatory factors, and state-reported implementation strategies. Descriptive thematic summaries were developed to capture themes.

Results

State A: Fee Increase

In State A, prior to the changes reported here, neither the EPSDT nor the adult dental program had experienced upward changes in the fee schedule for many years. While the children's dental program had higher reimbursement rates than the adult dental program, dental providers were frustrated, and participation was low. Advocates came together and launched an appeal to lawmakers which brought about successful legislative rate reform. The entire dental policy was repealed and replaced. This legislative action led to four significant changes— 1) the development of a new methodology for assessing dental fees; 2) an upward adjustment in the fee schedule for both the EPSDT and adult dental program; 3) a priority focus on preventive services affording a higher percentage of increase on preventive fees; and 4) the passing of a more robust adult dental benefit.

As a result of these efforts, State A now has one new increased fee schedule applicable to both the EPSDT and adult dental programs; a more expansive adult dental benefit and a priority focus on preventive services.

Structure of the Increase in Dental Fees

The structure of the increase included an overhaul of all EPSDT and adult dental benefits and fees—Repeal and Replace**.** A new process was established for assessing fees to support greater alignment with commercial rates. All EPSDT fees were increased first with a higher percentage rate of increase allocated to preventative services. The adult dental benefit was then expanded, and fees were aligned with the EPSDT dental schedule to create one new fee schedule.

Outcomes

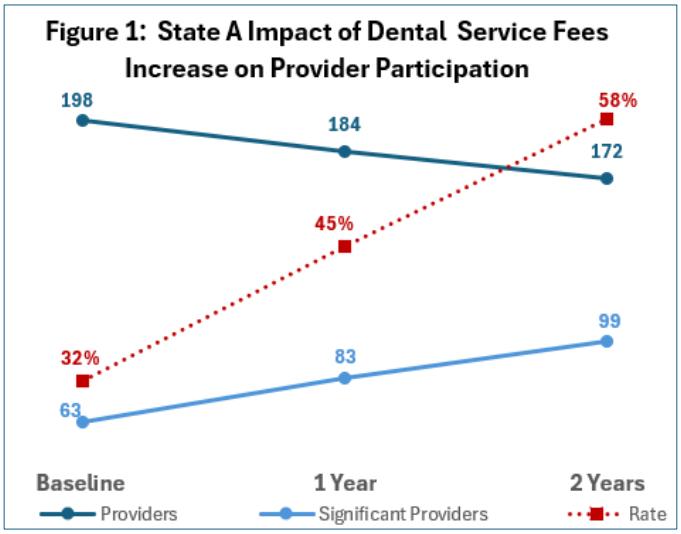


Figure 1: State A Impact of Dental Service Fees Increase on Provider Participation

The data from State A indicate that the 2022 increase in dental reimbursement fees for 11 + dental services included in the EPSDT dental program was associated with a modest decrease in overall provider participation—declining from 198 to 172 clinicians submitting at least one claim over the two-year observation window—yet concurrently produced a pronounced shift toward higher-value engagement. Specifically, the subset of significant providers (those submitting claims ≥ $20,000 annually) rose from 63 to 99, elevating their proportional representation from 32 % at baseline to 58 % after two years. While the increase in fees many account for some of the increase in the number of significant providers, these trends suggest that the revised fee schedule may have intensified claim volume among participating dentists, thereby reallocating participation toward more economically consequential activity.

Potential Impact

The fee increases in State A shifted provider behavior, reducing overall participation slightly while substantially increasing the proportion of significant providers. Because the fee change increased the number of significantly participating dentists, some of which may now be included in this category as a result of the higher rates, more members may likely face expanded provider access, additional appointment slots, reduced wait times, and improved oral health outcomes.

Conclusions

Overall, the fee increase in State A appears to have catalyzed greater engagement in high-value, comprehensive care among dentists—demonstrating the policy's capacity to elevate treatment intensity and quality—while also creating a timely opportunity to pair these gains with targeted incentives that sustain provider breadth and extend the benefits of enhanced reimbursement to all patient populations.

State B: Fee Increase

State B's decision to raise Medicaid dental fees was driven squarely by a legislative mandate. Lawmakers instructed the Medicaid agency to boost dental provider reimbursement rates without layering in service-specific incentives or regional adjustments. Acting on the directive in the 2021–23 biennial budget, the Medicaid agency doubled fees associated with every adult dental fee-for-service (FFS) code: the statute required payment "up to 100 percent of the schedule in effect on January 1, 2019."

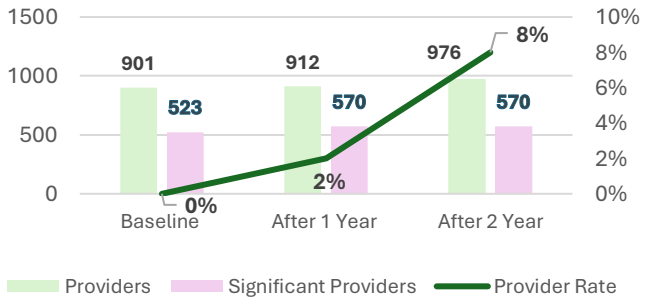
For the EPSDT dental program, administrators applied a formula that mirrored the adult approach. Each CDT code that existed in the adult benefit was included in the pediatric benefit and paid at 70 percent of the adult amount—for instance, an adult rate of $10 had a pediatric rate of $7.

This approach provided a "one-size-fits-all" fee adjustment to both programs

Structure of the Increase in Dental Fees

In 2023 State B executed a Medicaid dental-fee reset across all dental programs. The legislative directive automatically doubled the FFS amount for every adult service included in the benefit. Lawmakers followed with a narrower adjustment for the EPSDT program in the 2023 supplemental budget allocating fees at 70% of the adult fee schedule.

Figure 2. State B Impact of Dental Service Fee Increase on Provider Participation



Outcomes

Following the 2023 fee schedule adjustments, State B's Medicaid dental

network broadened slightly, climbing from 901 participating providers at baseline to 912 in 2024 and ultimately to 976 in 2025 (an 8.3 percent cumulative increase).

As a result, their share of all providers climbed 2% after one year, then jumped again an additional 6% in year two yielding an overall increase of 8% in the number of participating providers since the fee schedule was adjusted.

At the same time, the cohort of significant providers grew from 523 at baseline to 570 in the first year (a 9% increase) before holding steady at 570 in year two.

These sequential trends suggest that the revised fee schedule successfully broadened access and stimulated higher-value engagement.

Potential Impact

Following State B's dental fee increase, overall provider participation rose by 8.3% over two years and significant provider engagement increased 5 percentage indicating that fee changes drove initial gains. The expansion of State B's dental network and the early surge in significant providers likely translated into more appointment slots and a rise in procedures delivered to Medicaid enrollees, thereby improving both utilization and access to comprehensive dental care; however, the flattening of "significant" providers in year two signals that further policy or engagement efforts, may be

Conclusions

State B's fee schedule increase successfully broadened network participation and significant provider engagement. The plateau in year two among significant providers underscore the need for complementary strategies and/or ongoing fee increases to cement and sustain long-term improvements in care delivery.

State C: Fee Increase

State C's Medicaid adult dental benefit had long been a patchwork. Although adult coverage was reinstated in 2016, eligibility remained largely limited to disability-restricted populations. Medicaid fees rarely keep pace with commercial costs. As a result, dentists often viewed Medicaid work as a community service rather than a sustainable part of their practices, leading to mounting frustration and declining provider enrollment.

The tipping point arrived when State C's oral health coalition and state dental society joined forces. The groups mounted an advocacy campaign that resonated with legislators and Medicaid administrators. Close collaboration among providers, advocates, and state officials created "the perfect environment" for support in the state's legislative and executive branches that led to meaningful rate reform and benefit expansion.

Structure of the Increase in Dental Fees

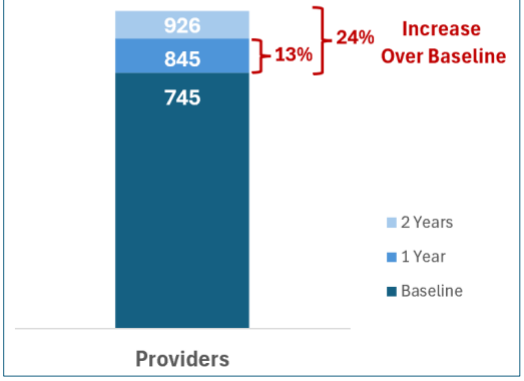
The dental fee changes occurred in stages in State C, starting with preventive services –subsequently extending to most specialty procedures, sedation, and facility payments for hospital and ambulatory surgical center care. A number of dental codes increased to 80 percent of the 50th-percentile values

published by the National Dental Advisory Service. The state dental director and front-line providers essential to sustain gains in service delivery and access were engaged in this process to determine which procedures should receive higher payments. Collectively, this brought Medicaid payments closer to prevailing commercial rates, and the update made participation far more appealing to new and existing dentists. Additionally, several CDT codes that had been covered only for children were added to for all Medicaid-eligible adults, eliminating a long-standing barrier to comprehensive treatment. By design, the overall fee adjustments affected "the majority of dental codes," giving providers a clearer financial path to increase services for adult as well as pediatric Medicaid patients.

Outcomes

Although data on significant providers was not available for State C, the post-implementation trend indicates a clear, expansion of overall program participation following the dental fee increase: the number of providers submitting at least one claim grew from 745 at baseline (2022) to 845 after one year—an increase of 13 percent—and reached 926 after two years, a cumulative 24 percent rise over 2022. These sequential gains suggest that the revised reimbursement schedule successfully attracted additional clinicians and/or retained existing ones.

Figure 3: State C Impact of Dental Service Fees Increase on Provider Participation



Potential Impact

State C's fee increases expanded overall provider participation by 24 % within two years (from 745 to 926 clinicians). A 24 % expansion in the pool of dentists submitting at least one claim should, in principle, translate into wider geographic coverage, reduced waiting times, and greater appointment availability for routine services, thereby improving first-level access to oral health care across State C. Because no information is available on the subset of substantial providers, it remains unclear whether the new entrants (or returning providers) are incentivized to provide a significant amount of care through the state's Medicaid program.

Conclusions

The fee increases in State C demonstrably broadened the provider network—raising total claim-submitting dentists by 24 % within two years—thereby strengthening baseline access to routine dental services. This growth was powered largely by the across-the-board boost in adult dental fees, which made serving adult Medicaid patients far more financially viable for providers. The significant progress in State C was possible thanks to sustained communication and collaboration among the state's oral health coalition, dental society, state dental director, legislator involvement and individual providers.

State D: Fee Increase

In State D, adult Medicaid dental fees had been frozen at early-1990s levels for nearly three decades, squeezing provider participation until only 15 percent of adults aged 25–64 obtained any dental care—and just 10 percent benefited from preventive visits. A comprehensive legislative package was assembled seeking statutory authority to raise the fees and submitted three times; yet each bid for legislative action failed at a different checkpoint—first the Medicaid director, then the secretary, and finally the governor—leaving the proposal to languish.

During the COVID-19 era, a windfall of federal relief produced an unexpected state-budget surplus. Recognizing the newfound fiscal flexibility, the governor invited agencies to request additional funds. Medicaid came forward with a list of long-deferred priorities, placing an adult-dental rate increase—stuck on the "waiting list" for years—at the top. Lawmakers used a slice of the surplus to fund that request, delivering the first meaningful boost to adult dental fees since 1992.

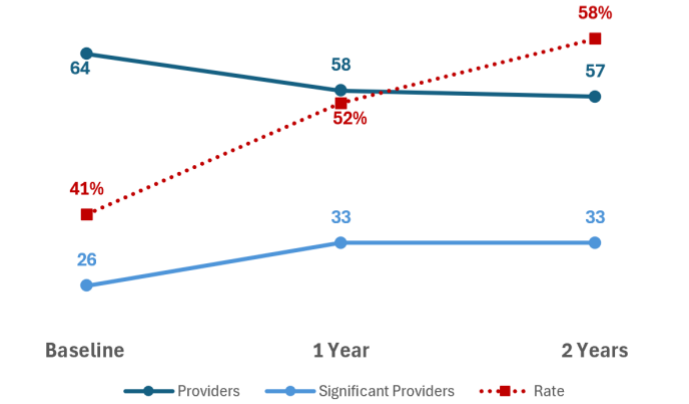
Structure of the Increase in Dental Fees

State D's reform zeroed in on adult Medicaid dental fees. In the first step, officials lifted every adult procedure code up to the pediatric (EPSDT) reimbursement levels so that providers would receive the same payment for treating adults as for children. A second adjustment soon followed, taking the full adult fee schedule even higher—this time calibrated against a region of the state's adult Medicaid rates. Crucially, the overhaul was comprehensive: every adult dental code moved in lockstep, rather than targeting just a handful of services.

Outcomes

Following the rate increase for adult dental services in State D, overall provider participation declined slightly—from 64 at baseline to 57 after two years, while the number of significant providers rose from 26 to 33, raising their share from 41% to 58%. Because many group practices, hospitals, and FQHCs bill under a single NPI in this state, these figures likely undercount the true number of individual dentists—some health centers with multiple sites and providers still appear as just one entry. Even so, the steady albeit slight increase in significant providers over two years indicates a positive shift toward more sustained and comprehensive Medicaid participation. Viewed in this light, the modest drop in total provider counts still underscores the need to balance reimbursement improvements with strategies that preserve network breadth and ensure access in underserved areas.

Figure 4: State D Impact of Rate Increase for Adult Services Among Providers at One and Two Years After Rate Change



Potential Impact

The observed shift toward higher-value engagement in State D has important implications for both access and care delivery. This pattern suggests that the reimbursement adjustment successfully

promoted deeper clinical engagement among active providers and potentially encouraged those already in the network to expand the volume or complexity of care delivered. As a greater proportion of participating dentists are delivering more services, patients who secure appointments may benefit from more comprehensive and consistent care. While the concurrent decline in overall provider participation raises concerns about network adequacy—particularly in geographically underserved areas, this trend reflects a move toward a more efficient and patient-centered system, where fewer but more engaged providers are delivering comprehensive care.

Conclusions

The observed shift toward higher-value engagement in State D has important implications for both access and care delivery. As a greater proportion of participating dentists are delivering more services, patients who secure appointments may benefit from more comprehensive and consistent care. The decline in overall provider participation suggests that the network may not yet be operating at full capacity. To fully realize the benefits of increased reimbursement, policymakers should continue to support strategies that foster both sustained provider engagement and thoughtful network expansion—ensuring that depth of participation is matched by geographic reach and equitable access.

State E: Fee Increase

In State E, a broad alliance of oral-health advocates—spanning the statewide oral-health coalition, the dental and dental-hygienist associations, and a network of community clinics—mounted an intensive, months-long lobbying campaign that fundamentally reshaped the budget conversation. Their sustained effort paid off: in the FY 2023 budget, lawmakers carved out a dedicated line item that injected new funds into Medicaid's dental program and explicitly directed that the money be used to raise provider reimbursement rates.

Structure of the Increase in Dental Fees

State E's Medicaid agency recalibrated its fee schedule and codified a forward-looking adjustment formula in the State Plan Amendment (SPA). The SPA mandated that, each year, program staff survey three comparable commercial dental plans, average their reimbursement levels, and use that benchmark to update Medicaid fees. When the policy debuted, analysts pulled the three reference schedules, calculated the mean, and sent the draft figures through an actuarial review to verify budget impact and rate adequacy. The resulting increases covered every dental code except orthodontic services for the Children with Special Health Needs program, which remained unchanged.

Outcomes

In the two years after implementing a rate increase for adult dental services, State E experienced a significant shift in provider participation dynamics. When both fee-for-service (FFS) and managed-care organization (MCO) encounters—including services delivered to dual-eligible beneficiaries—are tallied, the total number of providers submitting at least one claim declined from 1,629 to 1,176, while the number of significant providers increased from 308 to 435 in Year 1 and remained elevated at 369 in Year 2. This transition raised the proportion of significant providers from 19% at baseline to 31% at the end of the study period. This is a pattern that has been seen with other states described above, again indicating that although the provider network contracted in size, the rate increase stimulated a higher level of engagement among those who remained active, with more dentists delivering a greater volume of services under Medicaid.

Potential Impact

The growth in significant provider participation suggests an increasingly committed Medicaid dental workforce capable of delivering more comprehensive and sustained care. For patients, this could mean improved treatment continuity and greater availability of complex services from providers more deeply invested in the program. At the same time, the reduction in total provider numbers indicates untapped potential to broaden the network's reach. To mitigate these risks, similar strategies described above are needed to pair reimbursement enhancements with recruitment and retention strategies that preserve geographic and demographic balance.

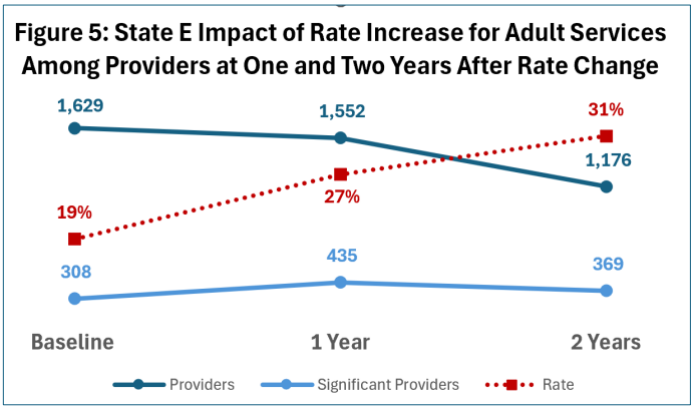
Conclusions

The experience in State E demonstrates a similar pattern seen with other states, where rate increases can successfully drive greater clinical investment among core Medicaid providers, even amid broader network contraction. This realignment highlights the value of strategic reimbursement policies in strengthening the program's delivery capacity. Moving forward, maximizing the benefits of such policies will require continued attention to network retention, targeted outreach to underserved areas, and administrative reforms that support both participation and long-term engagement.

State F: Fee Increase

For years, State F's adult Medicaid dental benefit offered only limited coverage, historically capped at a modest annual dollar limit and excluding major restorative services such as dentures for most adults. While the cap was gradually raised and preventive care carved out, the benefit remained "limited," leaving many adults without access to full restorative treatment options.

Figure 5: State E Impact of Rate Increase for Adult Services Among Providers at One and Two Years After Rate Change



At the same time, dental reimbursement rates stayed essentially flat for nearly a decade, even as operating costs rose and commercial fees climbed, eroding the program's competitiveness and straining practice finances. These financial

pressures coincided with a wider workforce contraction—dentists, hygienists, and specialists were in short supply, and the state experienced a "significant loss of dentists," relying increasingly on border-state providers to fill gaps.

Against this backdrop of limited benefits, stagnant fees, and mounting access challenges, recent legislative action directed the Medicaid agency to assess provider participation, geographic adequacy, emergency-dental utilization, and the fiscal impact of further benefit expansion, setting the stage for the subsequent modernization of the fee schedule.

Structure of the Increase in Dental Fees

State F adopted a two-step, market-benchmarking strategy to modernize its long-standing Medicaid dental fee schedule. After nine years without a comprehensive update, the program first injected about $1 million in February 2022, selectively lifting the most frequently billed codes to 60 percent of commercial rates. Building on that boost, a far broader adjustment took effect in July 2023 when the schedule was reset to 75 percent of 2023 commercial fees. This phased approach—initially focusing on high-volume services, then realigning every code—was designed to deliver an immediate access jolt while moving the whole fee schedule much closer to market benchmarks.

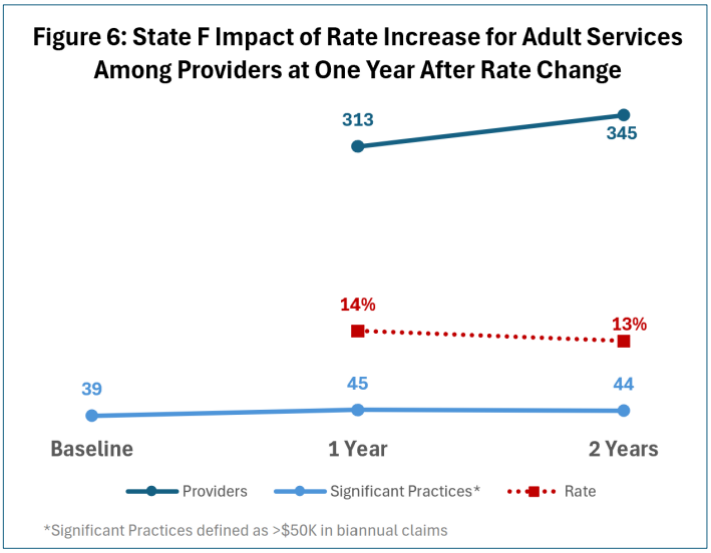


Figure 6: State F Impact of Rate Increase for Adult Services Among Providers at One Year After Rate Change

Outcomes

No baseline provider data from 2022 was available. However, 2 years after the adult-service fee increase in State F, the total number of Medicaid-enrolled dental providers climbed from 313 to 345—an expansion of roughly 10 percent—signaling that the higher reimbursement attracted or retained additional clinicians in the network. High-volume "significant programs" (in this case, the data is at the practice level, with significant practices defined as those with ≥ $50 K in paid claims per half-year) increased from 39 to 45 practices in the first year and then remained essentially level during the second year. Taken together, the data suggest that the rate change successfully broadened overall provider participation while sustaining the cohort of practices delivering substantial volumes of care.

Potential Impact

Wider participation in State F's Medicaid dental program can translate to preventive and restorative treatment for patients and can curb downstream dental and medical complications tied to poor oral health. The enlarged network can also promote continuity of care, thereby improving long-term outcomes. Network adequacy also remained strong, with a 2024 provider-to-adult-enrollee ratio of 1:288. Collectively, these trends indicate that the rate change broadened overall provider participation and stabilized high-volume practices. Of note, no subsequent increases have been

made, with commercial prices still climbing, the Medicaid schedule now averages about 70.6 percent of 2025 commercial rates. This presents risk in sustaining the impact of the fee increase.

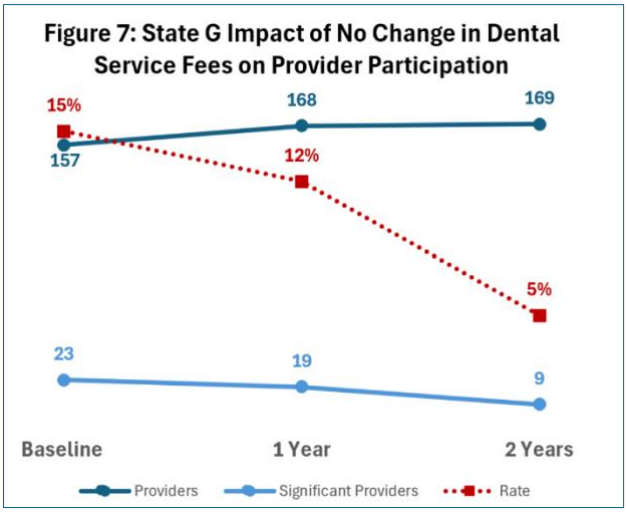
Conclusions

State F's fee modernization has translated into measurable access gains: the Medicaid dental network has grown by roughly 10 percent, and the number of high-volume practices has held steady despite an overall contraction in the state's dentist workforce. These gains, however, remain vulnerable because no additional adjustments been made, resulting in the Medicaid schedule now at 70.6 percent of 2025 commercial charges. This risks erosion of recent progress. Sustained improvements will therefore depend on regular increases alongside continued monitoring of workforce capacity and utilization trends to ensure that initial access benefits endure over time.

Maintaining static dental fees preserved routine-care participation in the short term but furthered a sharp decline of significant providers, indicating that without periodic reimbursement adjustments, patient access will shrink and inequities in care are likely to widen. Faced with this evidence, State F moved to reverse course, approving an upcoming comprehensive $8 million increase across 125 procedure codes to stem provider attrition and restore the network's capacity to serve Medicaid patients.

State G: No Fee Change

State G's dental program has been operating on a fee schedule that has remained virtually static since at least 2007. There have been no systematic adjustments to match inflation, changes in service-mix, or rising practice costs. Because rates have stayed flat, dentists who treat Medicaid patients have effectively been paid less each year in real terms. The state's own 2016–18 data offer a clear snapshot of how stagnant Medicaid dental reimbursement rates have affected provider engagement and service delivery during this period.



Outcomes

Over the 2016-2018 interval in which State G kept dental service fees flat, overall provider participation remained effectively unchanged, however engagement among significant providers deteriorated sharply. The number of significant providers fell from 23 to 9, with the proportion down from 15 % to 5 %. These trends suggest that fee stagnation progressively discourages providers from delivering comprehensive care to more patients, a dynamic that could erode patient access to dental care.

Potential Impact

Holding dental service fees constant kept overall provider participation steady but led to a three-fold decline in significant providers, signaling that stagnant reimbursement dampens engagement in state Medicaid programs. With far fewer dentists willing to deliver a significant amount of care under Medicaid, patients are likely to encounter limited capacity and longer wait times; consequently, access will deteriorate, disproportionately affecting those with limited means or living in underserved areas.

Current Plans for Fee Increase

Growing evidence that flat fees were eroding provider engagement and shrinking service capacity in State G finally spurred decisive action. The turning point came when the state dental society—backed by frontline dentists—took their concerns to the legislative oversight hearing committee. Convinced that a token bump to a single "headline" code would only distort relative values within the schedule, program officials insisted on a holistic fix: linked procedures had to move in tandem. The program is currently in the process of increasing reimbursement rates across 125 dental procedure codes impacting both EPSDT and adult coverage, a sweeping adjustment aimed at restoring provider confidence and stabilizing the state's dental-care network. The nearly $8 million fee adjustment will be disseminated via a public transmittal that triggers a mandatory pop-up acknowledgment for billing staff, while the interactive fee-schedule portal and back-end claims tables are simultaneously updated so providers instantly see—and are automatically paid—the new rates without extra paperwork.

Health Plan 1: Fee Increase

The Medicaid dental benefit in Health Plan 1 is administered by a local dental benefits administrator, offering a consistent and familiar administrative framework for participating providers. Dental offices follow the same pre-determination process for Medicaid as they do for commercial patients, which helps streamline operations and reduce administrative burden.

Before the 2016 fee adjustments, Health Plan #1 was wrestling with a mix of modest, across-the-board inflationary bumps and persistent access pressures**.** Although the legislature appropriated an annual dental inflation factor, Medicaid often funneled that money toward the most widely used codes in an attempt to "maintain current levels of access," a strategy that did little to draw new providers into the network.

Complementing these measures, since 2004 the state's Loan Repayment for Service initiative forgives up to $75 000 in education debt for dentists who maintain ≥ 15 % Medicaid patient panels.

Structure of the Increase in Dental Fees

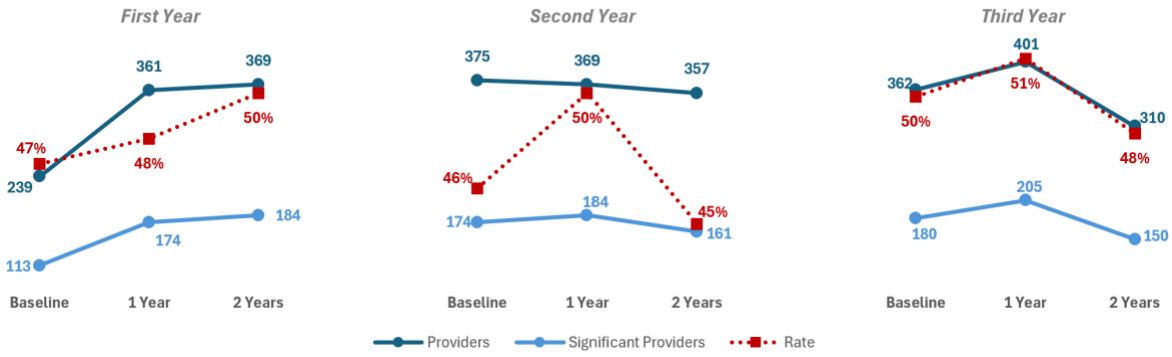
Over a three-year period, Health Plan #1 in collaboration with state Medicaid administrators implemented a phased approach to increasing dental reimbursement rates. In the first year (2016), dental fees increased 1.65% based on the prevailing reimbursement schedule. In the second year (2017), all providers received a uniform 4% rate increase. This increase continued the momentum and provided an additional layer of financial support across the provider network. In the third year

(2018), the rate increase was more modest at 0.5%. Despite the smaller rate increase, this change represents the ongoing commitment to incremental improvements in reimbursement.

Outcomes

Across three successive fee-change cohorts in Health Plan #1 (baseline years 2016, 2017, and 2018), provider participation consistently surged or held steady in the first post-increase year—providers changing by 239 → 361, 375 → 369, and 362 → 401, respectively. The number significant providers increased in parallel, elevating to roughly one-half of the network (47 – 51 %). By the second year, however, overall participation in the latter two cohorts decreased (-4 % in 2017–19 and -14 % in 2018–20), while the proportion of significant providers stabilized at 45 – 50 %. These patterns suggest that each fee increase produced an immediate, but only partially durable, expansion in both total and significant providers; nonetheless, the system retained a relatively high concentration of dentists capable of delivering more extensive care.

Figure 8: Healthplan #1 Impact of a 5% Dental Service Fees Increase Over 3 Years on Provider Participation



Potential Impact

Each fee increase under Health Plan #1 produced transient gains in overall providers but durable engagement with significant providers. Beyond reimbursement rates, providers reported two primary issues impacting participation during this time frame:

- **Missed appointments** – Unreimbursed chair time due to missed appointments significantly impacts provider schedules, especially when restorative care or family blocks are involved. In response, the state is developing a Missed Appointment Toolkit to disseminate best practices in patient education, reminders, and scheduling.
- **Professional limitations** – Some providers expressed frustration with the inability to deliver comprehensive care due to coverage restrictions. This concern has lessened in recent years following benefit enhancements, including coverage for bridges and crowns on posterior teeth.

Another impactful strategy is the Loan Repayment for Service program. Since 2004, Health Plan #1 has invested over $3 million to support 82 dentists who agreed to serve at least 15% Medicaid recipients. Of these, 80% continue to provide Medicaid services. Although these dentists represent just 13% of the dental workforce, they deliver care to over 35% of the state's dental patients.

Conclusions

Repeated fee increases in Health Plan #1 reliably generated short-term surges in both total and high-value provider participation, yet overall dentist numbers receded within two years while the proportion of significant providers remained near one-half of the network. Administrative consistency, supported by the dental benefit administrator's oversight of Medicaid dental benefits, has also helped maintain provider engagement by aligning Medicaid processes with commercial norms. Additionally, addressing non-reimbursement-related challenges, such as missed appointments and professional limitations related to patient coverage, is crucial. The state's Loan Repayment for Service program has also proven effective in supporting dental provider recruitment and retention.

Since the 2016-18 fee adjustments, Health Plan #1 has kept providers engaged through a series of incremental moves. Administrative upgrades in 2022 doubled the adult annual maximum to $2,000, eliminated cost-sharing, and added sealants, fluoride varnish, bridges for select groups, and posterior crowns. In 2023 the schedule was reset to 70 percent of average billed charges —changes welcomed by general dentists but flagged by specialists as inadequate. A four percent across-the-board increase and a targeted endodontic boost followed in 2024, with a 1.25–1.5 percent increase projected for 2025. Currently, more than 70 percent of dentists remain enrolled, yet ongoing workforce shortages and the state's limited training pipeline—one hygiene school and no dental school, combined with Medicaid expansion that swelled the eligible population—continue to strain capacity. Overall, these stepwise enhancements have preserved broad provider participation, and the durability of access gains will depend on sustained, targeted reimbursement increases and long-term workforce development.

Health Plan 2: Fee Increase

The state's dental environment for Health Plan #2 has continually struggled with providing adequate access to specialized dental care, facing persistent shortages of critical specialists such as endodontists and oral surgeons. These limitations significantly affected the provision of preventive and comprehensive dental services. The Medicaid environment within the state is structured such that each managed care organization (MCO) independently secures approval for incentive plans. Additionally, MCOs must regularly submit quarterly reports detailing specific outcome measures, which are reviewed and approved annually. This structured oversight fosters a proactive environment that emphasizes value-based payments and targeted provider incentives.

In response to these challenges, Health Plan #2 implemented a series of targeted provider incentives focused on high-need areas, including preventive services, endodontic procedures, and oral surgery. Crucially, these incentives were not developed in isolation. Prior to implementation, the health plan engaged directly with providers—both generalists and specialists—in face-to-face meetings to determine appropriate incentive levels and define mutually agreed-upon outcome expectations. This proactive engagement ensured that the financial increases were not only meaningful but also tailored to the needs and capacities of the provider community.

Structure of the Increase in Dental Fees

Health Plan #2 strategically implemented targeted reimbursement increases to address critical gaps in dental services. Preventive dental services, including exams and cleanings, received a 10% rate increase. Endodontic services saw an even more significant increase of 25-30%, directly addressing the substantial shortage of endodontic specialists, with only 8-9 specialists initially available statewide. Oral surgery services were similarly targeted with enhanced incentives. Medicaid approved these targeted rate increases without requiring additional policy or benefit modifications, streamlining their implementation and effectiveness.

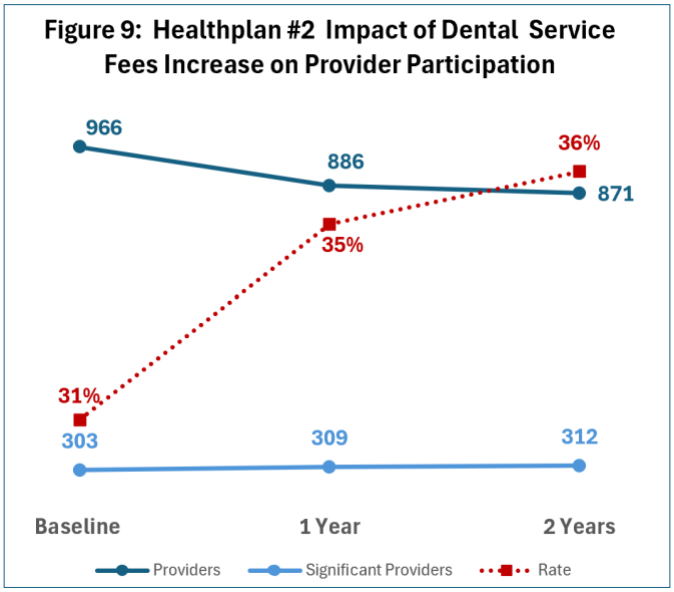


Figure 9: Healthplan #2 Impact of Dental Service Fees Increase on Provider Participation

Outcomes

Under Health Plan #2, the dental fee increase produced a modest realignment of provider participation: the total number of providers declined from 966 at baseline (2023) to 886 after one year (–8 %) and to 871 after two years (–10 %), while the count of significant providers rose slightly from 303 to 309 and then to 312. This divergence elevated substantial provider engagement from 31 % at baseline to 35 % in 2024 (year 1) and 36 % in 2025 (year 2), indicating that the revised reimbursement schedule selectively retained and/or attracted a few more substantial providers even as lower-volume participants exited the network, thereby narrowing overall breadth but increasing the proportion of providers delivering more extensive services.

Potential Impact

The fee increase for Health Plan #2 modestly shrank the overall provider pool yet raised both the number and proportion of significant providers potentially signaling a shift toward a more concentrated but higher-value network. With roughly 10 % fewer dentists billing the plan, patients may face longer travel distances and reduced appointment availability—especially in areas already underserved—yet the slight rise in significant providers suggests that capacity will be preserved or even strengthened among the clinicians who remain. Such compelling data and advocacy initiatives led to legislative approval, recently culminating in a significant funding increase of $2.1 million for dental reimbursements

Conclusions

The fee increase under Health Plan #2 re-balanced the network by modestly reducing overall provider participation while incrementally expanding the cadre of significant providers, possibly yielding a more productive workforce; however, this concentration of capacity underscores the need for complementary strategies to safeguard access—particularly in underserved areas. Insights from Health Plan #2's experience underscore the value of implementing targeted rate increases to bolster

participation among providers already heavily engaged with Medicaid. The proactive pre-implementation engagement with providers, involving direct consultations to determine effective incentive levels, specialist involvement in strategic planning, and transparent data-sharing practices, emerged as best practices.

Health Plan 3: Fee Increase

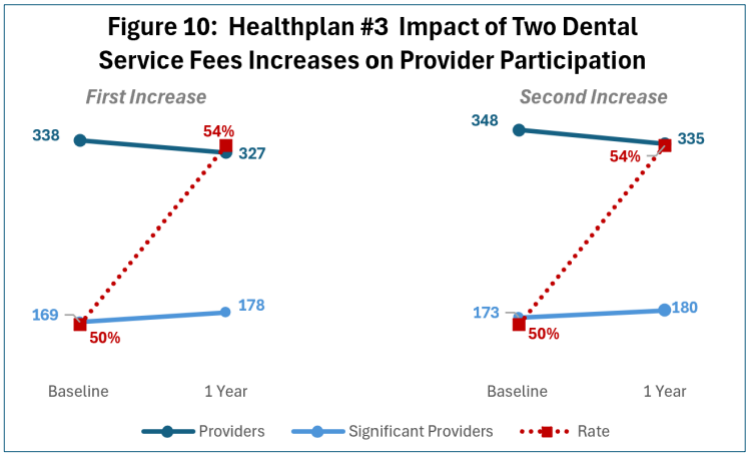
Health Plan #3 functions within a state whose dental environment operates under a straight fee-for-service model, with providers reimbursed per procedure rather than through capitation. Although overall participation has remained stable, many providers in both the EPSDT and adult dental programs have long voiced concerns about under-reimbursement. After years without any fee adjustments, stakeholders called for a comprehensive review of reimbursement levels to safeguard continued access and encourage provider engagement.

Structure of the Increase in Dental Fees

The reimbursement adjustments for Health Plan #3 were rolled out incrementally to remain in step with the prevailing commercial rate schedules. Beginning in 2023, the first wave of increases coincided with the introduction of comprehensive adult dental benefits and enshrined the Medicaid agency's commitment to reach at least 60 percent of commercial fees in one region and 65 percent elsewhere—without reducing any fees that already exceeded those thresholds.

In 2024, a second tranche of increases was implemented under an agreement to update rates in the EPSDT program, again based on shifts in commercial schedules. By May 2025, a modest further adjustment took effect only after careful evaluation of multiple commercial-rate benchmarks. Additionally, a no-show tracking program was launched in April 2024.

Figure 10: Healthplan #3 Impact of Two Dental Service Fees Increases on Provider Participation



Outcomes

Following an initial fee increase in 2023, overall provider participation in Health Plan #3's adult dental program remained effectively stable, decreasing marginally from 338 to 327 providers—while the cohort of significant providers rose from 169 to 178, elevating their participation rate from 50% to 54% within one year. These data suggest that the revised reimbursement schedule may have shifted the distribution toward higher-volume engagement. Similarly, a second fee adjustment in 2024 among dentists participating in the EPSDT dental program showed similar results. Although provider participation slightly decreased from 348 to 335, engagement of significant providers participation grew from 173 to 180 providers, with similar gains in participation rate from 50% to 54%. These parallel outcomes from consecutive adjustments suggest that the combined fee increases effectively consolidated provider commitment to the plan's service mix, reinforcing sustainable engagement among higher-volume providers.

Since the roll-out of the no-show tracking program, roughly 1,600 letters have been sent to Medicaid members educating them about the impact of missed appointments, and 116 of the state's 300 enrolled dentists have signed up to report and review their own no-show rates.

Potential Impact

The consecutive fee increases in Health Plan #3 maintained overall provider participation levels while consistently enhancing and sustaining the proportion of significant providers, confirming a persistent shift toward higher-value engagement while increasing the network's reach. Because both consecutive fee adjustments maintained overall provider numbers while progressively increasing the proportion of higher-value dentists, patients will likely continue experiencing stable access to routine dental care and simultaneously benefit from greater availability of clinicians motivated to perform more comprehensive and costly procedures.

Conclusions

When the state launched its new online registration system in 2024, targeted outreach to high-volume practices ensured that core providers remained in the network even as some low-volume dentists chose to exit. Successive dental fee increases under Health Plan #3 maintained overall network size across both programs, while potentially boosting the share of high-value providers, demonstrating that reimbursement increases can reinforce provider commitment and foster sustained higher-value engagement, ultimately enhancing patient access to dental services and enhancing the network's overall capacity.

Finally, the structured "no-show" initiative that began in April 2024—combining patient education letters with provider reporting—demonstrated how pairing member outreach with clear accountability can raise awareness of appointment adherence, reduce wasted visit slots, and reinforce provider commitment to the program.

Strengths and Weakness

This analysis offers several notable strengths that enhance its relevance and credibility. First, it draws directly from real-world administrative data and program records across multiple states and health plans, providing authentic insight into how dental provider participation responds to Medicaid reimbursement changes in diverse policy environments. The use of consistent, clearly defined metrics—such as total providers submitting at least one claim and "significant providers" submitting ≥$20,000 in annual claims—enabled standardized comparisons across jurisdictions and timeframes. By incorporating longitudinal observations spanning multiple years, the analysis also captured both immediate and sustained effects of fee adjustments, revealing patterns that may be obscured in single-year snapshots. The inclusion of both EPSDT and Adult program fee-for-service and managed care contexts further strengthens the generalizability of findings, offering actionable information for a range of Medicaid program types. Importantly, the study provides a balanced interpretation of outcomes—acknowledging where provider engagement intensified or plateaued—while identifying promising structural strategies, such as targeted fee adjustments and provider engagement initiatives, that can inform future reimbursement policy.

While the analysis offers useful insights, some limitations present opportunities for future refinement. Reliance on claim-volume thresholds to define provider participation does not capture broader aspects of access and quality—such as appointment availability, regional distribution of dentists, or patient experience—leaving room for more nuanced metrics in subsequent work. Details on "significant providers" (those billing ≥ $20,000 annually) was not uniformly available across all states. The Medicaid environment, due to changes in federal program administration and policy, limited some state Medicaid agencies' ability to supply the level of granular data required for a fully multi-faceted analysis. Additionally, data was not available to control for the extent to which higher reimbursement levels elevated total claim values per provider; therefore, some of the observed growth in "significant providers" may reflect larger payments per procedure rather than expanded service volume or clinical engagement. This highlights the value of more consistent reporting standards. Finally, because participation in this study was voluntary, the results may reflect a degree of selection bias. Addressing these gaps in future analyses would enhance knowledge of how reimbursement adjustments influence both providers and the patients they serve.

Source of Funding

This project was supported by the Funders Group, which includes ARCORA Foundation, Delta Dental of California Foundation, Delta Dental of Iowa Foundation, Delta Dental of South Dakota Foundation, the Maine Oral Health Funders Group, Washington Dental Service Foundation, and West Health Foundation.

Acknowledgements

The Medicaid Medicare CHIP Services Dental Association (MSDA) wishes to acknowledge the Advisory Team Members who provided support and guidance to this effort; the states and health plans that submitted responses to the reimbursement surveys; Mary E. Foley, MPH and Marty Dellapenna, MEd, who conducted the research and writing of this report; and Julie Frantsve-Hawley, PhD, for her contributions to data analysis and the development of the final manuscript.

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