

# Access to Dental Services for Adults with Intellectual and Developmental Disabilities

Individuals with intellectual and developmental disabilities (I/DD) experience a wide range of conditions that affect their physical, intellectual, and emotional development, and are more likely to have Medicaid coverage than those without such conditions (Fosse et al. 2021, NIH 2021). Adults with I/DD have a varying and complex set of health care needs, including oral health, which may require specialized services and supports.<sup>1</sup> About nine million adults in the United States with I/DD rely on Medicaid for their oral health care needs (NCD 2023). Dental care is an important component of overall health as it affects health outcomes, speech, nutrition, behavior, and quality of life (Ward et al. 2019). Studies have identified dental care as among the top unmet health needs for adults with I/DD, and adults with I/DD are the largest marginalized population with unmet oral health needs (NCD 2023, Chavis and Macek 2022).

States have the option to cover oral health services for adult Medicaid beneficiaries, and federal law does not mandate minimum requirements for oral health coverage in the states that offer it. As with other optional benefits, states define the amount, duration, and scope of the services covered. Thus, Medicaid dental coverage varies by state from comprehensive coverage to emergency-only to no dental coverage. States may also provide additional dental coverage to certain populations. For example, states may offer coverage for restorative dental services to adults with I/DD and not to the general adult population (CareQuest 2024, MACPAC 2015). In 2023, 12 states covered one or more dental services for adults with I/DD that were not provided to other adult beneficiaries ages 21–64 (CareQuest 2024).<sup>2</sup> In states with no dental coverage, evidence suggests Medicaid-enrolled adults with I/DD may forgo preventive and routine dental care and seek emergency dental care instead (NCD 2022).

This issue brief examines state Medicaid policies for providing dental services for adults with I/DD and the challenges states face in providing access to this population.<sup>3</sup> MACPAC conducted a literature review and studied four states using a variety of approaches to provide oral health services to adults with I/DD.<sup>4</sup> Stakeholders noted that Medicaid adults with I/DD face many of the same challenges accessing dental services as Medicaid adults without I/DD. However, those with I/DD face additional barriers. This issue brief provides an overview of the oral health needs of adults with I/DD and considerations for their dental service provision. Then, it describes state Medicaid approaches to covering dental services, such as through waiver authority and managed care, as well as dental access and utilization data. Finally, it examines the challenges with and considerations for improving access to dental care, including issues with provider capacity, access to sedation, access to care for those in residential and institutional settings, and teledentistry.

## Oral Health Needs of Adults with I/DD

Adults with I/DD have greater oral health needs and are at risk for poorer oral health outcomes compared to other adults and they may require additional services and supports to receive oral health care (Milano 2017, APHA 2016).

### Oral health status

People with I/DD have a higher prevalence of periodontitis (gum disease) and untreated caries (i.e., cavities), as well as higher rates of extractions, compared to people without I/DD. One study of adults with I/DD found that 32.2 percent of study participants had untreated dental caries, 80.3 percent were diagnosed with periodontitis, and 10.9 percent were missing all of their natural teeth. The study also found that all of these oral health outcomes worsen with age (Morgan et al. 2012). Contributing factors include a lack of access to preventive care



matching the needs of adults with I/DD, challenges completing regular oral hygiene, and behavioral challenges. Poor oral health can exacerbate chronic conditions (e.g., cardiovascular disease or respiratory disease), have an effect on mental health, such as increased anxiety, lead to difficulty of performing daily activities, impair social interactions, and reduce nutritional intake (Wilson et al. 2019).

## Effects of I/DD diagnosis on oral health

The specific I/DD diagnosis or the severity of the condition can also affect oral health and the provision of dental care (Table 1). Common oral health problems associated with I/DD include problems with chewing, swallowing, and drooling; malformations in the mouth (e.g., abnormal tooth alignment, such as an open bite, variations in the size or number of teeth); damaging oral habits (such as teeth grinding or clenching, mouth breathing); or negative oral health side effects from using certain prescriptions. In addition, compromised immune systems can lead to more oral infections (NIDCR 2009).

## Dental services needed by adults with I/DD

Adults with I/DD may require specialized services and support, such as additional cleanings, specialized equipment, or accommodations, that are not typically provided to the general adult population. Advocates and dentists interviewed noted that adults with I/DD may need more frequent cleanings than the standard two cleanings every six months to address poor oral hygiene. People with I/DD may have difficulty with aspects of tooth brushing that require greater dexterity and comprehension, such as brushing inside and outside of teeth and removing plaque (Wilson et al. 2019). Sensory sensitivities in and around the mouth may also lead to difficulty in completing oral hygiene activities. People with I/DD may also have co-occurring behavioral health conditions, cognitive impairments, or sensory processing disorders, which may lead them to fear professional dental services at higher rates than the general population (Berens et al. 2022, Koball et al. 2020, Wilson et al. 2019). They may have emotional responses to the physical and sensory stimuli of dental exams or have difficulty understanding what will happen during the procedure. These responses can contribute to difficulties in following instructions and uncooperative behavior, and in some cases, these patients may exhibit aggressive behaviors toward dental staff and providers (Berens et al. 2022). Dental patients with autism or other sensory processing disorders may require a sensory adapted dental environment in which sensory modifications are made to a clinical space to reduce dental anxiety. For example, dental offices may be equipped with dimmable lights, quiet spaces in waiting rooms, or weighted blankets (Wilson et al. 2019, Potter et al. 2018).

In addition, physical manifestations of I/DD or co-occurring physical disabilities may include uncontrolled body movements, neuromuscular issues (e.g., drooling, gagging, or swallowing disorders), or limited mobility, which may make it challenging to provide oral health care (NIDCR 2023). Dental patients with I/DD and co-occurring physical limitations and movement disorders may require dental offices with wheelchair accessibility, stabilization devices, transfer devices, and other adaptive equipment (NCD 2023, ASTDD 2021, Taylor 2018).<sup>5</sup> Advocates noted that people with I/DD may have hearing loss that requires the use of a translator or need to communicate nonverbally through augmentative and alternative communication, such as speech-generating devices or choice cards.

Experts also indicated that behavioral management services, longer appointment times, or sedation, help improve access to care and ease patient anxiety. Behavioral management services (e.g., desensitization) are techniques dental providers can use to create positive experiences and promote cooperation. Dental offices that specialize in treating people with I/DD often use desensitization, which involves gradually exposing an individual to the instructions and stimuli associated with dental exams. Desensitization often takes place over several visits before dentists provide any dental care and may require longer appointment times (Berens et al. 2022, Bonardi et al. 2018). Sedation can also mitigate challenges providing dental care related to physical limitations, advanced oral disease, or instances in which there is a lack of behavioral supports. Many adults with I/DD currently receive dental care services under general anesthesia or deep sedation (NCD 2022). Yet sedation—particularly general anesthesia—is difficult to access, can produce undesirable side effects, and, as one advocate noted, can be traumatic for patients (Berens et al. 2022). In our interviews, stakeholders had mixed views about the extent to which alternative strategies could prevent the need for sedation. Some interviewees indicated sedation was often

necessary for most individuals with I/DD, while others indicated it was mostly unnecessary given the availability of appropriate sensory tools and behavioral management techniques.

In daily life, adults with I/DD are often unable to independently complete oral hygiene activities, such as tooth brushing and flossing, and may need caregiver's assistance (Jones and Taylor 2024, Wilson et al. 2019). Caregivers, including direct support staff and family members, assist in hygiene activities that require dexterity, but research has found that adults with I/DD who rely on caregiver support for oral hygiene often do not achieve the recommended frequency of brushing and flossing (Minihan et al. 2014). Advocates noted caregivers may lack the time, motivation, or training to support regular oral hygiene, especially if an adult has severe behavioral challenges, sensory sensitivities, or physical limitations. Additionally, interviewed beneficiaries indicated that providers could spend additional time training and educating the caregivers of adults with I/DD on preventive oral health strategies to avoid negative effects on oral health. This training is particularly important for family caregivers, who report having less formal training with at-home oral care and less confidence in their skills than paid caregivers (Minihan et al. 2014).

**TABLE 1.** Common Intellectual and Developmental Disabilities, Conditions, Associated Oral Health Effects, and Examples of Dental Services and Supports

Symptoms	Oral health effect	Services and supports
<b>Autism</b> <ul style="list-style-type: none"> <li>• Sensory sensitivities</li> <li>• Teeth grinding or self-injurious behavior</li> </ul>	<ul style="list-style-type: none"> <li>✗ Difficulty with oral hygiene</li> <li>✗ Damage to teeth</li> </ul>	<ul style="list-style-type: none"> <li>✓ Sensory adapted dental environments</li> <li>✓ Desensitization appointments</li> <li>✓ Prescription of a mouth guard</li> </ul>
<b>Cerebral palsy</b> <ul style="list-style-type: none"> <li>• Swallowing disorders or drooling</li> <li>• Uncontrolled body movements</li> </ul>	<ul style="list-style-type: none"> <li>✗ Misaligned teeth, commonly an open bite</li> <li>✗ Difficulty with oral hygiene</li> </ul>	<ul style="list-style-type: none"> <li>✓ More frequent suction</li> <li>✓ Wheelchair accommodations</li> <li>✓ Stabilization techniques</li> <li>✓ Transfer devices</li> </ul>
<b>Down syndrome</b> <ul style="list-style-type: none"> <li>• Specific orofacial features leading to increased drooling and strong gag reflex</li> <li>• Compromised immune systems</li> </ul>	<ul style="list-style-type: none"> <li>✗ Periodontal disease</li> <li>✗ Misaligned teeth, commonly an open bite</li> <li>✗ Tooth anomalies</li> </ul>	<ul style="list-style-type: none"> <li>✓ Desensitization appointments</li> <li>✓ More frequent suction</li> </ul>
<b>Epilepsy</b> <ul style="list-style-type: none"> <li>• Seizures</li> <li>• Muscle spasticity and rigidity</li> </ul>	<ul style="list-style-type: none"> <li>✗ Damage to teeth and temporomandibular joint</li> <li>✗ Certain anticonvulsant medications can increase oral health infections &amp; dry mouth</li> </ul>	<ul style="list-style-type: none"> <li>✓ Minimize seizure triggers</li> <li>✓ Seizure management during treatment</li> </ul>

**Notes:** State Medicaid agencies have the flexibility to determine whether to covered dental services and supports for adults with I/DD, as well as the amount, duration, and scope. Thus, state coverage of these services varies. In addition, when states provide oral health services through managed care delivery systems, the managed care entity may opt to provide additional services as value-added services.

**Source:** NIDCR 2009.

## State Medicaid Coverage of Selected Services

State Medicaid agencies can tailor dental benefits by expanding the amount, duration, and scope of certain services to address the specific needs of adults with I/DD using state plan and waiver authorities. Several states cover at least some additional or enhanced dental services for individuals with I/DD. However, beneficiaries and advocates noted that few states cover all the services necessary to support the oral health care needs of people with I/DD.

### Behavioral management and care coordination

Some interviewed states cover additional provider time to care for adults with I/DD. As of 2023, 21 state Medicaid programs covered behavioral management for oral health care in their Medicaid fee schedules, Current Dental Terminology (CDT) code D9920 (Jones and Taylor 2024).<sup>6</sup> In 2020, the American Dental Association (ADA) included a code for dental case management for patients with special needs, CDT code D9997. This code allows for dental providers to bill for care coordination for this high-need population (Roszel 2023). There are four states that cover dental case management services (Jones and Taylor 2024). States have also created claiming codes to account for the time providers need for patient intake and obtaining medical histories, coordinating transportation, and the extra staff time it takes to accommodate behavioral health needs. For example, Indiana's Medicaid agency contracts with case managers through the 1915(c) waiver to help beneficiaries with I/DD schedule dental appointments, arrange transportation if needed, and to provide the beneficiaries support during appointments.

### Non-invasive services

All states cover sedation, although state coverage of non-invasive services that can help mitigate the need for sedation is mixed. For example, few states cover desensitization services. Of our four study states, the District of Columbia covers desensitization for beneficiaries enrolled in the 1915(c) waiver. These desensitization techniques must be used before providers in the District of Columbia can prescribe sedation for dental procedures (DC 0307.R05.00). There are several states that cover minimally invasive dentistry, such as silver diamine fluoride (SDF) treatments, fluoride varnishes, and resin sealants, which helps to prevent the need for intensive procedures that could require sedation (Jones and Taylor 2024, Williams et al. 2023). SDF is a non-surgical alternative that stops tooth decay and sensitivity from cavities. For example, California uses its Section 1115 demonstration to cover SDF treatment, which is not covered under the Medicaid state plan, to all individuals with I/DD. California's SDF benefit provides 2 visits per member per year (once every 6 months), for up to 10 teeth per visit, with a lifetime maximum of four treatments per tooth; it is paid at a rate of \$12 per tooth (DHCS 2024). In addition, some states, such as New Jersey and the District of Columbia, cover more frequent dental cleanings if a provider demonstrates that the patients require additional cleanings (Jordan and Taylor 2024).

### Comprehensive services

Some states provide comprehensive services for its I/DD population only. For example, Louisiana offers limited dental services for the general adult population, but offers comprehensive dental coverage to adults with I/DD who are enrolled in their 1915(c) waivers, as of July 2022.<sup>7</sup> The coverage includes diagnostic services, preventive services, restorative services, endodontics, periodontics, prosthodontics, oral and maxillofacial surgery, orthodontics, and emergency care; coverage for the general adult population consists of diagnostic and preventive services. The state's waiver notes that investing in preventive dental care for this population is cost





effective because it will prevent emergency department visits, complicated treatments, and hospitalizations that arise from neglect of oral health (LDH 2022).

## Services through managed care

People with disabilities are less likely to be enrolled in managed care than the general population, but states are increasingly adding beneficiaries with special health care needs into managed care (Hinton and Raphael 2025).<sup>8</sup> An interviewee stated that the traditional fee-for-service (FFS) model raised concerns about providing dental care to adults with I/DD because the complexity of care coordination required is not reimbursable under their state's FFS system.

Managed care organizations (MCOs) may provide and manage the dental services themselves, or they may subcontract to other dental contractors, such as prepaid ambulatory health plans or dental benefits administrators, to offer the services for some or all of their Medicaid members. In addition, some MCOs provide additional dental benefits to their enrollees as value added services (MACPAC 2024). For example, a Pennsylvania MCO established a pilot program that pays providers, who receive additional training to treat adults with I/DD, at a higher rate to acknowledge the increased time spent treating this population (Fish-Parcham 2019).

State Medicaid programs can require MCOs to improve access to dental care, for example by strengthening network adequacy. One state that already imposes penalties on MCOs that do not meet network adequacy standards for dental providers, including those who care for adults with I/DD, is considering adding additional financial incentives to improve networks given ongoing challenges. The state is also considering providing incentives to increase member utilization of dental care services. A state Medicaid official noted that beneficiaries with I/DD enrolled in managed care have slightly better access to dental care services than those beneficiaries under FFS because MCOs can contract for some services above the Medicaid rates and can negotiate different arrangements for in-network services.

## Dental Access and Utilization Data

Data related to dental service access and utilization for the I/DD population are limited, which makes it difficult for state Medicaid agencies to monitor access and utilization of dental services for adults with I/DD. Interviewees noted that this is in part due to the lack of a common and universal definition of the I/DD population. Some definitions are narrow, such as those based on specific types of disabilities or used to determine eligibility for benefits, while others are broader and more inclusive of individuals with different types of intellectual or developmental disabilities (Mitra et al. 2022). States shared that without a consistent Medicaid definition of individuals with I/DD, they cannot confidently analyze dental service access or utilization for this population. Providers also shared that they do not always have data on which of their patients have any type of disability. When a dentist sees a patient, they bill and code the appointment based on services rendered (CDT codes) rather than underlying diagnoses. However, mental, behavioral, and neurodevelopmental disorders are captured in various International Classification of Diseases, Tenth Revision (ICD-10) codes used in medical billing, which dentists often do not use.

There are no federal requirements to report dental utilization data among Medicaid beneficiaries with I/DD. The Centers for Medicare & Medicaid Services (CMS) included two dental and oral health service quality measures that states can voluntarily report in the 2025 and 2026 Adult Core Set, but neither of these are specific to the I/DD population (CMS 2024). CMS officials indicated that some Medicaid beneficiaries with I/DD can be identified in the Transformed Medicaid Statistical Information System (T-MSIS) through 1915(c) HCBS waiver-related fields, if the beneficiaries' needs are significant enough to require institutional care, such as in a nursing home or in an intermediate care facility for individuals with intellectual disabilities (ICF/IID); through ICF/IID claims; or through the Chronic Condition Data Warehouse's I/DD chronic condition algorithm.<sup>9</sup> It can be difficult to identify all Medicaid enrollees with I/DD and their utilization in T-MSIS because not all adults with I/DD are enrolled in a waiver program or receive care for their I/DD condition. T-MSIS data may also include only limited data on

payment for services provided by Medicaid MCOs, making it difficult to clearly discern dental service utilization by adults with I/DD enrolled in managed care. Stakeholders characterized the methods of identifying the Medicaid adult population with I/DD as piecemeal and insufficient for understanding the population's dental service utilization.

States reported that their data collection on the use of dental services for adults with I/DD is limited. One state analyzes utilization and spending data for all Medicaid services but does not stratify these data by the I/DD population. Another state collects service utilization data for the I/DD population who are under the 1915(c) waiver, but these services are reported at an aggregate level, not specifically for dental services. One state said that while they participate in the National Core Indicators Survey, which asks people with I/DD about their health care access and utilization, including dental care, they do not track claims and encounter data specifically for the I/DD population.

## Challenges with and Considerations for Improving Access to Dental Care

Adults with Medicaid often experience barriers to accessing dental care; for adults with I/DD, their disability status exacerbates these challenges. Some of the interviewed states noted particular challenges in finding providers capable and willing to serve adults with I/DD. Providers may lack training and education in treating adults with I/DD and they may feel uncomfortable doing so. Dental offices may not be set up with facility accommodations for adults with disabilities. People living in rural areas may be hours away from the nearest dental providers. Beneficiaries may have difficulty identifying facilities that offer general anesthesia and accept Medicaid. In addition, hospitals may prioritize other types of surgeries over dental services in scheduling operating room time (NCD 2022).

### Provider capacity

Adult Medicaid beneficiaries with I/DD use dental services less often than other health services, in part due to difficulty finding a provider who participates in the program (NCD 2022). Due to a lack of provider capacity, interviewees reported being on long waitlists or traveling long distances to receive dental care services from a provider that accepts Medicaid and can accommodate people with disabilities. Interviewees noted the following reasons for providers choosing not to treat Medicaid-enrolled adults with I/DD:

#### Payment rates

Adults with I/DD often may require longer and more frequent dental visits to accommodate needed behavioral management, dental case management, time to meet accessibility needs, and patient or caregiver education, but few state Medicaid programs cover these additional services (Taylor 2018, NCD 2023). Providers indicated that payment rates do not adequately compensate for the time needed to care for beneficiaries with I/DD. However, several states have increased dental provider payments (e.g., routine visit payments, hospital facility fees for dental procedures) with the hope that new dental providers will agree to participate in the Medicaid program and existing providers will serve more adults with I/DD. For example, in the District of Columbia, providers receive an increased reimbursement rate of 20 percent for all dental care services provided to people enrolled in the I/DD waiver (DC §1921.10). However, studies have found that while increasing Medicaid reimbursement for dental services can help improve access to dental services for beneficiaries, these increases alone are insufficient to increase dental participation (Lipton et al. 2022, Reynolds and Naavaal 2021, Buchmueller et al. 2015).

#### Lack of experience or specialized training working with adults with I/DD

Dental providers may lack knowledge about disability diagnoses and how they affect oral care, lack experience communicating with patients who are nonverbal or have a limited ability to follow instructions, and be unprepared to treat patients with physical limitations or uncontrolled movements (Koball et al. 2020, NCD 2023, VBPD 2023). Dental schools are required to train students on how to treat patients with special health care needs, but



interviewed providers shared that dentists need more hands-on experience once they graduate to feel more comfortable serving this population. Beneficiaries and advocates noted that individuals with I/DD are more likely to receive care at academic institutions, however, these are not often located in rural areas. Some states are working to address provider qualification concerns. For example, New Mexico pays providers who treat individuals with developmental disabilities a special encounter fee under a specific procedure code once they have completed a training and certification program (Lyons and Catron 2007).<sup>10</sup>

## Limited access to sedation

Although all states cover sedation, access to sedation and general anesthesia is limited by the availability of qualified providers and operating rooms (Koball et al. 2020, Berens et al. 2022, NCD 2022). Sedation dentistry can be done in an office, ambulatory surgical center, or hospital setting. Oral health providers may need additional clinical staff, training, and alternate site of care depending on the level of sedation used. Some adults with I/DD may require general anesthesia for dental procedures because it protects their airways. Additional clinical staff may be needed to monitor breathing and cardiovascular function during and immediately following the procedure. For all levels of sedation, the provider must have the training, skills, drugs, and equipment available to address potential complications from the sedation. Deep sedation or general anesthesia are often administered in hospital operating rooms since many dental clinics do not have all the required equipment (Koball et al. 2020, ADA 2007). Interviewees indicated that there are not enough dental anesthesiologists to meet the need for people with I/DD, and some dental anesthesiologists do not accept Medicaid patients. Beneficiaries in one state said that wait times for dental care under general anesthesia in a hospital can be as long as two years.

Stakeholders indicated that reimbursement rates can limit access to hospital operating rooms for dental procedures performed under anesthesia. Hospital fees for dental-related procedures in hospital settings have historically been lower than fees for medical procedures, leading hospitals to deprioritize or limit operating room time for these procedures (ASTDD 2021, VBPD 2023). In addition, some hospitals do not grant dentists admitting privileges. To address the shortage of hospitals treating beneficiaries requiring dental care services under sedation, some states are enhancing payment rates for sedation services.<sup>11</sup>

Some state Medicaid programs cover mobile sedation services, in which anesthesia providers administer sedation in dental offices rather than hospital operating rooms, to increase access to dental care for adults with I/DD in underserved areas (NCD 2022). Dental anesthesiologists and certified registered nurse anesthetists can travel across the state to provide sedation in various settings, including private office settings. For example, Washington's Medicaid program allows a traveling anesthesiologist to provide anesthesia services in a dental office that otherwise would not have the equipment and qualifications to provide moderate or deep sedation for adults with I/DD (WHCA 2024). However, research shows that the number of dental anesthesiologists by state is lower than the need (Young et al. 2018). Providers stated that some of the state regulations that address licensing, equipment, and transportation of sedatives are burdensome (Koball et al. 2020). Traveling anesthesia, for example, requires the dental anesthesiologist and certified registered nurse anesthetist to have a special license in addition to the license they already have.

## Access to care for those in residential and institutional settings

Although residential and institutional settings (e.g., ICF/IIDs) have extensive requirements to provide dental care services to adults with I/DD, these requirements do not necessarily translate to better access or outcomes. According to federal regulations, oral health standards are included as conditions of participation in ICF/IIDs. Facilities must provide comprehensive diagnostic and treatment services for each client from qualified personnel in house or through external arrangements at least annually. One study found that individuals with I/DD living in an ICF/IID were more likely to have had a dental cleaning in the past 12 months compared to those who live in the community (Bershadsky and Kane 2010). Facilities must also provide education and training in the maintenance of oral health. In addition, facilities must have emergency dental treatment available on a 24-hour basis and provide care for the relief of pain and infections and restoration of teeth (42 CFR 483.460(e-h)). Despite these regulations, interviewed advocates described negative experiences with care and that there was limited



follow-up care if an issue was identified during the preventive visit. Advocates also shared that in addition to the annual visit, people with I/DD in these residential facilities need assistance brushing their teeth twice a day and require more frequent professional examinations, which is more than the annual exam that ICF/IIDs are required to provide. Few studies have been conducted to monitor the use of dental care in residential and institutional settings for adults with I/DD or examine the quality of dental care received in these facilities.<sup>12</sup>

## Teledentistry

States have flexibility to determine whether to provide oral health services via teledentistry. Teledentistry is the use of technologies to deliver virtual dentist care and education synchronously or asynchronously. Synchronous teledentistry is a live two-way interaction between a patient or caregiver and the provider using audiovisual technology (i.e., live video). Asynchronous teledentistry is the transmission of recorded dental information through a secure electronic system to a provider, who uses the information to evaluate a patient's condition or render a service outside of a real-time interaction, also known as store and forward (ADA 2020).

In response to the COVID-19 pandemic, states rapidly expanded their telehealth policies to allow for teledentistry services in Medicaid. Dental providers were the most common new provider type added (Libersky et al. 2020). One study found that dentists who had more than 50 percent of their patients covered by Medicaid were more likely to report the use of teledentistry (Tiwari 2022).

However, the interviewees noted that as beneficiaries have returned to in-person visits, teledentistry utilization has been low. Providers noted that since dentistry is a hands-on field, some dental providers may prefer in-person visits or lack comfort with teledentistry. Other experts noted that the low utilization could also be attributed to limited knowledge among dental providers about how to use the technology required for teledentistry, a lack of suitable technological devices and support, high cost of implementing this infrastructure, inadequate training, poor internet capabilities, and privacy concerns of patient data (Islam et al. 2022, Tiwari 2022).

While there has been low usage and coverage of teledentistry in their states, interviewees acknowledged it could help increase access to dental care services for the adult I/DD population. Teledentistry could also improve access to those who may have transportation issues, communication barriers, or difficulties with dental office hours of operation (Glassman 2021). Beneficiaries and advocates noted during interviews that teledentistry can identify areas of concern and the course of treatment before the individual's office visit, which may streamline the process and ease dental anxiety by eliminating uncertainties. Arizona recently passed a bill that requires Medicaid to reimburse dental care provided via teledentistry at the same rate as in-office visits (AHCCS 2024).

## Conclusion

Adults with I/DD report poor oral health status and require specialized services and supports to address their unique needs. These services include dental case management, minimally invasive dentistry, behavioral management services, and in some cases, sedation. The additional complexity of care for adults with I/DD, coupled with low Medicaid reimbursement rates, are some of the reasons why some providers are less willing to treat this population, which leads to long wait times for care and poorer dental health outcomes. State Medicaid agencies are using policy levers to address these challenges, such as increasing payments rates, working with dental schools to educate providers on the needs of adults with I/DD, or covering specific dental services, such as dental case management, alternatives to sedation (e.g., behavioral management), or teledentistry.





## Endnotes

<sup>1</sup> Although the terms intellectual disabilities and developmental disabilities are often used together to describe people with various conditions and functional limitations, they have different definitions. Federal statute defines developmental disability as a severe chronic disability in someone age five and older with onset before age 22 that results in substantial functional limitations in three or more areas of life activity (e.g., self-care, receptive and expressive language, learning, mobility, self-direction, capacity for independent living, and economic self-sufficiency) (42 USC § 15002(8)). There is not a federal definition for intellectual disability. The American Association of Intellectual and Developmental Disabilities defines intellectual disability as a condition characterized by significant limitations in both intellectual function and adaptive behavior that originates before the age of 22 (Schalock et al. 2021).

<sup>2</sup> The 12 states are Arizona, Colorado, Idaho, Louisiana, Nevada, New Hampshire, New York, South Carolina, Texas, Utah, Vermont, and Washington (CareQuest 2024).

<sup>3</sup> Previous MACPAC work has examined dental benefits for adults enrolled in Medicaid, the challenges that beneficiaries may face in accessing dental care, state initiatives to improve access, and comparisons of oral health utilization rates among Medicaid, private insurance, and the uninsured.

<sup>4</sup> MACPAC contracted with Mathematica to conduct the literature review and to facilitate interviews with stakeholders in Arizona, District of Columbia, Indiana, and New Jersey. Interviews were conducted with state Medicaid agency officials, state officials from departments of developmental disability services, advocates and beneficiaries with I/DD, dental providers or state dental associations, the Administration for Community Living Administration on Disability, American Academy of Developmental Medicine and Dentistry, the Medicaid | Medicare | CHIP Services Dental Association, and CMS. These interviews occurred between August and September 2024.

<sup>5</sup> Transfer devices safely move patients with limited mobility from a wheelchair to a dental chair. Stabilization devices physically restrain a patient's head, body, or extremities for receipt of medical treatment. Although a viable treatment modality, protective stabilization is increasingly controversial as restraints can be traumatic for patients and may be avoidable through alternative techniques (Chavis et al. 2021).

<sup>6</sup> The CDT is a standardized set of procedural codes for oral health services produced by the American Dental Association and used in all fifty states and the District of Columbia, to achieve uniformity, consistency and specificity in accurately documenting dental treatment (NCD 2023).

<sup>7</sup> These 1915(c) waivers in Louisiana are designed to provide services in the community as an alternative to institutional services to persons who meet the requirements for an institutional level of care. The New Opportunities Waivers is designed to provide home and community-based services (HBCS) to recipients who otherwise would require the level of care of an Intermediate Care Facility for the Developmentally Disabled (ICF/ID). The Residential Options Waiver provides an opportunity for eligible individuals with I/DD to transition from an ICF/ID, or from a nursing facility placement, back to a home setting. The Supports Waiver is designed to enhance the HBCS available to beneficiaries with developmental disabilities who require the level of care of an ICF/ID (LDH 2022).

<sup>8</sup> In 2022, 46.9 percent of Medicaid beneficiaries with disabilities were enrolled in managed care limited-benefit plans, which includes dental benefits in many states (MACPAC 2024).

<sup>9</sup> The Chronic Conditions Data Warehouse is a CMS research database of multiple chronic condition indicators of all beneficiaries in the Medicare, Medicaid, and dually enrolled populations. There are 14 disability-related conditions that researchers can code for the I/DD population (CMS 2025).

<sup>10</sup> Under the Special Needs Codes (SNC), a certified dentist is eligible for an encounter fee of \$90, in addition to other billable services when providing dental care to a person with developmental disabilities (Lyons and Catron 2007).

<sup>11</sup> CMS recently created a new Healthcare Common Procedure Coding System code, G0330, for providers to bill for covered services furnished to patients with special health needs, including adults with I/DD, that require general anesthesia in an operating room to receive dental care. However, this is currently for Medicare and not yet available for Medicaid beneficiaries (88 FR 81540).

<sup>12</sup> Studies have shown that oral health care in nursing homes is inadequate for elderly adults and institutionalized individuals, despite federal regulations mandating nursing homes evaluate oral health needs and facilitate access to dental care (Foiles Sifuentes and Lapane 2020).

## References

American Dental Association (ADA). 2020. ADA policy on teledentistry. Chicago, IL: ADA. <https://www.ada.org/about/governance/current-policies/ada-policy-on-teledentistry>.

American Dental Association (ADA). 2007. Guidelines for the use of sedation and general anesthesia. Chicago, IL: ADA. [https://www.ada.org/-/media/project/ada-organization/ada/ada-org/files/publications/cdt/anesthesia\\_guidelines.pdf](https://www.ada.org/-/media/project/ada-organization/ada/ada-org/files/publications/cdt/anesthesia_guidelines.pdf).

American Public Health Association (APHA). 2016. Access to integrated medical and oral health services. Washington, DC: APHA. <https://www.apha.org/policies-and-advocacy/public-health-policy-statements/policy-database/2016/11/29/access-to-integrated-medical-and-oral-health-services>.

Arizona Health Care Cost Containment System (AHCCCS). 2024. Fee-for-service provider billing manual. Phoenix, AZ: AHCCCS. [https://www.azahcccs.gov/PlansProviders/Downloads/FFSProviderManual/FFS\\_Chap10.pdf](https://www.azahcccs.gov/PlansProviders/Downloads/FFSProviderManual/FFS_Chap10.pdf).

Association of State and Territorial Dental Directors (ASTDD). 2021. *Best practice approach: Oral health care of people with special health care needs*. Reno, NV: ASTDD. <https://www.astdd.org/bestpractices/bpar-pshcn-2021.pdf>.

Berens J.C., L. Tsami, D.C. Lerman, et al. 2022. Preliminary results of an interdisciplinary behavioral program to improve access to preventative dental care for adults with intellectual and developmental disabilities. *Intellectual and Developmental Disabilities* 60, no. 6: 504–519. <https://doi.org/10.1352/1934-9556-60.6.504>.

Bershadsky J., R.L. Kate. 2010. Place of residence affects routine dental care in the intellectually and developmentally disabled adult population on Medicaid. *Health Services Research* 45, no 5p1: 1376-1389. <https://doi.org/10.1111/j.1475-6773.2010.01131.x>.

Bonardi, A., C.J. Clifford, and C.K. Fleming. 2018. *Oral health care for adults with IDD: A summary of evidence-based and promising practices*. Worcester, MA: Eunice Kennedy Shriver Center and University of Massachusetts Medical School. <https://onecaregiverresourcecenter.org/wp-content/uploads/2023/12/Oral-Healthcare-for-Adults-with-IDD.pdf>.

Buchmueller, T., S. Orzol, L., Shore-Sheppard. 2015. The effect of Medicaid payment rates on access to dental care among children. *American Journal of Health Economics* 1, no. 2. [https://www.nber.org/system/files/working\\_papers/w19218/w19218.pdf](https://www.nber.org/system/files/working_papers/w19218/w19218.pdf).

California Department of Health Care Services (DHCS). 2024. Silver diamine fluoride. Sacramento, CA: <https://www.dhcs.ca.gov/services/Pages/silver-diamine-fluoride.aspx>.

Carequest Institute for Oral Health. 2024. Medicaid adult dental benefits offered to specific beneficiary groups. Boston, MA: Carequest. [https://www.carequest.org/system/files/CareQuest\\_Institute\\_Medicaid-Adult-Dental-Benefits\\_10.9.24.pdf](https://www.carequest.org/system/files/CareQuest_Institute_Medicaid-Adult-Dental-Benefits_10.9.24.pdf).

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2025. Data tools for researchers. Baltimore, MD: CMS. <https://www.cms.gov/data-research/research/statistical-resources-dually-eligible-beneficiaries/data-tools-researchers>.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2024. Adult health care quality measures. Baltimore, MD: CMS. <https://www.medicare.gov/medicaid/quality-of-care/performance-measurement/adult-and-child-health-care-quality-measures/adult-health-care-quality-measures>.



Chavis, S.E., and M. Macek. 2022. Impact of disability diagnosis on dental care use for adults in the United States. *Journal of the American Dental Association* 153, no. 8: 797–804. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9339456/>.

Chavis, S.E., E. Wu, and S.M. Munz. 2021. Considerations for protective stabilization in community general dental practice for adult patients with special healthcare needs. *Compendium of Continuing Education in Dentistry* 42, no. 3: 134–138. <https://pmc.ncbi.nlm.nih.gov/articles/PMC8281605/>.

Fish-Parcham, C. 2019. *Improving Access to Oral Health Care for Adults with Disabilities Can Improve Their Health and Well-being*. Washington, DC: Families USA. [https://familiesusa.org/wp-content/uploads/2019/10/OH\\_Oral-Health-and-People-with-Disabilities\\_IssueBrief.pdf](https://familiesusa.org/wp-content/uploads/2019/10/OH_Oral-Health-and-People-with-Disabilities_IssueBrief.pdf).

Foiles Sifuentes, A., K.L. Lapane. 2020. Oral health in nursing homes: What we know and what we need to know. *Journal of Nursing Home Research* 61, no. 6: 1-5. <https://pmc.ncbi.nlm.nih.gov/articles/PMC7286629>.

Fosse, C., H. Luo, N. Laniado, et al. 2021. Dental access and expenditures for adults with intellectual and other disabilities. *Journal of Public Health Dentistry* 81, no. 4: 299–307. <https://doi.org/10.1111/jphd.12484>.

Hinton, E., and J. Raphael. 2025. 10 Things to know about Medicaid managed care. San Francisco, CA: KFF. <https://www.kff.org/medicaid/issue-brief/10-things-to-know-about-medicaid-managed-care/>.

Islam, M., R. Islam, S. Ferdous, et al. 2022. Teledentistry as an effective tool for the communication improvement between dentists and patients: An Overview. *Healthcare* 10, no. 8: 1586. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9408418/>.

Jones, D., and H.L. Taylor. 2024. State-level variation in Medicaid dental coverage for services beneficial to adults with intellectual and developmental disabilities. *Journal of the American Dental Association* 155, no. 7: 630–635. <https://www.sciencedirect.com/science/article/abs/pii/S0002817724002137?via%3Dihub>.

Koball, H., K. Ahluwalia, S. Setty, et al. 2020. *Addressing barriers to oral health and health care for adults with intellectual and developmental disabilities in New Jersey, five-year plan*. New York, NY: National Center for Children in Poverty. <https://www.nccp.org/wp-content/uploads/2020/07/1229.pdf>.

Libersky, J., E. Soyer, T. Masaoay, et al. 2020. Changes in Medicaid telehealth policies due to COVID-19: Catalog overview and findings. Washington, DC: Mathematica. <https://www.macpac.gov/wp-content/uploads/2020/06/Changes-in-Medicaid-Telehealth-Policies-Due-to-COVID-19-Catalog-Overview-and-Findings.pdf>.

Lipton, B., S. Decker, and B. Stitt. 2022. Association between Medicaid dental payment policies and children’s dental visits, oral health, and school absences. *JAMA Health Forum* 3, no. 9. <https://jamanetwork.com/journals/jama-health-forum/fullarticle/2796209>.

Louisiana Department of Health (LDH). 2022. Louisiana Medicaid expands dental care coverage for adults with intellectual or developmental disabilities. Baton Rouge, LA: LDH. <https://ldh.la.gov/news/dentalexpansion>.

Lyons, R., and B. Catron. 2007. *The New Mexico special needs dental procedure code*. Santa Fe, NM: New Mexico Department of Human Services. <https://www.astdd.org/bestpractices/DES34005NMspecialneedsdentalcode.pdf>.

Medicaid and CHIP Payment and Access Commission (MACPAC). 2024. Exhibit 30: Percent of Medicaid Enrollees in Managed Care by State and Eligibility Group, Fiscal year 2022. Washington, DC: MACPAC. <https://www.macpac.gov/wp-content/uploads/2024/12/EXHIBIT-30.-Percentage-of-Medicaid-Enrollees-in-Managed-Care-by-State-and-Eligibility-Group-FY-2022.pdf>.

Medicaid and CHIP Payment and Access Commission (MACPAC). 2015. Medicaid coverage of dental benefits for adults. In Report to Congress on Medicaid and CHIP. June 2015. Washington, DC: MACPAC. <https://www.macpac.gov/publication/coverage-of-medicaid-dental-benefits-for-adults/>.



- Milano, M. 2017. Oral healthcare for persons with intellectual or developmental disabilities: Why is there a disparity? *Compendium of Continuing Education in Dentistry* 38, no. 10: e5–e8. <https://pubmed.ncbi.nlm.nih.gov/29140099/>.
- Minihan, P.M., J. Morgan, A. Park, et al. 2014. At-home oral care for adults with developmental disabilities. *Journal of the American Dental Association* 145, no. 10: 1018–1025. <https://doi.org/10.14219/jada.2014.64>.
- Mitra, M., L. Long-Bellil, I. Moura, et al. 2022. Advancing health equity and reducing health disparities for people with disabilities in the United States. *Health Affairs* 41, no. 10: 1379–1386. <https://www.healthaffairs.org/doi/10.1377/hlthaff.2022.00499>.
- Morgan J., P. Minihan, P. Stark, et al. 2012. The oral health status of 4,732 adults with intellectual and developmental disabilities. *Journal of the American Dental Association* 143, no. 8: 838–848. <https://jada.ada.org/action/showPdf?pii=S0002-8177%2814%2961796-7>.
- National Council on Disability (NCD). 2023. *Incentivizing oral health care providers to treat patients with intellectual and developmental disabilities*. Washington, DC: NCD. <https://www.ncd.gov/report/incentivizing-oral-healthcare-providers-to-treat-patients-with-intellectual-and-developmental-disabilities/>.
- National Council on Disability (NCD). 2022. *Medicaid oral health coverage for adults with intellectual & developmental disabilities – A fiscal analysis*. Washington, DC: NCD. <https://www.ncd.gov/report/medicaid-oral-health-coverage-for-adults-with-intellectual-developmental-disabilities-a-fiscal-analysis/>.
- National Institutes of Health (NIH), U.S. Department of Health and Human Services. 2021. About intellectual and developmental disabilities (IDDs). Rockville, MD: NIH. <https://www.nichd.nih.gov/health/topics/idds/conditioninfo>.
- National Institute of Dental and Craniofacial Research (NIDCR), U.S. Department of Health and Human Services. 2023. Developmental disabilities & oral health. Bethesda, MD: NIDCR. <https://www.nidcr.nih.gov/health-info/developmental-disabilities>.
- National Institute of Dental and Craniofacial Research (NIDCR), U.S. Department of Health and Human Services. 2009. *Practical oral care for people with intellectual disability*. Bethesda, MD: NIDCR. <https://www.nidcr.nih.gov/sites/default/files/2020-10/practical-oral-care-intellectual-care.pdf>.
- Potter, C.N., J.L. Wetzel, and K.E. Learman. 2018. Effect of sensory adaptations for routine dental care in individuals with intellectual and developmental disabilities: A preliminary study. *Journal of Intellectual & Developmental Disability* 44, no. 3: 305–314. <https://doi.org/10.3109/13668250.2017.1409597>.
- Reynolds, J.C., and S. Naavaal. 2021. *Dentist participation in Medicaid*. Springfield, IL: American Association of Public Health Dentistry. [https://www.aaphd.org/assets/docs/Issue%20brief\\_Medicaid%202021.pdf](https://www.aaphd.org/assets/docs/Issue%20brief_Medicaid%202021.pdf).
- Roszel, C. 2023. Understanding and procedure coding for patients with special health care needs. Washington, DC: American Dental Association. [https://www.ada.org/-/media/project/ada-organization/ada/ada-org/files/publications/cdt/appendix-5\\_understanding-and-procedure-coding-for-patients-with-special-health-care-needs\\_2023jan.pdf](https://www.ada.org/-/media/project/ada-organization/ada/ada-org/files/publications/cdt/appendix-5_understanding-and-procedure-coding-for-patients-with-special-health-care-needs_2023jan.pdf).
- Schalock R., R. Luckasson, and M.J. Tassé. 2021. *Intellectual disability: Definition, diagnosis, classification, and systems of supports, 12<sup>th</sup> edition*. Silver Spring, MD: American Association on Intellectual and Developmental Disabilities. <https://www.aaidd.org/intellectual-disability/definition>.
- Taylor, M. 2018. *Improving access to dental services for individuals with developmental disabilities*. Sacramento, CA: Legislative Analyst's Office. <https://lao.ca.gov/reports/2018/3884/dental-for-developmentally-disabled-092718.pdf>.
- Tiwari, T., V. Diep, E. Tranby, et al. 2022. Dentist perceptions about the value of teledentistry. *BMC Oral Health* 22, no 176. <https://bmcoralhealth.biomedcentral.com/articles/10.1186/s12903-022-02208-z>.



Virginia Board for People with Disabilities (VBPD). 2023. *2023 Assessment of the accessibility of dental care*. Richmond, VA: VBPD. <https://www.vbpd.virginia.gov/downloads/Dental%20Care%20Assessment%202023-Final.pdf>.

Ward, L.M., L. Hughes-McCormack, L. Macpherson, and D. Kinnear. 2019. Oral health of adults with intellectual disabilities: as systematic review. *Journal of Intellectual Disability Research* 63, no. 11: 1359–1378. <https://doi.org/10.1111/jir.12632>.

Washington State Health Care Authority (WHCA). 2024. Mobile anesthesia for dental services billing guide. Olympia, WA: WHCA. <https://www.hca.wa.gov/assets/billers-and-providers/mobile-anesthesia-dental-bq-20240201.pdf>.

Williams, A.R., A. Yaqub, P. Glassman, and V. Phillips. 2023. Shortening-the-line: Reducing the need for sedation and general anesthesia for dental care for people with disabilities. *Journal of the California Dental Association* 51, no. 1. <https://doi.org/10.1080/19424396.2023.2253958>.

Wilson, N.J., Z. Lin, A. Villarosa et al. 2019. Countering the poor oral health of people with intellectual and developmental disability: A scoping literature review. *BMC Public Health* 19, no. 1: 1530. <https://doi.org/10.1186/s12889-019-7863-1>.

Young A.S., M.W. Fischer, N.S. Lang, et al. 2018. Practice patterns of dentist anesthesiologists in North America. *The Journal of Sedation and Anesthesiology in Dentistry* 65, no. 1: 9-15. <https://pmc.ncbi.nlm.nih.gov/articles/PMC5841489/>.

