

# Policy Changes to Expand Access to Oral Health Preventive Care for New York Children and Pregnant Women

April 2026

## Introduction

New York has the regulatory and financial tools to ensure all children and pregnant women receive the preventive oral health care they need, yet at present, many face barriers to receiving that care, especially those who are low-income or members of other underserved communities. Fortunately, the reasons for these barriers are known and fixable.

For young children on Medicaid, very few receive the preventive care that is recommended. Only 2.3% of children ages 1–2 received fluoride varnish from a medical provider in 2022. Connecticut and South Carolina achieve rates of 6.7% and 7.7% respectively, and North Carolina, a state often cited as a national model for oral health integration, reaches 21% of children ages 1-2 who are on Medicaid.<sup>1</sup>

New York's low fluoride varnish rate can be attributed to several factors, including restrictions on which medical team members can deliver fluoride varnish, low Medicaid reimbursement rates, and no payment for the bundled preventive services that make oral health integration economically viable for a busy practice.

Pregnant women also face formidable barriers to receiving critical oral health prevention services. Fewer than half of pregnant women in New York, 44.8%, reported having their teeth cleaned during pregnancy.<sup>2</sup> Physiological changes during pregnancy increase vulnerability to oral disease, and untreated dental problems during this period can affect both maternal and infant health.<sup>3</sup> Yet New York does not reimburse dental providers for fluoride varnish for pregnant women, leaving a tremendously effective prevention tool largely unused.

A broader workforce shortage compounds both problems. 2.7 million New Yorkers live in areas with a designated dental provider shortage, with only 16% of identified need currently being met.<sup>4</sup> Closing that gap requires expanding who can provide oral health services and improving the financial case for serving Medicaid patients.

The five recommendations in this brief address each of these barriers directly, drawing on approaches that other states have already put into practice.



## About This Report

The data in this brief comes from the Maternal and Child Health–Improving Oral Health Integration (MCH-IOHI) initiative, a four-year federal demonstration project (2024–2028) funded by the Health Resources and Services Administration (HRSA). MCH-IOHI awarded grants to eight states and jurisdictions: New York, Colorado, Connecticut, Montana, Puerto Rico, South Carolina, Texas, and Wisconsin, to advance the integration of preventive oral health care into primary care settings for pregnant women, infants, and children. During the project, states contribute data to a shared environmental scan that tracks the oral health services different professions are allowed to provide, Medicaid reimbursement, and utilization of oral health services, among other metrics. This brief draws on the 2025 Environmental Scan Chartbook to compare New York's regulatory environment to that of the other seven states selected for the initiative.

New York's MCH-IOHI project is led by HealthEfficient and is called Transforming Oral Health for Communities (TOHC). The TOHC project focuses on pregnant women and children from birth through 40 months living in communities underserved by oral health care. The project works at both the state and local levels: at the state level, it aims to strengthen policy and expand scope of practice to include oral health preventive care within the scope of practice of community health workers and other medical team members; at the local level, it supports community health centers in integrating preventive oral health care into primary care through provider training, clinical workflow changes, and dental referral tracking.

The policy recommendations in this brief identify the specific regulatory and reimbursement changes that would allow New York to implement TOHC model recommendations and reach more patients, in more settings, across New York, and ultimately, improve health outcomes.



*Read the brief from the Maternal and Child Health-Improving Oral Health Integration (MCH-IOHI) initiative*

## Who Is Being Left Out

The regulatory and reimbursement barriers described in this brief have significant adverse consequences for the oral and overall health of many New Yorkers, but particularly, for children and pregnant women who rely on Medicaid.

**Children enrolled in Medicaid** are the most directly affected. In most years over the last decade, fewer than half of New York children enrolled in Medicaid received a single dental visit, and fewer still received a preventive dental visit. In the decade between 2014 and 2023, the percentage of Medicaid-enrolled children who had at least one dental visit exceeded 50% just once – in 2019. In the most recent year for which there is data (2023), the percentage was 46.8%. Preventive visit rates have remained even lower, peaking at 46.6% in 2019 before falling back to 43% by 2023.<sup>5</sup>

Disparities in dental disease closely track with race and ethnicity. Among New York children ages 1 through 17, Asian non-Hispanic children had the highest rate of decayed teeth or cavities in 2022–2023 at 15.6%, followed by Black non-Hispanic children at 11.1% and children of multiple races at 10.5%. White non-Hispanic children had the lowest rate at 8.7%. These disparities reflect the same social and economic conditions that drive broader health inequities, including poverty, racism, unequal access to nutritious food, and gaps in language access and cultural competence for immigrant and refugee families.<sup>6</sup>

**Pregnant women** face significant challenges accessing preventive oral health care. In 2022, 18.8% of pregnant women in New York reported needing dental care for a problem during pregnancy, yet only 14.4% reported actually going to a dentist or dental clinic.<sup>7</sup> The regulatory changes recommended in this brief, particularly adding fluoride varnish reimbursement for dental providers treating pregnant women, would directly improve preventive services for this population.

## What New York Has Built

New York has a strong foundation to build on:

- **Teledentistry:** New York authorizes and reimburses both synchronous and asynchronous teledentistry for dentists and dental hygienists at equal payment rates, making New York one of only three MCH-IOHI states with payment parity.
- **Medicaid dental coverage for pregnant women:** New York extends comprehensive dental benefits through 12 months post-partum, one of only four MCH-IOHI states to do so.
- **Medical provider reimbursement for children:** New York reimburses physicians for fluoride varnish, providing a base for additional preventive services.

Despite the foundation, three challenges prevent translating these assets into increased access.

## Three Challenges Holding New York Back

### Challenge 1: Primary care visits are a missed opportunity for oral health prevention.

In New York, medical providers such as physicians, nurses, and physician assistants, are authorized to apply fluoride varnish, but low reimbursement rates limit how often it happens. New York pays medical providers \$30 for fluoride varnish but has no additional reimbursement for related preventive services such as oral hygiene instruction, nutritional counseling or case management that would be beneficial.

Another reason this service is underutilized is that medical assistants (MAs) are not permitted to apply fluoride varnish in New York, which leaves it to doctors or nurses to fit this into their already busy workflow. Notably, MAs are neither registered nor licensed in New York. In each of the five MCH-IOHI states that allow MAs to perform this service, the profession holds some form of state registration or licensure. Not being able to rely on MAs to perform fluoride varnish presents another barrier that prevents many primary care visits acting as a point of oral health intervention.

These limitations make it hard for providers to integrate oral health into primary care visits in a manner that is economical and doable.

### Challenge 2: Dental providers lack the financial incentives to serve Medicaid patients.

New York has the lowest dentist Medicaid participation rate of all MCH-IOHI states: 37%, against an average of 52% and Montana's high of 73%. New York reimburses dental providers for only two

preventive services included in the environmental scan, fluoride varnish and silver diamine fluoride, while other MCH-IOHI states reimburse caries risk assessment, oral hygiene instruction, nutritional counseling, and care management. Montana's bundled preventive payment for high-risk children under 5 totals \$145; New York pays \$30.

### Challenge 3: New York's dental workforce is too small and too restricted to meet demand.

The *Oral Health Needs Assessment for New York* (2024) identified more than 2.8 million people across the state living in high oral health need areas, predominantly in rural portions of the state.<sup>8</sup> Federal shortage area designations tell a similar story: there are 161 dental health professional shortage areas covering 2.7 million New Yorkers, with only 16% of identified need currently being met.<sup>9</sup> According to the needs assessment, factors most strongly associated with an area having a high oral health need include disability status, low educational attainment, pregnancy, and low population-to-dentist and dental hygienist ratios, the very populations and conditions that a well-designed workforce expansion strategy would target.

Dental therapists are not allowed to practice in New York, leaving it without a provider type that Colorado, Connecticut, and Wisconsin have authorized. Dental therapists can provide preventive and routine restorative care in federally qualified health centers, rural clinics, and school-based settings where dentist access is limited and where children on Medicaid and pregnant women are most likely to seek care. Authorizing dental therapy is the highest-leverage long-term tool available to close the gap between where the need is greatest and where care is currently being delivered.<sup>10</sup>

## Five Recommended Changes

### 1. Increase reimbursement for oral health prevention in medical settings

**Current state:** New York reimburses medical providers \$30 for fluoride varnish, below Colorado's \$42 and Texas's \$36.

**What this requires:** Administrative changes through Medicaid.

**What it would change:** Increasing the reimbursement rate and adding payment for bundled preventive services gives medical practices enough financial support to incentivize them to integrate oral health into their workflow, not just a regulatory permission to do so.

### 2. Add reimbursement for a preventive services bundle for dental providers

**Current state:** New York reimburses dental providers \$30 for fluoride varnish only. Six of seven MCH-IOHI states reimburse for additional services; Montana's full bundle totals \$145.

**What this requires:** Administrative changes by Medicaid.

**What it would change:** Adding reimbursement for caries risk assessment (D0601–D0603), oral hygiene instruction (D1330), nutritional counseling (D1310), and oral health case management (D9992) at rates comparable to other MCH-IOHI states (\$10–\$46 per service) would incentivize comprehensive preventive care rather than single procedures.

### 3. Allow medical assistants to apply fluoride varnish through delegation

**Current state:** Medical assistants in New York cannot apply fluoride varnish. Among the MCH-IOHI states, Colorado, Connecticut, Montana, Texas, and Wisconsin all allow it through delegation although all these states have certified or licensed medical assistants, unlike New York. Notably, a few states not in the cohort do not certify or license their medical assistants – like New York – yet allow their MAs to apply fluoride varnish under delegation after they have taken a course.<sup>11</sup>

**What this requires:** Statutory amendment to education law to allow medical assistants to apply fluoride varnish under delegation after they take a course.

**What it would change:** Allowing fluoride varnish provision through delegation would reduce the time burden on physicians and nurses and should increase the number of children who receive the application during a visit.

### 4. Add fluoride varnish reimbursement for dental providers treating pregnant women

**Current state:** New York Medicaid reimburses dental providers for silver diamine fluoride for pregnant women over 21, but not fluoride varnish. Colorado, Connecticut, Montana, and Wisconsin reimburse for both.

**What this requires:** Administrative changes by Medicaid.

**What it would change:** New York's Medicaid program covers many adult oral health preventive and treatment services already. Fluoride varnish is a targeted, low-cost service consistent with a focus on the prevention for those at high risk of dental disease.

## 5. Authorize dental therapy

**Current state:** New York has no dental therapy law. Colorado, Connecticut, and Wisconsin have authorized dental therapists; Montana has limited authorization for tribal settings.

**What this requires:** A law authorizing dental therapy.

**What it would change:** Dental therapists are providers, similar to physician assistants in medicine, who can provide preventive and routine restorative care including filling cavities, and some extractions.<sup>12</sup> They are designed for exactly the settings where New York's shortage is most acute: rural areas, federally qualified health centers, and safety-net clinics. With 2.7 million New Yorkers living in dental shortage areas, this is the highest-leverage long-term workforce change available.



### Looking Ahead: Oral Health Services for Pregnant Women in Medical Settings

One gap in New York's oral health system has no MCH-IOHI model to follow: no state participating in this initiative reimburses medical providers for preventive oral health services provided to pregnant women, such as oral health education and fluoride varnish. This is a significant missed opportunity since prenatal visits are often the most consistent point of contact pregnant women have with the health care system.

New York already extends comprehensive Medicaid dental benefits through 12 months post-partum. Building on that foundation to create a medical-side reimbursement pathway for oral health services at prenatal visits would put New York at the forefront of maternal oral health policy.

### For More Context

The data in this brief focus on New York's regulatory and reimbursement environment compared to other MCH-IOHI states. For a broader picture of children's oral health in New York, including trends in dental disease, Medicaid utilization, and the impact of

provider shortages on families, see [Ensuring Oral Health Care for All Children](#) in the Schuyler Center's [State of New York's Children 2026](#) report, available at [scaany.org](https://scaany.org). Primary data source: Phipps KR. 2025. Maternal and Child Health—Improving Oral Health Integration (MCH-IOHI): Environmental Scan Chartbook 2025. Washington, DC: National Maternal and Child Oral Health Resource Center.

[MCH-IOHI-environmental-scan-chartbook.pdf](#)

For more information, see [From Barriers to Bridges and Moving Oral Health Workforce Reform into Practice](#).



[From Barriers to Bridges](#)



[Moving Oral Health Workforce Reform into Practice](#)

---

### Endnotes

- 1 E Phipps KR. (2025). [Maternal and Child Health—Improving Oral Health Integration \(MCH-IOHI\): Environmental Scan Chartbook 2025](#). Washington, DC: National Maternal and Child Oral Health Resource Center. p. 27
- 2 New York State Department of Health. (2024). [New York State Community Health Indicator Report Dashboard \(CHIRS\)](#).
- 3 Hartnett E, Haber J, Krainovich-Miller B. (2016) [Oral Health in Pregnancy: Journal of Obstetric, Gynecologic & Neonatal Nursing](#). 45, 565-573
- 4 Phipps KR. (2025). [Maternal and Child Health—Improving Oral Health Integration \(MCH-IOHI\): Environmental Scan Chartbook 2025](#). Washington, DC: National Maternal and Child Oral Health Resource Center. p. 57.
- 5 New York State Department of Health. (2024). [New York State Community Health Indicator Report Dashboard \(CHIRS\)](#).
- 6 Schuyler Center for Analysis and Advocacy. (2025) [Ensuring Oral Health Care for All Children](#).
- 7 New York State Department of Health. (2022). [Pregnancy Risk Assessment Monitoring System](#).
- 8 Harun N, Kang B, Fernando T, Surdu S. (2024). [Oral Health Needs Assessment for New York State Center for Health Workforce Studies](#). Center for Health Workforce Studies. University at Albany, School of Public Health.
- 9 E Phipps KR. (2025). [Maternal and Child Health—Improving Oral Health Integration \(MCH-IOHI\): Environmental Scan Chartbook 2025](#). Washington, DC: National Maternal and Child Oral Health Resource Center, p 57
- 10 Schuyler Center for Analysis and Advocacy, (2025) [Moving Oral Health Workforce Reform into Practice: Advancing the Barriers to Bridges Agenda](#).
- 11 States without licensed medical assistants that allow them to apply fluoride varnish include, Minnesota, Virginia and Illinois.
- 12 Schuyler Center for Analysis and Advocacy, (2025) [Moving Oral Health Workforce Reform into Practice: Advancing the Barriers to Bridges Agenda](#).

## Appendix

### Supporting Evidence for Five Recommended Changes

New York rows are in **bold** throughout. All data from MCH-IOHI Environmental Scan Chartbook 2025 unless noted.

#### Section A: Medical Settings

Supporting evidence for Gap 1, Recommendation 1 (medical provider reimbursement), and Recommendation 3 (medical assistant delegation).

##### A1. Medical Team Members — Authorized Services

State	RN: FV	LPN: FV	MA: FV	RN: SDF	LPN: SDF	MA: SDF
Colorado	Delegated	Delegated	Delegated	No	No	No
Connecticut	Delegated	Delegated	Delegated	No	No	No
Montana	Delegated	Delegated	Delegated	Delegated	Delegated	Delegated
<b>New York</b>	<b>Delegated</b>	<b>Delegated</b>	<b>No</b>	<b>No</b>	<b>No</b>	<b>No</b>
South Carolina	Delegated	Delegated	No	Delegated	Delegated	No
Texas	Yes	Yes	Delegated	No	No	No
Wisconsin	Delegated	Delegated	Delegated	Delegated	Delegated	Delegated

RN = registered nurse | LPN = licensed practical nurse | MA = medical assistant | FV = fluoride varnish | SDF = silver diamine fluoride

**What this shows:** New York is one of only two states in this initiative (with South Carolina) where medical assistants cannot apply fluoride varnish even through delegation. In high-volume pediatric and family medicine practices, MAs handle much of the routine preventive workflow. The five states in this initiative allow MA delegation for fluoride varnish license or regulate MAs, but there are states without regulated MAs that allow them to provide fluoride varnish. New York’s restriction can limit how fluoride varnish is delivered during a visit and directly supports Recommendation 3.

##### A2. Medical Providers — Billable Services for Children (Birth to Age 21)

State	Caries risk assessment	Fluoride varnish	SDF	Oral hygiene instruction	Nutritional counseling
Colorado	No	Yes	No	No	No
Connecticut	Yes*	Yes	No	Yes*	No
Montana	No	Yes	No	No	No
<b>New York</b>	<b>No</b>	<b>Yes</b>	<b>No</b>	<b>No</b>	<b>No</b>
South Carolina	No	Yes	No	No	No
Texas	Yes	Yes	No	Yes	Yes
Wisconsin	No	Yes	No	No	No

SDF | silver diamine fluoride

\*Connecticut bills caries risk assessment via a modifier on well-child visit codes; oral hygiene instruction billed under anticipatory guidance.

**What this shows:** New York reimburses only for fluoride varnish. The gap is that New York provides no reimbursement for the additional preventive services. This directly supports Recommendation 1.

**A3. Medical Providers — Reimbursement Rates for Fluoride Varnish Application, Children**

*Medicaid fee-for-service reimbursement rates, 2024*

State	Reimbursement rate
Colorado	\$42
Texas	\$36
<b>New York</b>	<b>\$30</b>
Montana	\$23
Connecticut	\$20
Wisconsin	\$13
South Carolina	\$10
Puerto Rico	\$0

**What this shows:** New York’s \$30 rate is above the middle of the pack for fluoride varnish. Increasing rates to the Texas and Colorado level could improve provision of fluoride varnish in medical settings.

**A4. Medical Providers — Billable Services for Pregnant Women (Over Age 21)**

*Supporting the Looking Ahead section*

State	Caries risk assessment	Fluoride varnish	SDF	Oral hygiene instruction	Nutritional counseling
Colorado	No	No	No	No	No
Connecticut	No	No	No	No	No
Montana	No	No	No	No	No
<b>New York</b>	<b>No</b>	<b>No</b>	<b>No</b>	<b>No</b>	<b>No</b>
South Carolina	No	No	No	No	No
Texas	No	No	No	No	No
Wisconsin	No	No	No	No	No

**What this shows:** No state in this initiative reimburses medical providers for oral health services for pregnant women at prenatal visits. This is a universal gap that represents a significant missed opportunity, particularly given how consistently pregnant women interact with prenatal care providers. New York has the opportunity to lead on this issue. See Looking Ahead section.

## Section B: Dental Settings

Supporting evidence for Gap 2, Recommendation 2 (dental provider bundle), and Recommendation 4 (fluoride varnish for pregnant women)

### B1. Dental Providers — Billable Services for Children (Birth to Age 21)

State	Caries risk assessment	Fluoride varnish	SDF	Oral hygiene instruction	Nutritional counseling	Case management
Colorado	Yes	Yes	Yes	No	No	No
Connecticut	Yes	Yes	Yes	No	No	Yes*
Montana	Yes	Yes	Yes	Yes^	Yes^	Yes
<b>New York</b>	<b>No</b>	<b>Yes</b>	<b>Yes</b>	<b>No</b>	<b>No</b>	<b>No</b>
South Carolina	No	Yes	Yes	Yes+	Yes+	No
Texas	No	Yes	Yes	Yes	No	No
Wisconsin	No	Yes	Yes	No	No	No

\*Connecticut: case management is manually priced, reimbursement determined case by case. ^Montana: oral hygiene instruction and nutritional counseling available only through AbCd program for children under age 5. +South Carolina: covered through EPSDT.

**What this shows:** New York covers fluoride varnish and silver diamine fluoride for children but nothing else. Adding reimbursement for caries risk assessment, oral hygiene instruction, nutritional counseling, and case management as proposed in Recommendation 2 would incentivize comprehensive preventive visits rather than single-procedure encounters.

### B2. Dental Providers — Reimbursement Rates, Children (Birth to Age 21)

State	Caries risk assessment	Fluoride varnish	Oral hygiene instruction	Nutritional counseling	Case management	Total
Colorado	—	\$42	—	—	—	<b>\$42</b>
Connecticut	\$23	\$28	—	—	Manual	<b>\$51+</b>
Montana (AbCd)	\$12	\$23	\$27	\$46	\$37	<b>\$145</b>
<b>New York</b>	—	<b>\$30</b>	—	—	—	<b>\$30</b>
South Carolina	—	\$19	\$10	\$33	—	<b>\$62</b>
Texas	—	\$15	\$13	—	—	\$28*
Wisconsin	—	\$18	—	—	—	<b>\$18</b>

\*Texas rates are part of a bundled billing code.

**What this shows:** Adding the four services in Recommendation 2 at rates comparable to other states would bring New York's meaningfully above the current rate.

### B3. Dental Providers — Billable Services for Pregnant Women (Over Age 21)

#### Supporting Recommendation 4

State	Caries risk assessment	Fluoride varnish	SDF	Oral hygiene instruction	Nutritional counseling	Case management
Colorado	No	Yes	Yes	No	No	No
Connecticut	Yes	Yes	Yes	No	No	No
Montana	No	Yes	Yes	No	No	No
<b>New York</b>	<b>No</b>	<b>No</b>	<b>Yes</b>	<b>No</b>	<b>No</b>	<b>No</b>
South Carolina	No	No	No	No	No	No
Texas	No	No	No	No	No	No
Wisconsin	No	Yes	Yes	No	No	No

**What this shows:** New York reimburses dental providers for silver diamine fluoride for pregnant women but not fluoride varnish, a gap Recommendation 4 addresses. Four states in this initiative cover both. New York already extends comprehensive dental coverage through 12 months post-partum. Adding fluoride varnish reimbursement is a targeted, low-cost fix within an existing benefit structure.