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Teledentistry Adoption and Use During the COVID-19 Pandemic

OHWRC
Oral Health Workforce Research Center

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PREFACE

The Oral Health Workforce Research Center (OHWRC) at the Center for Health Workforce Studies (CHWS) at the University at Albany's School of Public Health completed a study to describe the impact of the COVID-19 pandemic on the delivery of oral health services in the dental safety-net using teledentistry to consult with patients.

This report was prepared for OHWRC by Margaret Langelier, Theekshana Fernando, Simona Surdu, and Alex Romero. OHWRC is supported by the Health Resources and Services Administration (HRSA) of the US Department of Health and Human Services (HHS) as part of an award totaling $450,000 with 0% financed with non-governmental sources. The content of this document is reported by the authors and does not necessarily represent the official views of nor an endorsement by HRSA, HHS, or the US government. For more information, please visit HRSA.gov.

The mission of OHWRC is to provide accurate and policy-relevant research on the impact of the oral health workforce on oral health outcomes. The research conducted by OHWRC informs strategies designed to increase access to oral health services for vulnerable populations. OHWRC is based at CHWS at the School of Public Health, University at Albany, State University of New York (SUNY), and is the only HRSA-sponsored research center with a unique focus on the oral health workforce. The views expressed in this report are those of OHWRC and do not necessarily represent positions or policies of the School of Public Health, University at Albany, SUNY.

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Institutional Review Board

The plan for this study was reviewed and approved by the Institutional Review Board of the SUNY Research Foundation (Study No. 22X153).

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EXECUTIVE SUMMARY

BACKGROUND

Prior to the COVID-19 pandemic, the use of teledentistry was limited mostly to unique providers and programs focused on specific populations of patients,[1] including, for instance, veterans, children, and elders in group residential settings. The utility of teledentistry was widely questioned in light of the predominately procedural nature of dentistry. Many clinicians were concerned about the quality of virtual consultations in contrast to face-to-face encounters.[2] Adoption was hindered by many factors including reluctance to innovate, concerns about costs related to infrastructure and software, reservations about having the necessary technological skills to use teledentistry to the benefit of patients,[2] and concerns about patients' acceptance of a virtual visit.[3]

One major disruption occasioned by COVID-19 was the full or partial closure of health care provider organizations, including dental practices, across the US. These shutdowns during the early months of the national public health emergency were part of state and national efforts to slow COVID-19 transmission when little was known about actual pathways to infection. These circumstances catalyzed innovative thinking about how best to connect patients with their clinical providers when face-to-face consultation was unavailable.

Teledentistry quickly became a useful tool to connect with patients for both private practice dentists and those in public health practice. A study by Choi et al. in the early months of the COVID-19 pandemic in 2020 found that during the week of April 6 dental care use had declined by 94.5% compared to the same week in the previous year.[4] The authors also found that in April 2020, the use of teledentistry increased to approximately 60 times the level of use in April 2019. By August 2020, when dental offices had reopened and visit rates were approaching normalcy, teledentistry use was still 12.7 times higher than in the same period in the previous year.[4]

This research study had 2 objectives. The first was to conduct a review of enabling statutes and regulations for the provision of teledentistry services in each of the 51 regulatory jurisdictions in the US. The second was to conduct interviews with dental providers and dental staff in the dental safety-net in the US to understand the use of teledentistry prior to, during, and subsequent to the most intense months of the COVID-19 pandemic.

METHODS

Researchers compiled a concise dictionary of the basic regulatory parameters for providing teledentistry services in each of the 50 states and the District of Columbia. The project plan included a review of current state statutes, dental board regulations and opinions, and state Medicaid directives relative to the delivery of teledentistry services. Researchers also used already compiled documentation from the Center for Connected Health Policy,[5] the American Dental Education Association,[6] and MouthWatch[7] to compare and validate findings.

Between May-October 2022, project staff also conducted interviews with 26 key informants in

various positions at 11 safety-net dental organizations, 9 of which were Federally Qualified Health Centers (FQHCs). Two organizations were private not-for-profit community dental organizations that provide oral health services for low-income populations, those with special needs, and children.

The topics of interest for the key-informant interviews included the general effects of COVID-19 on the provision of dental services in the safety-net, the use of teledentistry as a supplement or complement to face-to-face encounters with patients during the COVID-19 pandemic, and the impact of COVID-19 and related stressors on dental staff burnout, recruitment, and retention.

KEY FINDINGS

The review of enabling statues and regulations for provision of teledentistry resulted in the development of an infographic describing the requirements for teledentistry service provision in each state. The interactive graphic, which is available on the website of OHWRC, catalogues data about the 8 regulatory directives:

1. The source of authority to provide teledentistry services (eg, statute, regulation, etc.)
2. The types of allowable services (ie, synchronous, asynchronous)
3. The required modality for synchronous teledentistry (eg, video, audio only, etc.)
4. Other modalities allowed (eg, mobile applications, etc.)
5. Patient of record required (ie, yes or no and when established)
6. Patient informed consent required (ie, yes or no)
7. Allowed providers (ie, dentist, dental hygienist, or both)
8. Medicaid reimbursement for CDT codes D9995 and/or D9996 (ie, yes or no)

The sources of regulatory authority to provide teledentistry services vary widely in states as do the ways in which appropriate usage is addressed. Our review of requirements for practice of teledentistry revealed significant variation in every aspect of enabling regulation. These variations were sometimes quite complex, which likely effected uptake by clinicians.

The analysis of key informant interviews indicated that the ability to quickly implement teledentistry services depended on the prior experience of the organization, availability of secure technology, willingness of providers and patients to engage, and state directives relative to conduct and payment. Teledentistry was commonly used for triage, consulting, diagnosing, and education.

Common themes among the interview participants included:

1. Teledentistry was critical in bridging access to care gaps during the initial months of the COVID-19 pandemic.
2. Teledentistry had the potential to be a satisfactory treatment modality for patients.

3. Patients were somewhat reluctant but, once engaged, were comfortable using teledentistry.
4. The majority of providers were satisfied with offering services via teledentistry.
5. Instituting a teledentistry program required trial and error, but once established the benefits of virtual visits became apparent.
6. Several benefits of using teledentistry with patients emerged with the use of the technology.
7. Clear guidance on teledentistry regulation and reimbursement continued to be the primary environmental barrier for provision of teledentistry services by safety-net providers.

CONCLUSIONS

Teledentistry was a useful alternative to in-person care delivery during the early months of COVID-19 when service availability was severely limited due to stay-at-home orders and lockdowns of health care organizations. Teledentistry proved to be an effective intervention allowing for triage, risk assessment, diagnosis, treatment and palliation, education, and referral for emergency in-person services. As with any novel practice, organizations and dental clinicians experienced various degrees of comfort or discomfort with using technology to conduct virtual encounters with patients. Many became more comfortable with the utility of teledentistry as an adjunct to in-person care while some continued to feel it was not a viable alternative to face-to-face encounters. Several organizations that established teledentistry programs before or during COVID-19 were continuing to use it in a more limited format, especially for specific communities within their patient populations. While the COVID-19 pandemic was inconvenient and disruptive to health care, it provided an important opportunity—in a sense a natural experiment among a broader and more generalized population—to explore the benefits of virtual visits and how they can be used to augment in-person services and increase access to dental providers.

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TECHNICAL REPORT

BACKGROUND

Prior to the COVID-19 pandemic, the use of teledentistry was limited mostly to unique providers and programs focused on specific populations of patients,[1] including, for instance, veterans, children, and elders in group residential settings. The utility of teledentistry was widely questioned in light of the predominately procedural nature of dentistry. Many clinicians were concerned about the quality of virtual consultations in contrast to face-to-face encounters.[2] Adoption was hindered by many factors including reluctance to innovate, concerns about costs related to infrastructure and software, reservations about having the necessary technological skills to use teledentistry to the benefit of patients,[2] and concerns about patients' acceptance of a virtual visit.[3]

Pre-COVID-19, asynchronous or store and forward teledentistry often involved acquisition of patient imaging, oral health screening and assessment, and recording of medical information by a dental hygienist in a remote location such as a school or skilled nursing facility. These patient records were then forwarded to a dentist for later diagnosis and treatment planning. This method for improving availability of scarce dental services was increasingly used in mobile and portable dentistry programs in community settings for patients with limited access to dentistry. The introduction of the virtual dental home model by Dr. Paul Glassman in several states, including California and Hawaii, demonstrated the utility of these virtual encounters.[4]

Also, prior to 2020, synchronous or real-time teledentistry was used in limited circumstances. Synchronous virtual visits with a patient might occur from a "spoke" or "originating" location such as a Federally Qualified Health Center (FQHC) with an established teledentistry platform connecting to a "hub" or "distant" location where a general or specialty dental provider offered consultation. With the exception of remote patient monitoring, which is not commonly used in dentistry, the conduct of teledentistry was required to occur from specific health provider and community locations that were properly prepared with Health Insurance Portability and Accountability Act (HIPPA)-compliant equipment and processes to protect patient privacy. In addition, federal regulation limited reimbursement for these services to patients in particular geographic areas or circumstances who could not otherwise access services.

One major disruption occasioned by COVID-19 was the full or partial closure of health care provider organizations, including dental practices, across the US. These shutdowns during the early months of the national public health emergency were part of state and national efforts to slow COVID-19 transmission when little was known about actual pathways to infection. These circumstances catalyzed innovative thinking about how best to connect patients with their clinical providers when face-to-face consultation was unavailable and emergency care providers, especially hospitals, were overwhelmed with caring for those who were seriously ill with COVID-19.

The most obvious solution was technology-enabled/virtual telehealth and teledental visits using a variety of modalities including video conferencing, audio connections, mobile applications, email, etc. However, in many places, regulatory safeguards prevented providers from offering either communication technology-based services or telehealth/teledental care for their patients. Communica-

tion-enabled visits generally include relatively brief telephone and email consultations with patients to determine a need for an in-person encounter, for instance. Telehealth/teledental encompasses the provision of virtual health services that are substantially equivalent to those provided in a face-to-face visit between a patient and a clinical provider.[5]

While having appropriate technology and processes in place to securely and easily provide health services in a virtual environment are essential for effective use of telehealth, regulations at both state and federal levels during the COVID-19 pandemic impacted if and how telehealth could be embraced as an alternative platform to face-to-face service delivery. With the declaration of the federal public health emergency, both federal and state regulators were given broader latitude to implement alternative solutions to meet public need.

Executive orders from federal and state regulators encouraged use of technology to consult with patients. Federal directives extended the parameters for reimbursement for teledentistry. These directives included newly acceptable modalities such as audio only and allowance for electronically interfacing with patients in their homes.[6] The opportunity to use teledentistry was also enabled by emergency directives that loosened stringent HIPPA requirements, which enabled use of certain commonly available communication platforms that were not public facing. Use of teledentistry extended care to a broader group of patients including those in areas that lacked access to dental care; teledentistry became a tool for triage, consultation, and follow-up care. Teledentistry also assisted dentists and patients with maintaining continuity of care.[3]

Teledentistry quickly became a useful tool to connect with patients for both private practice dentists and those in public health practice. A study by Choi et al. in the early months of the COVID-19 pandemic in 2020 found that during the week of April 6 dental care use had declined by 94.5% compared to the same week in the previous year.[7] The authors also found that in April 2020, the use of teledentistry increased to approximately 60 times the level of use in April 2019. By August 2020, when dental offices had reopened and visit rates were approaching normalcy, teledentistry use was still 12.7 times higher than in the same period in the previous year.[7]

This current OHWRC study had 2 objectives. The first was to conduct a review of enabling statutes and regulations for the provision of teledentistry services in each of the 51 regulatory jurisdictions in the US. The second was to conduct interviews with dental providers and dental staff in the dental safety-net in the US to understand the use of teledentistry prior to, during, and subsequent to the most intense months of the COVID-19 pandemic. The report is divided into 2 sections to describe the outcomes of each activity. The first section describes the regulatory review and subsequent development of an infographic delineating basic teledentistry requirements by state. The second section is a narrative describing the common themes developed from interviews with staff from 11 safety-net dental organizations across the US.

Methods

A primary objective of this project was to compile a concise dictionary of the basic regulatory parameters for providing teledentistry services in each of the 50 states and the District of Columbia. The project plan included a review of current state statutes, dental board regulations and opinions, and state Medicaid directives relative to the delivery of teledentistry services.

The review and subsequent compilation of data were conducted to:

- Understand the basic circumstances and permissions for the conduct of teledentistry services in each jurisdiction
- Determine common elements that could be compared across states
- Identify current standing law that guided the provision of teledentistry once executive orders expanding privilege had or would expire

To accomplish these objectives, researchers were required, in many states, to review umbrella legislation guiding the use of telehealth or telemedicine including relevant regulatory activity. This task was particularly difficult because, at the time of the review in the summer and fall 2022, there were numerous executive orders still in effect due to the public health emergency. These orders expanded the circumstances under which teledentistry services could be provided. However, some remained in effect pending legislative review to consider permanence while others were expiring within a short time period. The data presented here represent conditions for teledentistry practice that were permanently codified in states; temporary permissions were not included in this compilation. Therefore, there may be some variance between this information and currently allowable practice. The Appendix of this report contains the hyperlinks to many of the reference sites used in the compilation of these data.

The data aggregation was accomplished by 2 researchers who each reviewed regulation and guidance documents in every state multiple times to assure accuracy. In addition to the primary source data, the researchers also used already compiled documentation from the Center for Connected Health Policy,[8] the American Dental Education Association,[9] and MouthWatch[10] to compare and validate findings. The results were then compiled under 8 topics within an infographic. The interactive graphic was designed to provide a resource to describe the parameters for teledentistry practice in each state. The topic areas are:

1. The source of authority to provide teledentistry services (eg, statute, regulation, etc.)
2. The types of allowable services (ie, synchronous, asynchronous)
3. The required modality for synchronous teledentistry (eg, video, audio only, etc.)
4. Other modalities allowed (eg, mobile applications, etc.)
5. Patient of record required (ie, yes or no and when established)
6. Patient informed consent required (ie, yes or no)
7. Allowed providers (ie, dentist, dental hygienist, or both)

8. Medicaid reimbursement for CDT codes D9995 and/or D9996 (ie, yes or no)

Results and Discussion

The sources of regulatory authority to provide teledentistry services vary widely in states as do the ways in which appropriate usage is addressed. Many states discuss telehealth policy in umbrella legislation that covers the use of information and communication technology to provide any health service including medical, dental, and behavioral health and the range of specialties and subspecialties within each. In some states, dentists are explicitly included in enabling statutes, while in other states statutes are nonspecific, granting permission to provide "telemedicine" services to any licensed health care provider described in specific sections of professional regulation.

Telehealth legislation is far from uniform and is highly nuanced. In some states, regulatory language is detailed and descriptive, while enabling statutes or regulations in other states are vague and subject to broad interpretation. Fundamental terminology and definitions related to virtual services vary considerably. Some states' laws distinguish between telehealth and telemedicine, using the term "telehealth" to encompass any health-related service including, for instance, education and nursing services. Telemedicine is described as the provision of clinical services, usually by medical and other health clinicians, sometimes including dentists, psychologists, etc., which are substantially equivalent to those provided in face-to-face encounters. Other states enact very specific regulations that distinguish virtual visits by clinical specialties including telemedicine, teledentistry, telepsychiatry, etc. Acceptable practice may vary for each specialty; for instance, audio-only encounters may be reimbursable for telebehavioral health but not for teledentistry.

Legislative activity focused on enabling telehealth/telemedicine services was especially lively in the most recent 3 years as states attempted to ensure the availability of optimal health care services for patients in the face of the real structural impediments that arose during the COVID-19 pandemic. Many private practices and public clinics were shuttered for in-person care for a period of time or limited face-to-face encounters to ensure patient and staff safety. The utility of telehealth was patently obvious although in many places existing regulation limited broad uptake.

Federal and state regulators recognized the importance of enabling health care providers and their patients to interface, if only to reduce the number of medical emergencies unrelated to COVID-19 at a time when COVID-19 patients were overwhelming emergency rooms and hospitals. Regulations were adjusted at the federal level and many states also responded with emergency orders to allow and reimburse for virtual communications between providers and patients. At the federal level, the Centers for Medicare and Medicaid issued notices of expanded standards; many state governments and Medicaid programs also responded by loosening restrictions. These changes included:

- Removal of restrictions on the geographic location of patients; for instance, a rural location was no longer essential
- Expansion of allowable origination sites to include the homes of patients
- Allowance for either real-time video or audio-only interface between providers and patients with the provision that the

care provided was substantially equivalent to a face-to-face encounter

- Loosening of HIPPA-privacy requirements to expand options for allowable software platforms to include nonpublic facing communication applications like Zoom and FaceTime
- Expansion of reimbursement for telehealth services by Medicare and state Medicaid programs[11]

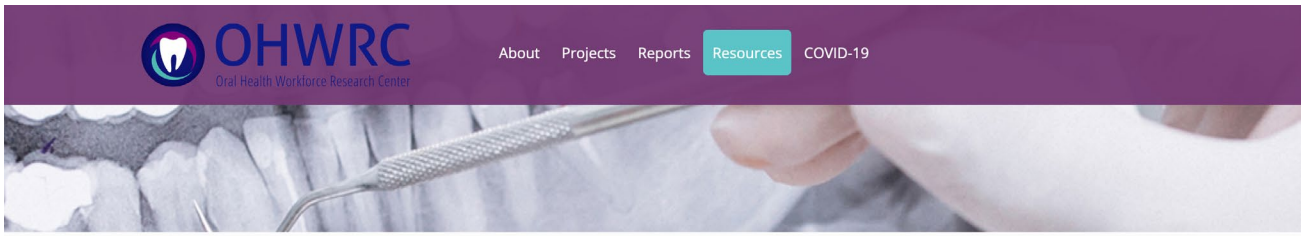
Our review of requirements for practice of teledentistry revealed significant variation in every aspect of enabling regulation. These variations were sometimes quite complex, which likely effected uptake by clinicians. For instance, the Louisiana rules stated that only a licensed dentist could provide teledentistry services; supervision of a dental auxiliary via teledentistry was not allowed except under particular circumstances defined in regulation in separate clauses. Those exceptions included dental hygienists working in specific community settings, such as qualifying schools. Under those circumstances, a dentist could provide direct supervision by teledentistry but must review the exams and images of a patient's oral cavity synchronously (in real time) unless there were bandwidth restrictions that prevented live review. In that case, the dentist could review the patient information asynchronously (store and forward) but the patient could not be dismissed until the dentist had completed the review on the day of the treatment.[12] While this is an example of inordinate complexity, the variation across states in legislative language was considerable making it difficult to build a standard classification system like the one offered in this report.

Another instance of state-based differences provides a further example of the lack of regulatory uniformity. Many states allowed audio-only teledentistry during the COVID-19 pandemic but many were removing those permissions as their public health emergency expired. Some states allowed audio -only services but may have limited the type of clinical services for which it was allowed, such as mental health counseling. Wisconsin allowed audio-only teledentistry if a patient preferred that modality or if technology limitations prevented video consultation. Guidance relative to audio services indicated that such encounters must be "functionally equivalent" to a face-to face service.[13] Nebraska allowed audio only to deliver behavioral health counseling services but not for other types of health services.[14]

States often addressed the types of clinicians who could provide any virtual health services in legislation and Medicaid directives. However, even when dentists were mentioned in telehealth statutes as allowable providers, there were not always dental board regulations to describe the particular practice of teledentistry. This made it difficult for dentists to embrace virtual delivery of services without direct guidance. These examples suggest that teledentistry is still an emerging practice. Hopefully, over time, more conformity across states will emerge so that uptake of teledentistry will increase.

This review resulted in the development of an infographic describing the requirements for teledentistry service provision in each state. The interactive graphic, which is available on the website of OHWRC, catalogues data about the 8 regulatory directives listed above. The conditions for practice of teledentistry described in this infographic include only those that are codified in law or by regulatory agencies with the power to determine lawful practice. The infographic does not include conditions allowed during the public health emergency which expired at termination of the public health emergency on May 11, 2023.

Infographic

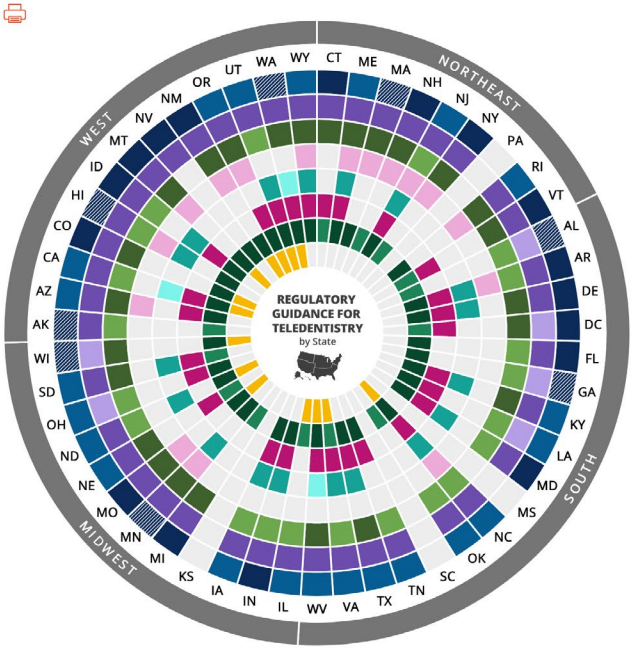


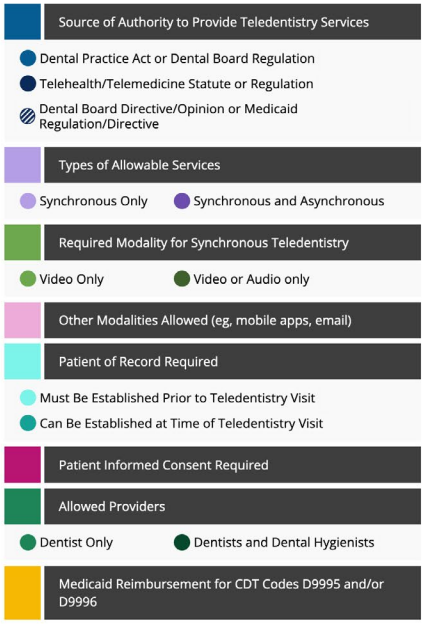
Variation in Teledentistry Regulation by State

Teledentistry is the use of information and communication technology to deliver virtual oral health services in real time (synchronous) or through store-and-forward (asynchronous) methods. Regulatory guidance during the COVID-19 pandemic facilitated the swift adoption and expansion of teledentistry.

Considerable variability in regulation of teledentistry by states limits the ability of clinicians to provide virtual oral health care. This infograph is designed to help oral health stakeholders understand those differences.

USER GUIDE:
Click on the States, Regions, or on specific tags
for more details.





This graphic is for informational purposes only. State regulatory guidance for teledentistry is subject to change. Contact the applicable dental board or an attorney for specific legal advice.

This graphic was developed by the Oral Health Workforce Research Center (OHWRC), Center for Health Workforce Studies at the University at Albany's School of Public Health. This work is supported by the Health Resources and Services Administration (HRSA) of the US Department of Health and Human Services (HHS) as part of an award totaling $450,000 with 0% financed with non-governmental sources. The information presented in this infographic is based on research conducted by the authors and does not necessarily represent the official views of, nor an endorsement, by, HRSA, HHS, or the US government. For more information, please visit HRSA.gov.

Last Updated November 2022.

KEY-INFORMANT INTERVIEWS

Methods

Between May-October 2022, project staff conducted interviews with 26 people in various positions at 11 safety-net dental organizations, 9 of which were Federally Qualified Health Centers (FQHCs). Two organizations were private not-for-profit community dental organizations that provide oral health services for low-income populations, those with special needs, and children.

The interviews were organized to obtain information for 3 different projects that were conducted in 2022 at the Oral Health Workforce Research Center (OHWRC) at the Center for Health Workforce Studies (CHWS) at the University at Albany, School of Public Health. The subjects of interest included the general effects of COVID-19 on the provision of dental services in the safety-net, the use of teledentistry as a supplement or complement to face-to-face encounters with patients during the COVID-19 pandemic, and the impact of COVID-19 and related stressors on dental staff burnout, recruitment, and retention. The interview questionnaire was designed with modules that individually and collectively addressed each of these areas of interest. The questions in the protocol that were specific to teledentistry uptake were as follows:

Module C: Effects on Teledentistry Services

- Prior to the COVID-19 pandemic, did your organization use teledentistry to provide patient care? If so, what technologies were used? Did your organization bill any dental-insurance for teledentistry activities? If not, how were teledentistry services funded?
- Did COVID-19 impact the adoption or expansion of teledentistry services by your organization? Please elaborate.
- What are the benefits of using teledentistry? Please describe patient and provider satisfaction or dissatisfaction with these services.
- Are there any barriers that affect your organization's ability to adopt or expand teledentistry since COVID-19?
- Does your organization have any plans to continue using teledentistry? Please describe the targeted patients and services that would use teledentistry.

These questions guided the semi-structured interview process; not all questions were asked of all informants. The objective of the interviews was to understand how safety-net organizations modified their dental practices to continue to meet the needs of their patients during the COVID-19 pandemic. Enhanced safety precautions and greater use of telecommunication were expected to be common strategic initiatives.

The safety-net organizations that were invited to participate in the interviews were identified based on guidance from staff at the National Network for Oral Health Access (NNOHA). Each organization was sent a letter explaining the project objectives and soliciting participation in the interviews. Once organizational management consented to involvement, each primary contact in an organization was sent the standard interview protocol that had been developed by researchers.

The participating organizations and their geographic distribution by region were as follows:

- **Northeast**
  - Community Health Center of the North Country, New York
  - Whitney Young Health, New York
- **West**
  - Petaluma Health Center, California
  - Ravenswood Family Health, California
  - Alameda Health System, California
  - Salud Family Health, Colorado
  - Terry Reilly, Idaho
  - Future Smiles, Nevada
- **Midwest**
  - Apple Tree Dental, Minnesota
- **South**
  - Mary's Center, District of Columbia and Maryland
  - Charlotte Community Health Center, North Carolina

A description of each of these organizations and their strategic initiatives during the COVID-19 pandemic can be found in Appendix A of the OHWRC's companion report, **Implications of COVID-19 on Safety-net Oral Health Services,** posted in the reports section of the OHWRC's website, https://oralhealthworkforce.org.

Researchers worked with these organizations to identify key informants. The roles of the 26 interview participants, each of whom occupied different positions within their organizations included:

- CEO/Founder/Executive Director - 2
- Nonclinical director/manager/supervisory level staff - 6
- Clinical dental/Program director - 9
- Dentist - 2
- Dental hygienist - 4
- Dental assistant - 1
- Administrative/Support staff - 2

All interviews were conducted using the Zoom platform. The majority of interviews were conducted with a single informant but several included 2 or more participants. Each of the 15 individual interviews lasted 30-45 minutes. The 5 group interviews lasted 30-60 minutes. Each interview was facilitated by a single moderator although 2-4 other researchers were passive participants taking notes for later transcription.

Following each interview, the multiple notes were consolidated to a single transcript detailing informants' insights. When the interview process was complete, all transcripts were uploaded to Dedoose V.9.0[15] for coding and analysis. Two descriptor fields were used to differentiate the transcripts:

- Descriptor Set 1 - Name of safety-net organization
- Descriptor Set 2 - Informant described by primary responsibility

Researchers applied a mixed-coding framework for analysis. The results were then sorted to common themes that emerged from the consolidated resources. Coding and analysis of interview responses resulted in researchers identifying 7 distinct but interconnected themes. Those themes and the supporting commentary are described in the following pages.

Results and Discussion

Approximately half of the interview participants indicated using some form of teledentistry prior to the COVID-19 pandemic. Most respondents stated that the services that were offered prior to the COVID-19 pandemic were limited to asynchronous teledentistry in mobile dental programs for management of dental emergencies and for provider-to-provider communication only.

The range in previous experience with teledentistry varied. One safety-net organization had implemented teledentistry in the early 2000s, while others had only recently begun to conduct virtual visits. Some had used pilot demonstration projects before adopting use, while others had limited use to very specific occasions based on the needs of patients. The ability to quickly implement teledentistry services depended on the prior experience of the organization, availability of secure technology, willingness of providers and patients to engage, and state directives relative to conduct and payment. Teledentistry was commonly used for triage, consulting, diagnosing, and education.

Common themes among the interview participants included:

- **Theme 1:** Teledentistry was critical in bridging access to care gaps during the initial months of the COVID-19 pandemic
- **Theme 2:** Teledentistry had the potential to be a satisfactory treatment modality for patients
- **Theme 3:** Patients were somewhat reluctant but, once engaged, were comfortable using teledentistry
- **Theme 4:** The majority of providers were satisfied with offering services via teledentistry
- **Theme 5:** Instituting a teledentistry program required trial and error, but once established the benefits of virtual visits became apparent
- **Theme 6:** Several benefits of using teledentistry with patients emerged with the use of the technology
- **Theme 7:** Clear guidance on teledentistry regulation and reimbursement continued to be the primary environmental barrier for provision of teledentistry services by safety-net providers

The following paragraphs paraphrase the comments of the interview participants relative to each theme. While there were many common experiences with teledentistry, there were also individual perspectives that were notable. These are described under the appropriate theme.

Theme 1: Teledentistry was critical in bridging access to care gaps during the initial months of the COVID-19 pandemic

Most informants described the rapid adoption and expansion of teledentistry in 2020 as critical to bridging the gaps in access to care during the initial months of the COVID-19 pandemic. Using teledentistry was necessary to mitigate infection risks for patients and providers while providing care for vulnerable patient populations. However, the experience of using teledentistry varied widely among informants.

Organizations that had used teledentistry in the past more easily transitioned to virtual care than others in which teledentistry was a novel undertaking. Among safety-net organizations with established teledentistry infrastructure and processes, the increased use of teledentistry was less time consuming and resource dependent than for providers without that experience. A benefit of piloting novel or "anticipatory" technologies or models of care delivery was that those pilots drove regulatory guidance and reimbursement policies that enabled use. This benefit was especially evident with teledentistry during the COVID-19 pandemic when the utility of the model was apparent with restrictions on in-person care. Patients benefitted sooner from provider services via teledentistry in organizations that had been innovators.

Among organizations that needed to "build that infrastructure and those processes from the ground up," it took up to 3 months to establish teledentistry programs. One respondent described teledentistry as the biggest reconfiguration that happened within their safety-net organization during the pandemic.

While the implementation of teledentistry programs was challenging for various informants, several also discussed the opportunities inherent in deciding to conduct virtual visits. The flexibility of teledentistry allowed for testing the efficiency and effectiveness of several different workflow models before finally selecting the one that best suited the needs of the patients and organization. At the same time as these trials were occurring, patients were receiving care.

Theme 2: Teledentistry had the potential to be a satisfactory treatment modality for patients

The experience of introducing teledentistry services to a broader audience during COVID-19 varied among the safety-net providers. Some described relative ease with engaging patients with teledentistry visits. Informants with experience with teledentistry prior to COVID-19 remarked that having staff who were familiar with the benefits of virtual visits was critical to helping patients embrace teledentistry. Other respondents, with less familiarity, stated that redirecting patients to use teledentistry was one of their biggest challenges during COVID-19, offering that it required effort to convince patients of the usefulness of teledentistry visits.

A respondent commented that it was "hard for our patients because we were closed for a few months" early in the COVID-19 pandemic. Therefore, patients who needed services were referred to other community settings in which dental providers were treating patients. That changed a bit with the implementation of the teledentistry program. Dental clinicians were able to "stay in constant contact with patients so they didn't feel abandoned." The respondent continued noting that "not many people were keen on teledentistry; that was a barrier until teledentistry became the norm."

Another respondent commented on a benefit of teledentistry for their patients. The dental center had a large catchment area; it was one of the only dental providers within many miles for patients with public dental benefits. Some patients drive 5 or 6 hours for appointments. The respondent indicated that in the early months of COVID-19 some patients would drive distances only to find that they did could not be seen. Sometimes, patients were unaware of

the COVID-19 regulations that were in effect and of the documentation needed to receive care (eg, a negative COVID-19 test, a COVID-19 vaccination, etc.). As a result, some patients were turned away until they fulfilled the requirements. The respondent commented that "teledentistry really played a big role" in ensuring that patients were screened and were knowledgeable about COVID-19-related protocols prior to making a long trip for an appointment. After implementing teledentistry, patients who lived at a distance were able to consult with providers from the convenience of their homes.

Theme 3: Patients were somewhat reluctant but, once engaged, they were comfortable using teledentistry

Several respondents indicated that patients were reluctant about teledentistry. The reasons for the hesitancy included subjective attitudes including "patients who were unsure of the value in teledentistry" as well as technology-related challenges. Technology barriers included patients with devices that were incompatible with the teledentistry platform and digital literacy issues including difficulty navigating teledentistry software, especially among elderly patients. One respondent indicated that the initial teledentistry platform used by their organization was "not great" and there were technical difficulties with delivery. The respondent offered that an issue was that the teledentistry platform "didn't translate to Spanish and it was hard for patients to access it because they were unable to read the instructions in English."

Overall, key-informants agreed that, once engaged, patients were increasingly comfortable using teledentistry; it allowed them to stay connected to providers, get their questions answered, and have their concerns addressed. This was especially true during the initial months of the COVID-19 pandemic when "patients were glad to have something rather than nothing; it allowed them to not feel abandoned." Overall, informants commented that patients were generally satisfied with teledentistry visits and were comfortable meeting their providers in a virtual environment.

Theme 4: The majority of providers were satisfied with offering services via teledentistry

Several respondents commented on the initial apprehension and skepticism among some clinicians about the effectiveness of teledentistry services. A respondent commented that it was an effort to get the necessary acceptance from some dental providers for the use of teledentistry. Several informants also stated that buy-in from the dental directors and executive leadership at their organizations were important for adoption and implementation of teledentistry services.

A strategy used by informants to increase acceptance of teledentistry was to compare the diagnoses of patients during virtual visits with their diagnoses when they presented for in-person care. These data were then given to the clinicians. More than 99% of the diagnoses during teledentistry matched diagnoses in-person, which gave doubtful providers the necessary confidence to use teledentistry with patients. The respondent commented that the only time a diagnosis was discrepant was for an adult who was a new patient to the dental center. The difference was attributed to not having enough medical and dental history to make a more accurate diagnosis. The respondent stated it was unlikely that this would happen in the future since the organization had recently implemented a robust, integrated

electronic health record making it much easier to access the health history and other information necessary to inform a patient's diagnosis.

Positive attitudes towards teledentistry were not unanimous among informants. One clinician was clear about not liking virtual visits indicating that children were better behaved in-person with their parents than when patient-provider interactions were virtual. The respondent also stated that "other disruptions at home can be a problem including lack of attention to the visit and camera visibility issues."

Several respondents stated that the uptake of teledentistry had been positive among both patients and providers. Some dental centers now maintain permanent slot(s) on the schedule each week for teledentistry appointments. Another positive aspect of using teledentistry during the COVID-19 pandemic was that it allowed dentists to work from home while still providing care and support for their patient population.

Theme 5: Instituting a teledentistry program required trial and error, but once established the benefits of virtual visits became apparent

Several respondents indicated that reimbursement and regulatory changes relative to teledentistry during the early months of COVID-19 were welcomed. The greater flexibility in the directives enabled them to test different workflow and delivery processes allowing the model to evolve at the various dental centers.

According to an informant, the initial teledentistry process involved a dental hygienist performing an oral assessment, providing prophylaxis, obtaining x-rays and intra-oral photos, and completing clinical notes. At a later time, a dentist was informed of the queue of records in need of diagnosis and treatment planning. The process was eventually changed to improve efficiency so that the dentist received an electronic message requesting review of the records while the patient was still in the dental chair at the center. This evolution was enabled by a robust IT infrastructure which supported the seamless nature of the process. The teledentistry program will continue; it recently received a grant for procuring intra-oral cameras.

Several respondents discussed the difficulty with finding a teledentistry platform that adequately met the needs of providers and patients. This was described as an impediment to quick adoption of teledentistry; however, once an appropriate platform was identified, care delivery benefited.

Many of the providers who used teledentistry acknowledged its benefits, indicating that there were workarounds to not having the patient in front of them. One dentist spoke of a patient complaining about a painful molar during the virtual visit. He asked the patient to tap the tooth with a spoon to see if it elicited a pain response. Another clinician asked a patient to place a piece of ice on a tooth and to describe the sensation. These tests were helpful with arriving at an appropriate diagnosis, providing education to patients, and also discussing treatment options before the patient presented for in-person care.

Most respondents intended to continue using teledentistry beyond the COVID-19 pandemic. A respondent remarked that providers were looking forward to using teledentistry as an adjunctive tool. Many anticipated that the volume of teledentistry would decrease as patients returned to in-person

care and as capacity within the delivery system returned to pre-COVID-19 levels. Still, many recognized the utility of continuing some teledentistry services. One informant offered that there were ongoing conversations with other organizations about potentially partnering to provide asynchronous teledentistry enabled by off-site providers.

Theme 6: Several benefits of using teledentistry with patients emerged with use of the technology

During the interviews, several informants commented on surprising benefits that became apparent with use of teledentistry. Respondents offered that some of the main benefits of teledentistry were being able to triage a patient's problem, expedite diagnosis, and effect treatment exclusively via teledentistry. Others commented on the utility of teledentistry for prevention education. A respondent indicated that an interesting outcome from virtual encounters was that teledentistry had about a 6% no-show rate, which is relatively low compared to in-person appointments.

The rapid adoption of teledentistry enabled one organization to conduct a pilot project to evaluate if teledentistry would be an effective modality for a routine prevention activity. The pilot project's objective was to deliver fluoride varnish to children in their homes. The pilot was conducted in collaboration with a dental insurer and required participation of a parent or guardian to apply the fluoride varnish. When parents expressed interest in project participation, the center mailed a fluoride varnish kit to their home. During a subsequent virtual dental visit, the provider would guide the parent or guardian through the process of applying fluoride varnish to the teeth of their children. Informants described this pilot as having limited success due to difficulty with parental uptake. However, the flexibility, versatility, and novelty offered by teledentistry as an educational and clinical tool was applauded by informants. A reason for the limited uptake among parents, according to informants, was that parents viewed the fluoride application as a preventive measure rather than a fundamental need for their child.

One dentist informant commented on teledentistry's "untapped potential to provide care to patients" commenting that "the pandemic gave me the impetus to get there." Most informants who were using teledentistry offered that it had great potential in dentistry as an excellent adjunct to in-person care and as a useful tool to obtain information and data in anticipation of a patient's visit for a procedure.

A respondent offered that "one of the biggest takeaways with teledentistry was that when patients who'd had a teledentistry visit eventually came to the office, they were spending less time in the dental chair" because examinations and diagnosis had happened virtually. During the worst months of the COVID-19 pandemic, this was especially important because patients were hesitant about in-person care. Another respondent stated that the use of teledentistry as a consultative tool allowed everyone to "really think of the dental suite as an operating theatre."

Another respondent offered that "the biggest success in using teledentistry was for patients with special health care needs" commenting that "the anxiety of coming to a big hospitals is a trigger and teledentistry can be incorporated as part of a desensitizing technique." The respondent offered an example. One mother indicated that her child would not open her mouth for anyone. Once the parent

reluctantly agreed to initiate care through a teledentistry visit, the provider met with the parent and child via teledentistry multiple times. Several weeks later, when the child came to the hospital for in-person care, the child was delighted and began clapping when she saw the provider. She then allowed the dentist to complete the exam. The dentist recalled the mother's commenting that "she has never been excited to see a doctor before."

Furthermore, dentists commented on the teledentistry visit as particularly helpful for patients with complex medical histories. The dental provider could determine if there was any necessary pre-testing, if there was a need to see medical records, and to coordinate care with other providers before the patients came for services. The respondent offered that "in big hospital centers people get bounced around, and teledentistry will save patients 2 visits."

Theme 7: Clear guidance on teledentistry regulation and reimbursement continues to be the primary environmental barrier for provision of teledentistry services by safety-net providers

Many informants from the safety-net attributed the rapid expansion of teledentistry services to the rise of COVID-19. An informant remarked "that's a positive that came out of the pandemic." In the early months of 2020, a lack of clear guidance regarding regulations and reimbursement policies was widely regarded as the main barrier to broader provision of teledentistry services. Several respondents stated that vagueness about whether teledentistry was permitted practice was especially impactful early in the COVID-19 pandemic and limited the ability of safety-net dental clinics to adopt teledentistry in an expeditious manner.

Over time, and with the help of executive orders, regulatory directives, and specific guidance documents regarding use of telehealth modalities, providers were able to virtually interface with patients in various formats using publicly available platforms such as Zoom, or commercial platforms especially designed for telehealth/teledental service delivery. Once process and programs were in place, teledentistry visits were effective for communicating and consulting with patients.

Respondents who used teledentistry expressed significant concerns about reimbursement-related issues, including whether Medicaid programs would continue to pay for those services. Reimbursement policy determined if and how safety-net organizations were paid for teledentistry services. Several informants reiterated the importance and relevance of Medicaid reimbursement to continued use of teledentistry with their patient populations, who were predominately low income.

Many state Medicaid programs allowed payment for teledentistry services during the public health emergency, but many of those enabling directives were set to expire with the emergency. Stakeholders emphasized the importance of ongoing legislative advocacy to ensure continued reimbursement for virtual services. A respondent stated, "yes, we will continue using teledentistry depending on Medicaid reimbursement. It is currently available through the end of the year, and if it's approved thereafter, we will continue to offer it." Another remarked, "Concerns about reimbursement were significant in 2020, 2021, and now 2022. Now we are questioning if it's going to be covered in 2023. That's disappointing. It baffles me that this is even a question!"

While the overall costs of teledentistry services were described as somewhat lower than in-person visits, teledentistry required more effort from support and administrative staff than did typical dental visits.

Conclusions

Teledentistry was a useful alternative to in-person care delivery during the early months of COVID-19 when service availability was severely limited due to stay at home orders and lockdowns of health care organizations. Teledentistry proved to be an effective intervention allowing for triage, risk assessment, diagnosis, treatment and palliation, education, and referral for emergency in-person services. As with any novel practice, organizations and dental clinicians experienced various degrees of comfort or discomfort with using technology to conduct virtual encounters with patients. Many became more comfortable with the utility of teledentistry as an adjunct to in-person care while some continued to feel it was not a viable alternative to face-to-face encounters. Several organizations that established teledentistry programs before or during COVID-19 were continuing to use it in a more limited format, especially for specific communities within their patient populations. While the COVID-19 pandemic was inconvenient and disruptive to health care, it provided an important opportunity, in a sense a natural experiment among a broader and more generalized population, to explore the benefits of virtual visits and how they can be used to augment in-person services and increase access to dental providers.

APPENDIX

APPENDIX

Teledentistry Regulation by State: Reference Hyperlinks

Alabama

Alabama Legislative Acts
https://arc-sos.state.al.us/cgi/actsubject.mbr/input

Definition of physician
http://www.alabamaadministrativecode.state.al.us/docs/med/560-X-6.pdf

MouthWatch
https://www.mouthwatch.com/teledentistry-in-your-state-regulations-quick-facts/

Center for Connected Health Policy
https://www.cchpca.org/alabama/

ADEA
https://adea.org/uploadedFiles/ADEA/Download/ADEA-Teledentistry-Requirements-and-Permissable-Practices-Comparison-Chart.pdf

Fee Schedule/Provider Manual
https://medicaid.alabama.gov/content/Gated/7.3G_Fee_Schedules.aspx
https://medicaid.alabama.gov/content/Gated/7.6.1G_Provider_Manuals/7.6.1.3G_July2022/Jul22_13.pdf
https://medicaid.alabama.gov/content/Gated/7.6.1G_Provider_Manuals/7.6.1.2G_Apr2022/Apr22_28.pdf

Alaska

Alaska State Legislature. Senate Labor and Commerce Standing Committee
http://www.akleg.gov/PDF/31/M/SL!C2019-02-071331.PDF

Alaska Medicaid Manual
https://manuals.medicaidalaska.com/docs/dnld/Fees_Dental_SFY2022_Pdf_FINAL_20220613.pdf

MouthWatch
https://www.mouthwatch.com/teledentistry-in-your-state-regulations-quick-facts/#:~:text=No%20teledentistry%20regulations%20exist%20in%20Alaska.,does%20not%20specifically%20define%20teledentistry.

ADEA
https://adea.org/uploadedFiles/ADEA/Download/ADEA-Teledentistry-Requirements-and-Permissable-Practices-Comparison-Chart.pdf

Center for Connected Health Policy
https://www.cchpca.org/alaska/

Alaska Medicaid Fee Schedule and Covered Codes
https://manuals.medicaidalaska.com/medicaidalaska/providers/feeschedule.asp

Arizona

Arizona State Legislature
https://www.azleg.gov/viewdocument/?docName=https://www.azleg.gov/ars/32/01201.htm

Temporary Teledentistry Guidance
https://www.azahcccs.gov/PlansProviders/Downloads/MedicalCodingResources/COVID19EmergencyMedicalCodingTeledentistry.pdf

Center for Connected Health Policy
https://www.cchpca.org/arizona/?category=medicaid-medicare&topic=overview

Arizona Health Care Cost Containment System, Arizona Medicaid
https://www.azahcccs.gov/AHCCCS/Initiatives/Telehealth/

https://www.azahcccs.gov/PlansProviders/RatesAndBilling/FFS/Dental.html

ADEA
https://adea.org/uploadedFiles/ADEA/Download/ADEA-Teledentistry-Requirements-and-Permissable-Practices-Comparison-Chart.pdf

Arizona Health Care Cost Containment System Dental FFS Rates & Codes
https://www.azahcccs.gov/PlansProviders/RatesAndBilling/FFS/Dental.html

Arkansas

Minutes of the meeting of the Arkansas legislative council
Reports of the Standing Subcommittees, Administrative Rules and Regulations Subcommittee
https://www.arkleg.state.ar.us/Calendars/Attachment?committee=000&agenda=452&file=Exhibit+C+-+Minutes+of+the+last+meeting++-+April+20+2018.pdf

Administrative Rules and Regulations Subcommittee of the Arkansas Legislative Council
https://www.arkleg.state.ar.us/Calendars/Attachment?committee=040&agenda=411&file=ASummary+Agenda++4-17-18.pdf

University of Arkansas, Fort Smith, American Rescue Plan Act-Institutional Portion Plan
https://www.arkleg.state.ar.us/Calendars/Attachment?committee=020&agenda=5123&file=C.2.+arp+FY23.pdf

MouthWatch
https://www.mouthwatch.com/wp-content/uploads/2020/08/Mouthwatch-50-States_8-2020.pdf

Arkansas Medicaid Dental Fee Schedule
https://humanservices.arkansas.gov/wp-content/uploads/DENTAL-fees.pdf

ADEA
https://adea.org/uploadedFiles/ADEA/Download/ADEA-Teledentistry-Requirements-and-Permissable-Practices-Comparison-Chart.pdf

Center for Connected Health Policy
https://www.cchpca.org/arkansas/?category=medicaid-medicare&topic=definitions-medicaid-medicare

Arkansas Department of Human Services Fee Schedules
https://humanservices.arkansas.gov/divisions-shared-services/medical-services/helpful-information-for-providers/fee-schedules/

California

State Legislature
http://www.leginfo.ca.gov/pub/13-14/bill/asm/ab_1151-1200/ab_1174_bill_20140927_chaptered.pdf

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https://adea.org/uploadedFiles/ADEA/Download/ADEA-Teledentistry-Requirements-and-Permissable-Practices-Comparison-Chart.pdf

MouthWatch
https://www.mouthwatch.com/wp-content/uploads/2020/08/Mouthwatch-50-States_8-2020.pdf

Medi-Cal Dental Schedule of Maximum Allowances
https://www.dental.dhcs.ca.gov/MCD_documents/providers/SMA_CDT22_July22_draft.pdf

Center for Connected Health Policy
https://www.cchpca.org/california/?category=medicaid-medicare&topic=definitions-medicaid-medicare

Colorado

Colorado Dental Board: Laws and Rules
https://dpo.colorado.gov/Dental/Laws

https://hcpf.colorado.gov/sites/hcpf/files/COVID-19%20Guidance%20for%20Dental%20Providers%203-23-2020.pdf

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Center for Connected Health Policy
https://www.cchpca.org/colorado/?category=medicaid-medicare&topic=definitions-medicaid-medicare

Colorado Medicaid Dental FFS Fee Schedule
https://hcpf.colorado.gov/provider-rates-fee-schedule

https://dentaquest.com/getattachment/State-Plans/Regions/Colorado/Health-First-Colorado/Provider-Page/Provider-Facing-Dental-Fee-Schedule-July-2022.pdf/?lang=en-US

Connecticut

Connecticut General Assembly
https://www.cga.ct.gov/searchresults.asp?cx=005177121039084408563%3Ahs1zq3ague8&ie=UTF-8&cof=FORID%3A10&q=teledentistry&submission=%EF%80%82

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Center for Connected Health Policy
https://www.cchpca.org/connecticut/?category=medicaid-medicare&topic=overview

Medicaid Fee Schedule
https://www.ctdssmap.com/CTPortal/Provider/Provider-Fee-Schedule-Download

Delaware

Delaware General Assembly
https://legis.delaware.gov/Search/Global?searchTerm=teledentistry

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Center for Connected Health Policy
https://www.cchpca.org/delaware/?category=medicaid-medicare&topic=definitions-medicaid-medicare

Delaware Medicaid Fee Schedule
https://medicaidpublications.dhss.delaware.gov/docs/search/EntryId/17

Florida

Florida Legislature
http://www.leg.state.fl.us/statutes/index.cfm?StatuteYear=2021&AppMode=Display_Results&Mode=-Search%2520Statutes&Submenu=2&Tab=statutes&Search_String=teledentistry

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Center for Connected Health Policy
https://www.cchpca.org/florida/?category=medicaid-medicare&topic=definitions-medicaid-medicare

Florida Medicaid Dental Fee Schedule
https://ahca.myflorida.com/medicaid/review/fee_schedules.shtml

https://ahca.myflorida.com/medicaid/review/Reimbursement/2022-01-01_Fee_Sched_Billing_Codes/Dental_Fee_Schedule_2022.pdf

Georgia

Georgia General Assembly
https://www.legis.ga.gov/legislation/62271

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Center for Connected Health Policy
https://www.cchpca.org/georgia/

Georgia Medicaid Dental Fee Schedule
https://www.caresource.com/documents/ga-covered-dental-benefits-quick-reference-guide/

https://www.avesis.com/pdf/ga_medicaid_peach_care_kids.pdf

Hawaii

Hawaii State Legislature
https://www.capitol.hawaii.gov/Search/search?IW_INDEX=2022&IW_FIELD_WEB_STYLE=teledentistry

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https://www.cchpca.org/hawaii/?category=medicaid-medicare&topic=definitions-medicaid-medicare

Medicaid Fee-for-Service (FFS) Fee Schedule
https://medquest.hawaii.gov/en/plans-providers/fee-for-service/fee-schedules.html

Idaho

Idaho Legislature
https://legislature.search.idaho.gov/search?IW_FIELD_TEXT=teledentistry&IW_DATABASE=*

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Center for Connected Health Policy
https://www.cchpca.org/idaho/?category=medicaid-medicare&topic=overview

Idaho Medicaid Fee Schedule. Idaho Smiles Provider Manual
https://www.mcnaid.net/en/providers-docs

Illinois

Illinois General Assembly (Public Act 102-0093)
https://www.ilga.gov/legislation/BillStatus.asp?DocNum=335&GAID=16&DocTypeID=SB&LegID=131710&SessionID=110&GA=102&SpecSess=0

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Medicaid Fee Schedule. Illinois Department of Healthcare and Family Services
https://www2.illinois.gov/hfs/MedicalProviders/MedicaidReimbursement/Pages/Dental.aspx

Indiana

Indiana General Assembly
http://iga.in.gov/results/#

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Indiana Medicaid Dental Fee Schedule
http://provider.indianamedicaid.com/ihcp/Publications/MaxFee/fee_home.asp

Iowa

Iowa State Legislature
https://www.legis.iowa.gov/publications/search/document?fq=id:502416&pdid=701177&q=teledentistry#650.27.12

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Kansas

Kansas State Legislature and Kansas Administrative Regulations
https://sos.ks.gov/publications/pubs_kar_Regs.aspx?KAR=&Srch=Y

http://www.kslegislature.org/li_2012/b2011_12/statute/065_000_0000_chapter/065_014_0000_article/065_014_0056_section/065_014_0056_k/

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Center for Connected Health Policy
https://www.cchpca.org/kansas/?category=medicaid-medicare&topic=overview

Kansas Medicaid Dental Fee Schedule
https://portal.kmap-state-ks.us/Documents/Provider/Provider%20Manuals/Dental_Manual_21235_20238.pdf

Kentucky

Kentucky General Assembly
https://apps.legislature.ky.gov/law/kar/titles/201/008/590/

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Center for Connected Health Policy
https://www.cchpca.org/kentucky/?category=medicaid-medicare&topic=overview

Louisiana

Louisiana Register
https://www.doa.la.gov/media/4hwpirah/2102.pdf

MouthWatch
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