Addressing Oral-Health Challenges for Women and Single Mothers in North Carolina: The Role of Medicaid Insufficiency

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Abstract

This literature review examines how North Carolina's Medicaid system fails to provide equitable dental access to women, focusing specifically on pregnant women and single mothers. Despite recent policy reforms, most notably the extension of postpartum Medicaid coverage to 12 months, coverage expansions have not been paralleled proportionately by investments in dental provider capacity or the integration of services. This has produced a coverage–access paradox, where eligibility is broader than ever, yet the median dental utilization rate for low-income pregnant women in the state's Medicaid for Pregnant Women (MPW) program remains roughly 8.5% (Moss et al., 2021).

The review argues that this failure cannot be reduced to a simple shortage of resources. Rather, it reflects a three-part policy failure: (1) an economic failure, rooted in reimbursement rates that have hovered around 34–35% of usual dental charges since 2008 (North Carolina Institute of Medicine [NCIOM], 2024); (2) a structural failure, in which the exclusion of dental benefits from Medicaid managed-care plans reinforces the separation of oral health from prenatal and primary care; and (3) a geographic failure, in which most of the state's 100 counties—97 of them—are partially or fully designated Dental Health Professional Shortage Areas (HPSAs), and 188 dental HPSAs exist statewide (North Carolina Office of Rural Health, 2025; Rozier et al., 2024).

Introduction

In American health policy, the mouth is often treated as an optional add-on—a "body without a head." Oral health is removed from medical coverage, siloed in separate clinics, and frequently excluded from adult insurance benefits. For women in North Carolina, this separation is not an abstract design flaw but a devastating reality that shapes pregnancy outcomes, employment prospects, and long-term health. As summarized above, national surveillance documents widespread untreated caries and cost-related unmet needs.

Medicaid is the single largest payer of maternity care in the United States, financing 41% of all births in 2023 (KFF, 2025). In North Carolina, Medicaid paid for just over half

(50.9%) of the state's 120,065 resident births, or 61,126 births, when prenatal and emergency Medicaid are combined (NC SCHS, 2024). Among these Medicaid-covered births, two-thirds (67.0%) were to unmarried mothers, underscoring how closely Medicaid maternity coverage is intertwined with single motherhood and economic precarity in the state.

Dentally, however, Medicaid's promise is deeply constrained. An ecological study of the North Carolina Medicaid for Pregnant Women (MPW) program found that across 100 counties, dental utilization among pregnant beneficiaries ranged from 1% to 26%, with a median of just 8.5% (Moss et al., 2021). When unmet dental needs escalate into acute pain, many women end up in emergency departments. Nationally, tooth disorders accounted for 1.94 million ED visits per year from 2020–2022 (CDC NCHS, 2025), costing approximately $1.6 billion annually, about one-third paid by Medicaid (ADA, 2025).

This paper focuses on how these systemic failures uniquely burden women—particularly pregnant women and single mothers—in North Carolina, framing low dental utilization not as individual negligence but as the predictable outcome of Medicaid insufficiency.

The following literature review synthesizes biological, social, geographic, and policy evidence that together explain why expanded Medicaid eligibility has not translated into meaningful dental care for pregnant women and single mothers in North Carolina.

Literature Review

I. The Biological and Social Imperative

A. The Oral–Systemic Link in Obstetrics

Pregnancy is a physiological stress test. Rising levels of estrogen and progesterone increase blood flow and vascular permeability in gingival tissues, making pregnant women especially susceptible to "pregnancy gingivitis," which affects an estimated 60–75% of pregnant women worldwide (Le et al., 2021). Periodontal disease can progress when mild

gingivitis goes untreated, which is far more likely in low-income women who lack regular access to dental care.

The overarching clinical concern is the inflammatory load. Periodontal pathogens such as *Porphyromonas gingivalis* can provoke systemic inflammatory responses, including elevations in cytokines like interleukin-6 (IL-6), tumor necrosis factor-alpha (TNF-α), and prostaglandin E2 (PGE2). These inflammatory mediators can cross the placental barrier and may mimic the biochemical signals that trigger the onset of labor, contributing to uterine contractions and premature cervical ripening (Le et al., 2021).

A growing body of systematic reviews and meta-analyses suggests a statistically significant association between maternal periodontitis and preeclampsia, preterm birth, and low birth weight (Le et al., 2021). In North Carolina in 2023, about 10–15% of births in some racial and ethnic groups were preterm (KFF, 2025), suggesting this already-vulnerable population is more susceptible to an easily modifiable source of inflammation, like periodontal disease.

From a clinical standpoint, dental treatment, including scaling and root planing, is safe during pregnancy when performed with appropriate precautions. Yet in reality, obstetricians may not routinely screen for oral disease, and dentists may be hesitant to treat pregnant patients because of liability concerns or misinformation about what is "safe" during pregnancy. The result is a clinical barren land, in which no physician specialty regards the mouth, leaving pregnant Medicaid beneficiaries in North Carolina exposed to preventable risk.

B. The Intergenerational Cycle of Oral Disease

Oral disease is communicable and intergenerational. Mothers with untreated caries harbor high levels of cariogenic bacteria such as *Streptococcus mutans*. These organisms are vertically transmitted to infants through everyday behaviors like sharing spoons, tasting baby food, or cleaning pacifiers in the mouth. Once colonization occurs, a carbohydrate-rich diet and poor oral hygiene can rapidly lead to early childhood caries (ECC).

National data show that 46% of U.S. children aged 2–19 years have either untreated or restored caries in at least one tooth, making dental caries the most common chronic

disease of childhood (CDC, 2023). ECC can lead to pain, disrupted sleep, missed school days, and costly dental treatment, often under general anesthesia, much of which is financed by Medicaid. When North Carolina fails to treat mothers' oral disease during pregnancy and the postpartum period, a new cohort of Medicaid-enrolled children with high caries risk is created, perpetuating a cycle of disease and public expenditure.

C. The Smile Gap and the Single-Mother Penalty

Beyond its biological consequences, oral health is a powerful social marker. Teeth are visible–perhaps the most visible status symbol on one's body. Missing anterior teeth, broken incisors, or obvious decay can signal poverty and marginalization with a single glance. For single mothers, who are overrepresented in low-wage service, retail, and care work (all customer service-based, entry-level occupations), appearance is often tied directly to employability.

Experimental and observational studies have documented that job applicants with visible dental disease are perceived as less professional, less trustworthy, and less suitable for customer-facing roles, even when their qualifications are identical (CareQuest Institute for Oral Health, 2023). While such studies rarely focus exclusively on single mothers, they illuminate how oral appearance can reinforce the poverty cycle: women cannot access the jobs needed to afford dental care, and without care, their dental appearance continues to deteriorate and limit job prospects.

Cost is the central barrier here. ADA Health Policy Institute data show that in 2022, 12.7% of people in the United States reported not obtaining needed dental care during the past 12 months because of cost, compared with 3–5% for other health services (ADA Health Policy Institute, 2024). Cost barriers are highest among working-age adults, particularly those with low incomes. Adults below 100% of the federal poverty level (FPL) are far less likely to have seen a dentist in the last year—only about 20%—compared with roughly 51% of adults with incomes above 400% FPL (ADA Health Policy Institute, 2024).

For single mothers in North Carolina, this financial squeeze is compounded by time limitations. Many dental offices operate during a fraction of the 7-day week–standard work hours (8 a.m.–4 p.m., Monday through Thursday). For a woman working hourly shifts without paid leave, taking a full day to travel to a safety-net clinic, wait in a walk-in queue,

and possibly be turned away if the schedule fills is often so economically burdensome that the task becomes impossible. The result is care that continues to be deferred until pain is absolutely unbearable, at which point the emergency department becomes the last resort, de facto dental home.

The biological and social consequences described above are unevenly distributed across geographies. The following section situates these risks in North Carolina's specific workforce and geographic context.

II. The North Carolina Landscape: A Geography of Exclusion

A. The Rural–Urban Disparity and Dental Deserts

North Carolina's geography combines dense urban corridors—such as the Research Triangle and Charlotte area—with vast rural regions in the east and mountainous communities in the west. This spatial pattern maps onto dental access in stark ways.

National workforce data indicate that as of mid-2024, 58 million people in the U.S. live in dental HPSAs (Health Resources and Services Administration [HRSA], 2024). In North Carolina, the problem is particularly acute. A recent analysis in the *North Carolina Medical Journal* reported that all 100 counties in the state are either partially or fully designated as Dental HPSAs, with 188 separate dental shortage area designations (Rozier et al., 2024; Becker's Dental Review, 2024).

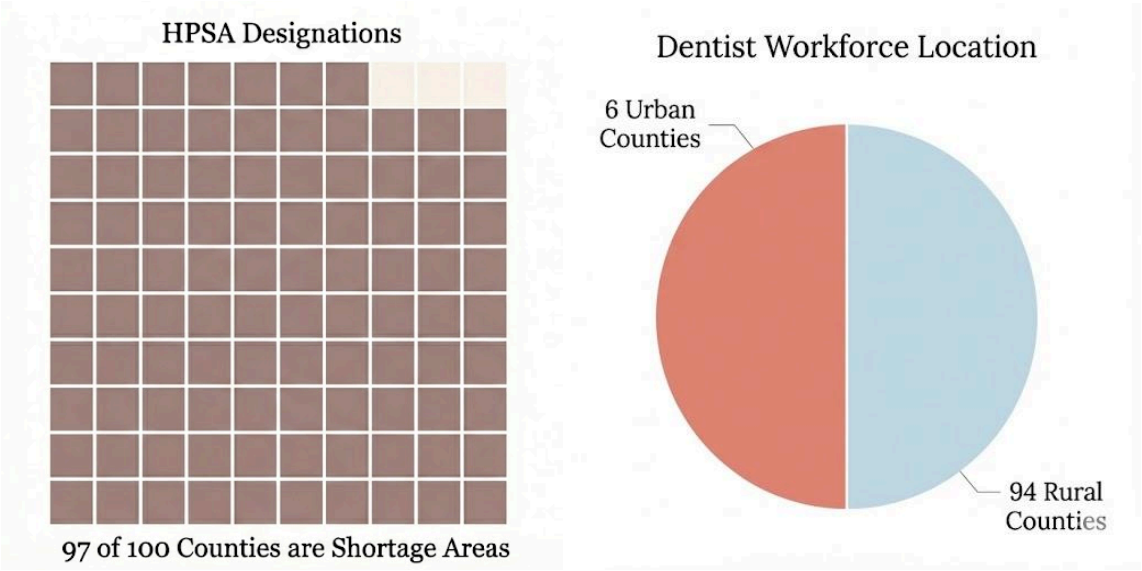
From a supply standpoint, the state housed 5,887 active dentists and 6,474 dental hygienists in 2022, translating to 5.5 dentists and 6.1 hygienists per 10,000 residents (Rozier et al., 2024). These workforce ratios would place North Carolina around the middle of national rankings, but the distribution is highly skewed. In fact, more than half of all dentists practice in just six of the state's 100 counties (Rozier et al., 2024). Many rural counties in the eastern North Carolina and western Appalachian regions are home to only a handful of dentists—or none at all.

The implications for pregnant women and single mothers on Medicaid are profound. When a woman lives in a county with one or no Medicaid-participating dentists, coverage becomes a promise solely on paper. A dental visit may entail 40–60 miles of travel one way,

often without reliable transportation or child care. Although Medicaid technically offers non-emergency medical transportation (NEMT), studies and local reports describe high rates of late pickups, missed rides, and complex scheduling processes that erode trust and make mothers reluctant to depend on the service (Oral Health NC, 2023; NCIOM, 2024).

Consequently, rural North Carolina is characterized by dental deserts, where the effective density of Medicaid-accepting dental providers is near zero. These deserts are not evenly distributed and overlap heavily with counties that have high poverty rates and large Black and Indigenous populations (Moss et al., 2021; County Health Rankings & Roadmaps, 2022).

Figure 2. Geography of Exclusion in North Carolina



B. Intersectionality: Race, Poverty, and Family Structure

The geography of dental access is tightly interwoven with race, poverty, and family structure. The Moss et al. (2021) analysis of MPW claims data demonstrated that counties designated as “persistent poverty” were significantly more likely to have extremely low dental utilization among pregnant women, even after accounting for dentist supply.

North Carolina’s vital statistics confirm that Medicaid-financed births are disproportionately concentrated among women of color and unmarried women. In 2023:

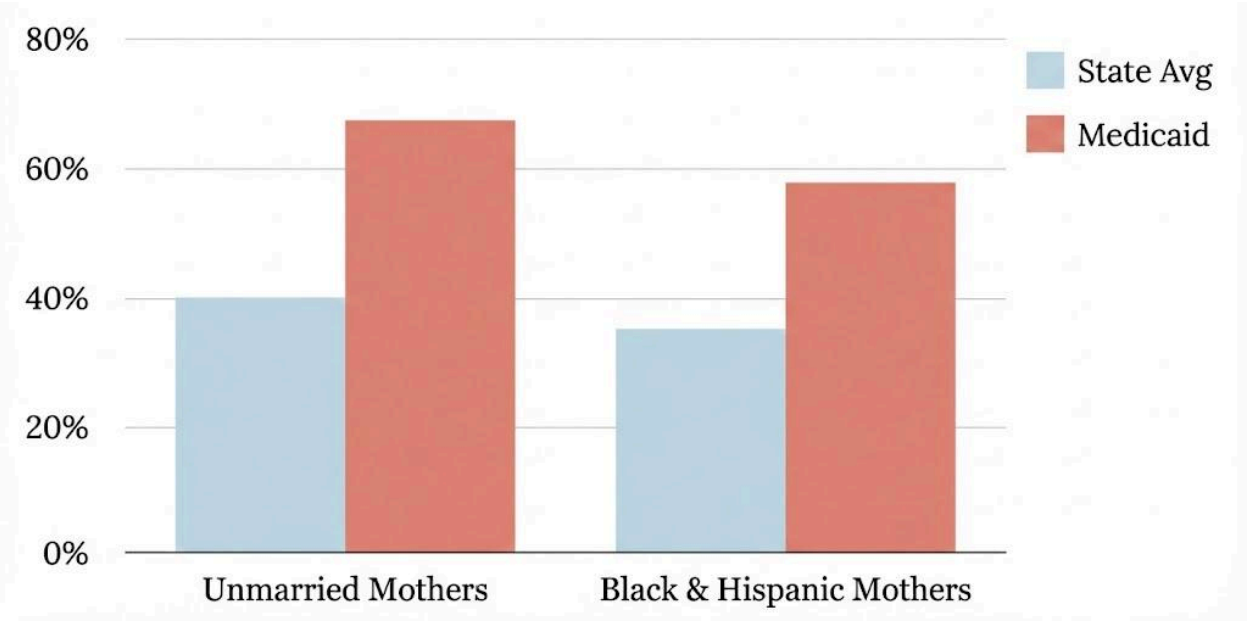
- Medicaid covered 61,126 births, or 50.9% of all resident births (NC SCHS, 2024).

- Among Medicaid-financed births, 67.0% were to unmarried mothers, compared with 32.9% to married mothers (NC SCHS, 2024).
- Within that Medicaid cohort, about 30% of births were to non-Hispanic Black mothers and roughly 28% to Hispanic mothers, even though these groups account for smaller shares of the overall female population of reproductive age (NC SCHS, 2024).

These patterns illustrate why oral-health policy for Medicaid is, in practice, a policy for single mothers and women of color. When reimbursement rates and program rules de-incentivize providers from serving adult Medicaid patients, the burdens fall heavily on Black and Brown mothers in rural and under-resourced urban neighborhoods.

Furthermore, experiences of discrimination and mistrust in health care settings can deter preventive care use. Qualitative and survey research finds that Black and Latina women are more likely than white women to report feeling dismissed, disrespected, or stereotyped in medical encounters, leading to avoidance of both medical and dental settings (Van der Drift, 2019; CareQuest Institute for Oral Health, 2023). For pregnant women, this mistrust can interact with logistical barriers—transportation, child care, work schedules—to magnify the likelihood that oral disease goes untreated.

Figure 3. Demographics of Vulnerability



III. The Architecture of Insufficiency: Policy Mechanisms

The crisis facing women in North Carolina is not accidental. It is the predictable output of three interlocking policy mechanisms: chronically low reimbursement, administrative barriers, and structural fragmentation of dental benefits from medical care.

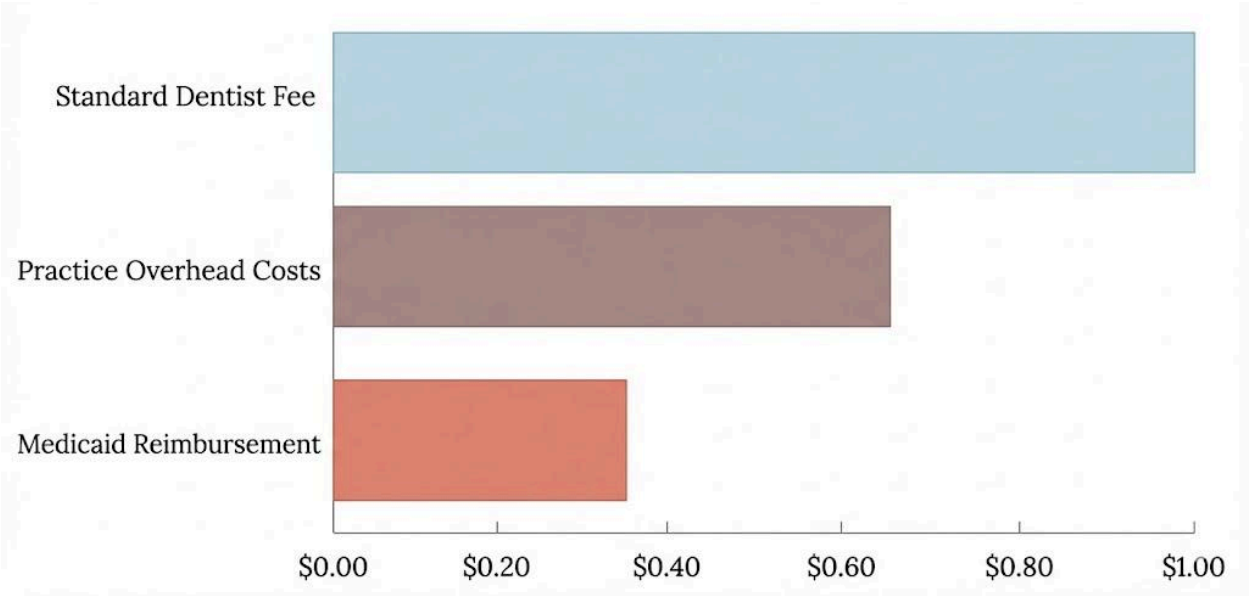
A. 34-Cent Reimbursement as a Structural Disincentive

In a predominantly private practice dental system, Medicaid's ability to ensure access rests heavily on reimbursement rates. North Carolina's Medicaid dental fee schedule, however, has remained largely frozen since 2008, without comprehensive adjustments for inflation or rising practice costs (NCIOM, 2024). The NCIOM Oral Health Transformation Task Force estimated that Medicaid pays providers roughly 34–35 cents on the dollar relative to usual and customary fees for many dental procedures (NCIOM, 2024).

This underpayment is catastrophic when compared to dental practice overhead. Across the United States, overhead, including but not limited to rent, staff, supplies, malpractice insurance, and equipment, is typically 60–70% of gross revenue. When Medicaid pays only 35% of standard fees, a dentist who relies substantially on Medicaid patients is effectively losing money on every visit.

Thus, provider participation is not surprisingly limited. While a moderate share of dentists in North Carolina are formally enrolled as Medicaid providers, many place a stringent cap on the number of Medicaid patients they accept and treat. State-level analyses suggest that while roughly 40–45% of dentists may be enrolled, only a much smaller subset—sometimes estimated around one-quarter to one-third—treats meaningful volumes of adult Medicaid patients (NCIOM, 2024; Oral Health NC, 2023). The result is a ghost network in which provider directories list names that ultimately offer little real access for mothers seeking care.

Figure 4. The Profitability Gap from Reimbursement



B. The Administrative Gatekeeper: Paper Barriers to Care

Even when dentists are willing to participate, administrative burdens can further discourage them from accepting women on Medicaid. Prior authorizations for routine periodontal services, frequent claim denials, documentation requirements, and the specter of audits all add to what many providers describe as a "hassle factor" (NCIOM, 2024).

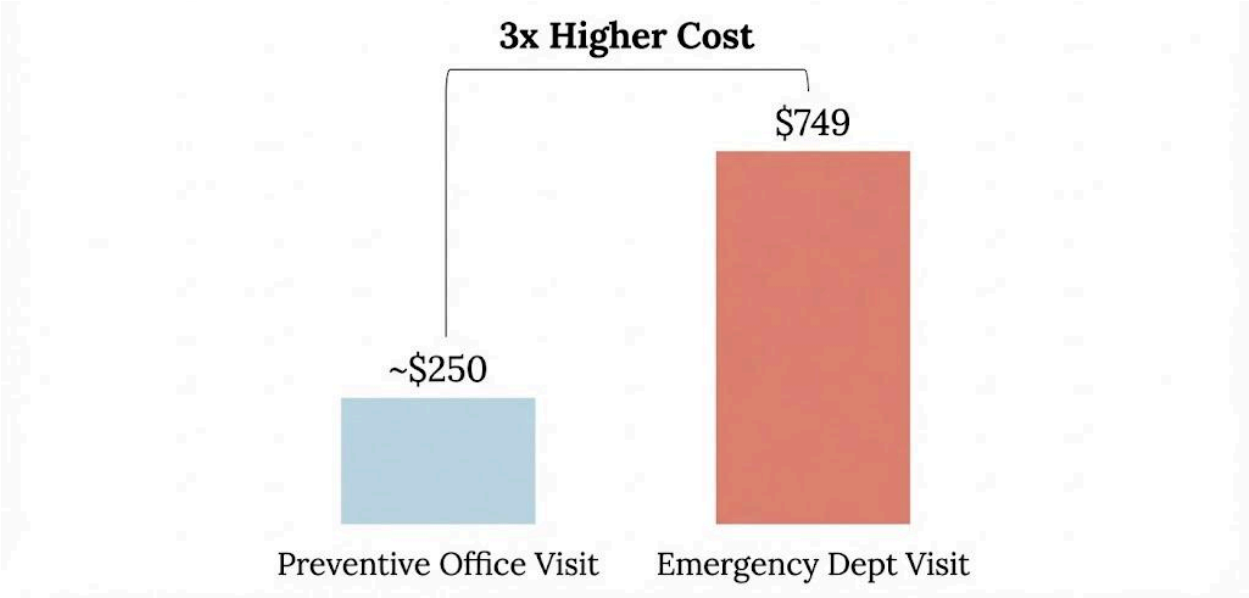
From the patient's perspective, the administrative gatekeeping appears in different ways:

- Long wait times for appointments at safety-net clinics.
- Confusing letters about benefits, covered services, or managed-care enrollment.
- Complex processes for arranging Medicaid transportation or identifying in-network providers.

These burdens amplify existing social determinants. A single mother juggling shift work and child care may simply not have the bandwidth to navigate a bureaucratic maze for a preventive cleaning or periodontal treatment. When pain becomes intolerable, she is far more likely to go to the emergency department, where care is immediate, but palliative and expensive.

The downstream emergency-department consequences of deferred dental care are discussed above (Introduction); these ED visits represent an expensive, palliative response to unmet dental need rather than treatment of underlying disease.

Figure 5. The Cost of Inaction



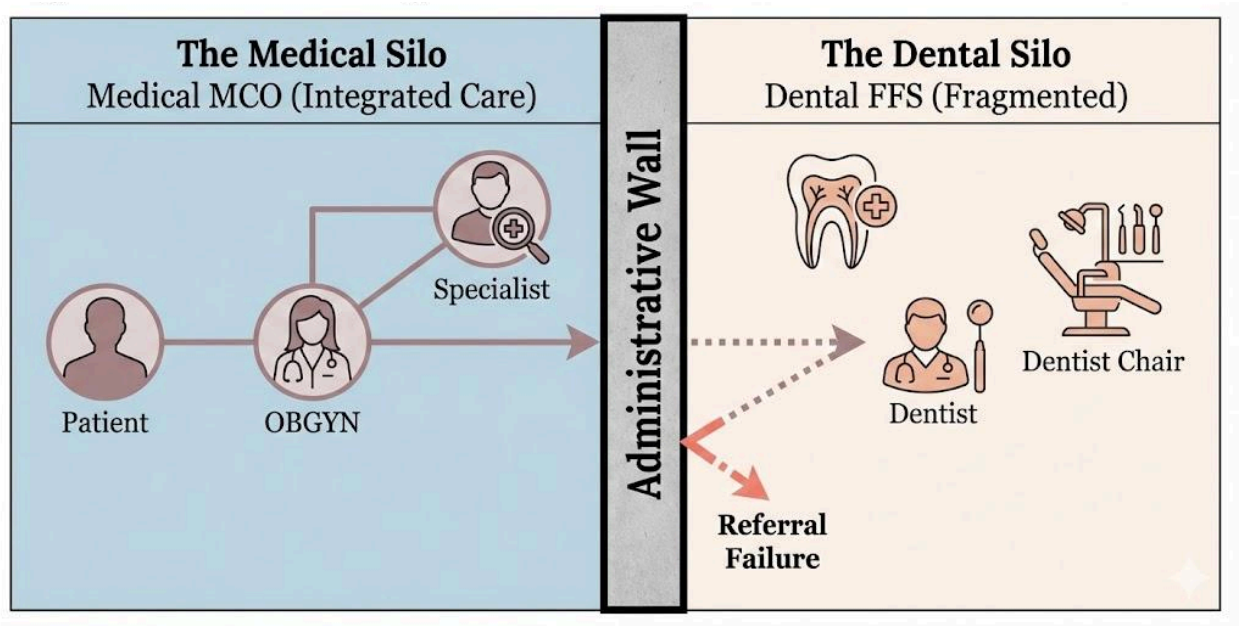
C. The "Carve-Out" Care Fragmentation

When North Carolina transitioned to Medicaid managed care via "Standard Plans," the state made a key structural decision: dental benefits for adults remained "carved out" of managed care and stayed in fee-for-service (NC Medicaid Direct) (NCDHHS, 2025). On paper, the goal was to protect dental benefits from the cost-cutting pressures of capitated care. In practice, this carve-out further entrenched the separation between oral and medical care.

Under this design, a pregnant woman's prenatal care is managed by a Medicaid managed-care organization (MCO), which is responsible for obstetric services and some elements of care coordination, but not for her dental benefits. Dental coverage sits in a separate administrative lane, with its own network, reimbursement schedule, and prior authorization rules. The MCO has no direct financial incentive to coordinate dental care that might reduce preterm birth risk or ED utilization for dental pain.

The absence of integrated incentives stands in contrast to evidence from other states. For example, quasi-experimental work in California found that changes in adult Medicaid dental benefits were associated with measurable changes in ED visits for nontraumatic dental conditions (Ranade et al., 2025). While details vary by context, such studies suggest that when adult dental benefits are strengthened and better integrated, states can reduce preventable ED use and overall costs—a lesson highly relevant for North Carolina's carved-out model.

Figure 6. Structural Fragmentation: The Medical-Dental Divide



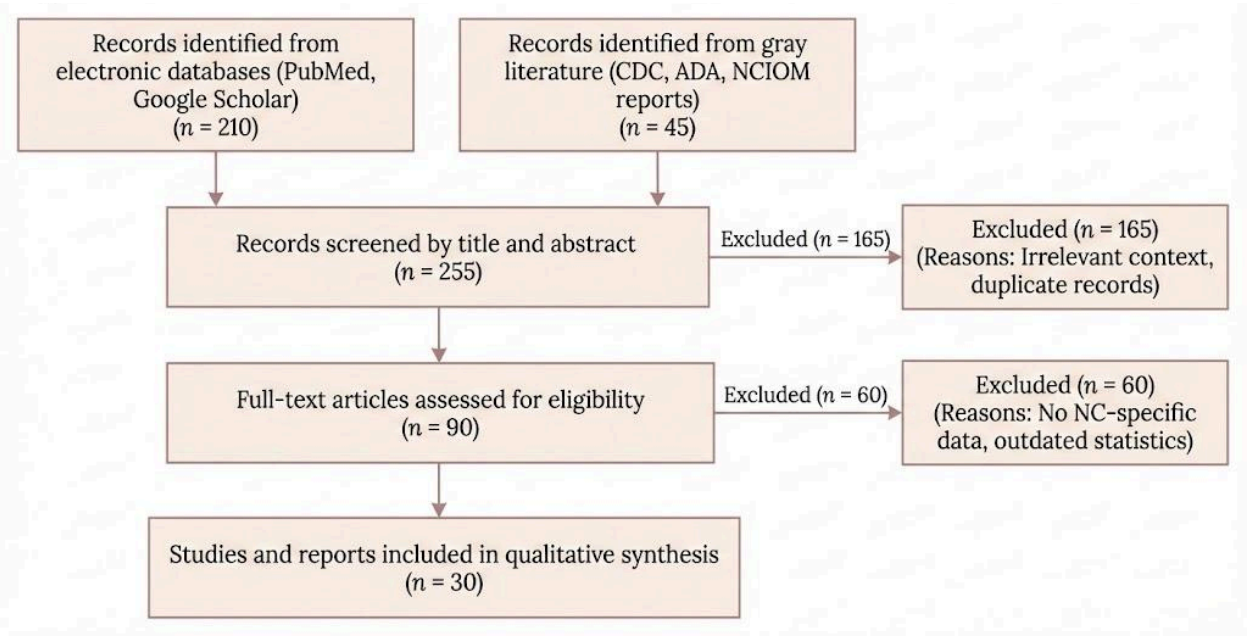
Research Methods

This review synthesizes peer-reviewed empirical studies, state administrative datasets, federal surveillance reports, and policy analyses published between 2014 and 2025. Key empirical inputs include county-level claims analyses of the MPW program (Moss et al., 2021), workforce studies and state reports (Rozier et al., 2024; NCIOM, 2024), and national surveillance data on dental utilization and ED visits (CDC NCHS, 2024–2025; ADA HPI, 2024). Selection criteria prioritized studies and reports that used statewide

administrative data, quasi-experimental designs, or comprehensive workforce analyses; commentaries and advocacy pieces were used selectively for context and implementation details.

This review is limited by its reliance on secondary sources and ecological analyses, which constrain causal inference at the individual level. Key empirical inputs (e.g., Moss et al., 2021) analyze county-level claims and cannot determine individual trajectories or the precise mechanisms by which policy features translate into utilization decisions. Additionally, administrative datasets and policy reports may lag rapid programmatic changes (for example, the 2022 postpartum extension), so some implementation effects may not yet be fully observable in the available literature.

Figure 1. Literature Selection Process



Findings & Analysis

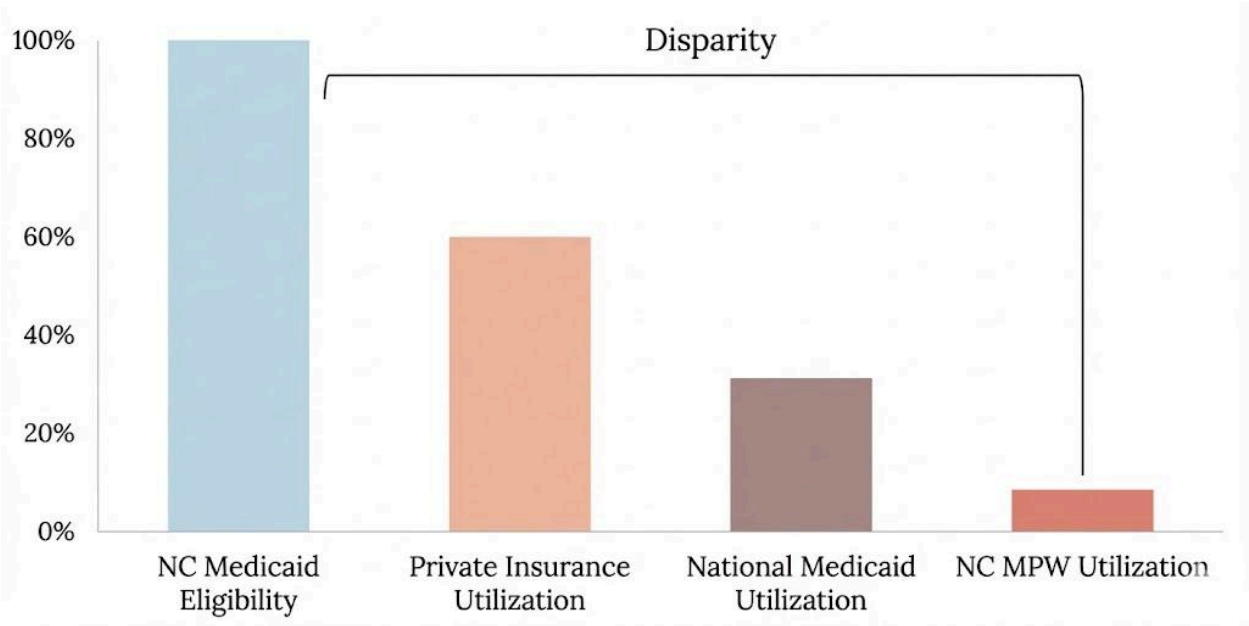
I. The 8.5% Utilization Rate and Its Implications

The most compelling evidence of the system's failure to meet the needs of pregnant women comes from Moss et al. (2021), who analyzed county-level Medicaid claims for the MPW program from 2014–2016. Their findings include:

- Dental utilization among pregnant women ranged from 1% to 26% across counties.
- The median county utilization rate was 8.5%, meaning that in half of North Carolina's counties, fewer than one in ten pregnant Medicaid beneficiaries had any dental claim during pregnancy.
- Counties characterized by persistent poverty and other indicators of social disadvantage had significantly lower utilization rates, even when controlling for dentist supply.

To translate the 8.5% figure into a sense of scale requires caution because denominators and timeframes differ across sources. Moss et al. (2021) calculated county-level dental utilization among MPW enrollees during 2014–2016, whereas the 61,126 figure reflects North Carolina's Medicaid-financed resident births in 2023 (NC SCHS, 2024). Because the populations and years are not identical, one cannot directly multiply 8.5% by the 2023 birth count without risking misinterpretation. However, contextualizing this rate against national benchmarks reveals the severity of the disparity. Nationally, 31% of pregnant Medicaid beneficiaries receive a dental cleaning during pregnancy, while utilization rates for privately insured women typically exceed 60% (Reynolds et al., 2025; CDC, 2023). These figures refer specifically to the percentage of women who reported having their teeth cleaned by a dentist or dental hygienist during their most recent pregnancy. Consequently, a median county rate of 8.5% suggests that access in these North Carolina counties is not merely lagging behind the national Medicaid norm, but has effectively collapsed.

Figure 7. The Implementation Gap



II. How Supply and Social Context Interact

Moss et al. (2021) also examined how dental utilization among pregnant women related to supply-side factors such as dentist-to-population ratios and the presence of Federally Qualified Health Centers (FQHCs). They found that:

- Higher dentist density and local FQHC presence were associated with higher dental utilization among pregnant women.
- However, the magnitude of this association was modest. Social determinants—including poverty, child maltreatment reports, and rankings in years of potential life lost—also had strong associations with utilization.

These findings echo broader national trends. ADA Health Policy Institute data show that only 43% of the U.S. population visited a dentist in 2021, and among adults aged 19–64, the share was only 38.7% (ADA Health Policy Institute, 2024). For adults living below 100% FPL, dental visit rates are dramatically lower than among higher-income groups. In other words, the North Carolina utilization gap for pregnant Medicaid beneficiaries is framed by a national pattern in which low-income adults are systematically disconnected from preventive dental care.

Yet the disparities are sharper in North Carolina because of the state's particularly pronounced maldistribution of providers and the unique structure of carved-out benefits. Rozier et al. (2024) emphasize that more than half of North Carolina dentists practice in only six counties, and 97 of 100 counties are partially or fully designated as Dental HPSAs. For a pregnant woman living in a rural county with no local dentist taking Medicaid, no amount of coverage expansion will translate into actual care unless transportation, navigation, and workforce issues are addressed simultaneously.

III. The Paradox of Postpartum Expansion

In April 2022, North Carolina implemented a major policy reform to extend postpartum Medicaid coverage from 60 days to 12 months (North Carolina Department of Health and Human Services [NCDHHS], 2025; KFF, 2025). This change signifies the state's alignment with a growing national movement to extend postpartum coverage, in recognition of the many serious maternal health issues, including mental health conditions and chronic disease exacerbations, that emerge after the immediate postpartum period.

A recent cohort study of 353,957 Medicaid-funded births in North Carolina found that the 12-month extension was associated with more than 95% of affected birthing parents maintaining continuous Medicaid enrollment through at least one year postpartum (Bundorf et al., 2025). From an eligibility perspective, the policy has seemingly achieved its immediate goal: it has dramatically increased postpartum coverage access.

However, the extension did not create new dental appointments, new providers, or new incentives for MCOs to coordinate dental care. For a woman in a rural county where no dentist accepts MPW or adult Medicaid, the extension simply lengthens the time during which she could theoretically receive care. The bottleneck, including provider capacity, logistics, and patient navigation, remains unchanged.

The result is a bridge-to-nowhere phenomenon, where women are now eligible for dental benefits for a longer period, but structural barriers prevent many from ever actually seeking out and receiving this care. Without targeted implementation strategies that connect women to dentists and prioritize oral health during pregnancy and postpartum, the extended coverage may have little impact on dental outcomes.

Comparative Models

Comparative evidence from other states reinforces a central conclusion of this review: coverage expansion alone does not guarantee access, but policy design choices can meaningfully alter utilization patterns when paired with provider engagement and integration strategies. States that have made progress in improving adult Medicaid dental access have done so not by relying on eligibility expansions in isolation, but by coupling benefits with payment reform, outreach, and care coordination mechanisms that directly address supply-side and navigational barriers.

Virginia's experience is particularly instructive. When the state implemented a comprehensive adult Medicaid dental benefit, enrollment increased rapidly, reflecting pent-up demand among low-income adults who had previously been excluded from coverage. However, utilization gains unfolded more gradually over several years, tracking investments in provider recruitment, patient outreach, and administrative simplification (CareQuest Institute for Oral Health, 2023). This temporal lag underscores a recurring theme in the literature: dental systems respond slowly to policy change, especially in states where provider participation has been historically low. Importantly, Virginia's experience suggests that utilization growth is not automatic but contingent on deliberate implementation strategies that make participation viable for dentists and care-seeking feasible for patients.

California offers a complementary lesson through a natural policy experiment. The state eliminated adult Medicaid dental benefits during the Great Recession and later restored them, creating an opportunity to examine how benefit design affects downstream utilization. Analyses of this period found that changes in adult dental coverage were associated with measurable shifts in emergency department visits for nontraumatic dental conditions (Ranade et al., 2025). When benefits were restricted, ED utilization increased; when benefits were restored, ED visits declined, indicating that robust adult dental benefits can redirect care away from costly emergency settings when access is real rather than nominal. While California's size and delivery system differ from North Carolina's, the

underlying mechanism, which is prevention substituting for crisis care, has direct relevance.

These comparative cases highlight an important contrast with North Carolina's current approach. The state's 12-month postpartum Medicaid extension expanded eligibility but did not meaningfully alter reimbursement rates, workforce distribution, or integration of dental services into maternal care pathways. Unlike Virginia, North Carolina has not paired expansion with systematic provider engagement. Unlike California, it has not leveraged adult dental benefits as a tool for ED diversion through strengthened access. The result is that North Carolina's reform remains largely administrative rather than operational.

Taken together, comparative evidence suggests that North Carolina's challenges are not inevitable, nor are they unique. Other states demonstrate that when dental benefits are treated as core components of health policy, rather than peripheral add-ons, states can increase utilization, reduce emergency department reliance, and improve equity. However, these outcomes require sustained investment and intentional alignment between benefits, payment, and delivery systems, rather than one-time eligibility changes.

Policy Analysis

North Carolina's Medicaid dental program reflects a broader pattern in U.S. health policy: oral health is formally covered but structurally marginalized. While statutory eligibility has expanded, most notably through the 12-month postpartum Medicaid extension, the policy architecture governing dental care continues to suppress access for women, particularly pregnant women and single mothers. This section analyzes the key policy gaps, barriers, and institutional dynamics that perpetuate this disconnect.

At the core of the problem is payment inadequacy. Medicaid dental reimbursement rates in North Carolina remain among the lowest in the region, hovering at approximately 34–35% of usual and customary charges and largely unchanged since 2008 (NCIOM, 2024). In a predominantly private-practice dental system with overhead costs routinely exceeding 60% of gross revenue, these rates function as a structural disincentive rather than a neutral policy choice. While some dentists remain enrolled as Medicaid providers, many limit the

number of Medicaid patients they see or decline to treat adults altogether, producing "ghost networks" that inflate nominal access without delivering care.

Administrative design further compounds these economic barriers. Prior authorization requirements, claim denials, documentation burdens, and audit concerns create what providers consistently describe as a "hassle factor" that discourages participation (NCIOM, 2024). For patients, administrative complexity manifests as confusing benefit communications, long waits at safety-net clinics, and unreliable transportation arrangements through Medicaid's non-emergency medical transportation system (Oral Health NC, 2023). These burdens disproportionately affect single mothers, whose work schedules, caregiving responsibilities, and lack of paid leave reduce their capacity to navigate bureaucratic systems for preventive care.

Structural fragmentation represents a third major policy failure. North Carolina's decision to carve adult dental benefits out of Medicaid managed care entrenches the separation between oral health and medical care. Under this model, managed-care organizations are responsible for prenatal and postpartum care but have no financial accountability for dental outcomes, even when oral disease contributes to adverse pregnancy outcomes or costly emergency department utilization. As a result, no entity within the system is incentivized to coordinate dental care for pregnant or postpartum women, leaving oral health outside the scope of maternal health reform.

The politics of Medicaid dental reform in North Carolina are shaped by a relatively narrow set of institutions with differing incentives. The General Assembly controls appropriations and therefore reimbursement floors; NCDHHS (and its Medicaid office) administers benefits and sets operational rules (e.g., prior authorization and transportation contracts); managed-care organizations administer prenatal/postpartum medical benefits and retain leverage over care coordination channels despite the dental carve-out; dental professional associations and private-practice dentists influence provider participation and regulatory discussions; Federally Qualified Health Centers and safety-net clinics bear frontline responsibility for serving Medicaid enrollees; and community advocates and patient groups represent demand-side pressure for more equitable access. These actors have asymmetrical power: budgetary control rests with the legislature and NCDHHS, while day-to-day access is mediated by providers and MCOs. Reform efforts must therefore

reckon with misaligned incentives across this set of stakeholders—who pays, who is accountable, and who has the capacity to implement change.

These policy choices interact with existing geographic and racial inequities. Nearly all counties in North Carolina are designated Dental Health Professional Shortage Areas, and provider distribution is heavily skewed toward urban centers (Rozier et al., 2024). Medicaid-financed births are disproportionately concentrated among unmarried women and women of color, meaning that the consequences of underpayment, fragmentation, and workforce maldistribution fall most heavily on populations already facing structural disadvantage (NC SCHS, 2024). Experiences of discrimination and mistrust in health care settings further suppress utilization, particularly among Black and Latina women (Van der Drift, 2019; CareQuest Institute for Oral Health, 2023).

In sum, North Carolina's Medicaid dental policy is characterized by a misalignment between goals and mechanisms. While maternal health equity is increasingly emphasized in rhetoric and eligibility rules, dental policy remains anchored in outdated assumptions that treat adult oral health as optional. Without confronting reimbursement adequacy, administrative burden, and structural fragmentation, current policies will continue to produce low utilization, preventable suffering, and inefficient public spending. These outcomes undermine the very objectives Medicaid is intended to serve. These structural misalignments are detailed below in Section 9.

Policy Recommendations

To transform North Carolina's dental safety net for women from symbolic coverage to functional care, policy changes must operate at multiple levels: economic, structural, and logistical. The recommendations below synthesize evidence from the literature, state reports, and successful models in other jurisdictions.

I. Modernize Reimbursement

1. Raise baseline dental reimbursement rates.

    - The General Assembly should increase Medicaid dental reimbursement to at least 46–50% of usual and customary charges, bringing North Carolina closer to the regional median and partially offsetting more than a decade of inflation (NCIOM, 2024).
    - A higher reimbursement floor is essential for attracting private dentists into the Medicaid network and preventing further erosion of the existing safety net.
2. Implement incentives for high-volume Medicaid physicians.
    - Providers who commit to serving a large number of Medicaid patients (e.g., ≥100 unique adult or pregnant Medicaid beneficiaries per year) could receive an enhanced "Gold Star" rate or per-member per-month payment for care coordination.
    - Such incentives should be tied not just to enrollment as a Medicaid provider, but to demonstrated access (measured by claims volume and new-patient appointments), reducing the problem of ghost networks.
3. Align incentives with ED diversion.
    - Given that dental-related ED visits cost roughly three times as much as dental office visits and contribute to $1.6 billion in national spending annually (ADA, 2025), North Carolina should consider shared-savings models in which part of the cost savings from reduced ED utilization flows back to community dental providers or FQHCs that expand access for Medicaid-enrolled women.

II. Integrate Oral Health into the Maternal Care Pathway

1. Create formal handoffs from prenatal care to dental care.
    - Every pregnant woman entering prenatal care through a health department, FQHC, or obstetric practice should receive a brief oral health screening and an immediate referral, ideally with an appointment date, to a Medicaid-participating dental provider.
    - WIC offices, which already serve roughly 36.6% of North Carolina mothers prenatally (NC SCHS, 2024), can be leveraged as key access points for these referrals.

2. Incentivize MCOs to coordinate dental care despite the carve-out.
    - Although dental benefits remain in fee-for-service, the state can require MCOs to report on and be accountable for oral-health-related outcomes among pregnant and postpartum members (e.g., percentage of pregnant members receiving a dental visit).
    - Performance metrics tied to value-based payments could reward MCOs that develop partnerships with dental providers and FQHCs to facilitate care for pregnant members, even if the dental claims are paid through NC Medicaid Direct.
3. Launch a targeted education campaign on dental safety in pregnancy.
    - Misconceptions that dental care is unsafe during pregnancy are common among both patients and providers (CareQuest Institute for Oral Health, 2023).
    - A multimedia "Healthy Teeth, Healthy Toddler" campaign could use social media, prenatal classes, and clinic waiting rooms to emphasize that dental treatment in pregnancy is recommended and safe, and to clarify available Medicaid benefits.

III. Invest in Patient Navigation and Logistics

For many single mothers, the primary barriers to dental care are logistical rather than conceptual.

1. Fund patient navigators and community health workers.
    - Patient navigators based in FQHCs, local health departments, or WIC sites can help women:
        - Identify Medicaid-accepting dentists.
        - Schedule appointments that align with work schedules.
        - Arrange transportation through NEMT.
        - Coordinate child care or flex appointments to accommodate children.
    - Evidence from navigation programs in medical settings suggests that such support can significantly reduce no-show rates and improve treatment completion, especially for low-income women (NCIOM, 2024).

2. Design “Dental Days” integrated with prenatal care timeline.
    - In communities with extremely limited dental capacity, the state could fund periodic “Dental Days” or “Tooth Time” at obstetric clinics or health departments, during which a mobile dental team provides screenings, prophylaxis, and basic restorative care for pregnant women.
    - Co-location minimizes transportation and child-care burdens and leverages existing trust between women and their prenatal providers.
3. Improve and enforce NEMT reliability.
    - Given the importance of transportation, North Carolina should monitor on-time performance of Medicaid transportation vendors and incorporate penalties or bonus payments based on reliability.
    - Women should have access to simple, multilingual systems to schedule rides, including text-based options for those without reliable internet access.

IV. Diversify and Deploy the Workforce

The dentist-centric model has not succeeded in ensuring access for low-income women in rural and underserved areas.

1. Support expanded roles for dental hygienists and explore dental therapy.
    - Dental hygienists in North Carolina already provide preventive services, but with appropriate legislative changes, they could be allowed to practice in community settings (e.g., WIC clinics, OB offices) under general supervision, performing screenings, cleanings, fluoride applications, and simple sealants.
    - Dental therapists, who are mid-level providers licensed in a growing number of states, can perform routine restorative procedures like fillings and simple extractions at a lower cost than dentists. Evidence from states such as Minnesota and Alaska suggests that dental therapists can successfully expand access in underserved areas without compromising quality (CareQuest Institute for Oral Health, 2023).
2. Align loan repayment and scholarship programs with women’s access needs.

    - Existing state and federal loan repayment programs often prioritize service in HPSAs broadly. North Carolina could layer additional priorities for providers who commit to:
        - Serving high volumes of adult Medicaid patients.
        - Providing dedicated appointment slots for pregnant women and single mothers.
        - Practicing in counties with the lowest dental utilization among pregnant Medicaid beneficiaries.
3. Monitor workforce distribution with a gender and equity lens.
    - Future workforce tracking should not only count providers but also assess whether their locations, practice types, and Medicaid participation are sufficient to meet the needs of low-income women, especially in counties where 97 of 100 are already recognized as Dental HPSAs (Rozier et al., 2024).

Conclusion

The oral-health crisis facing women and single mothers in North Carolina is not the result of a lack of medical knowledge or a lack of individual responsibility. It is the predictable outcome of systemic decisions that:

- Separate the mouth from the rest of the body in benefit programs.
- Set reimbursement rates so low that providers cannot sustainably participate.
- Allow workforce maldistribution and dental deserts to persist.
- Treat coverage as synonymous with access, even when utilization data refute that assumption.

In a state where more than half of all births are financed by Medicaid (NC SCHS, 2024) and where nearly all counties are designated Dental HPSAs (Rozier et al., 2024), it is unacceptable that only 8.5% of pregnant Medicaid beneficiaries in a typical county receive dental care during pregnancy (Moss et al., 2021). This statistic is not just a measure of underutilization; it is a structural indictment. It represents thousands of women suffering preventable pain, thousands of infants exposed to avoidable risk of preterm birth and early

childhood caries, and millions of public dollars diverted into emergency departments for palliative treatment instead of prevention.

The recent 12-month postpartum extension offers a historic opportunity. With extended coverage, North Carolina now has a broader window in which to provide comprehensive care to birthing parents. But unless the state also modernizes dental reimbursement, integrates oral health into maternal care pathways, and invests in navigation and workforce reforms, this window will remain largely symbolic.

Transforming the “Medicaid card” from a piece of plastic into a real passport to oral health for women requires political will and a willingness to invest in small but meaningful changes in infrastructure, such as reimbursement tables, data systems, navigational tools, and workforce pipelines. The payoff, however, is significant: healthier pregnancies, healthier children, reduced emergency department spending, and a tangible narrowing of the “smile gap” that currently functions as a silent barrier to women’s economic security.

In short, if North Carolina is serious about implementing maternal health equity, the state must acknowledge that the mouth is part of the body, and that women’s teeth, just like their blood pressure or hormone levels, are essential to a just and functional holistic health system.

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