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Dental Care for Older Adults in Long-Term Care and Home-Based Settings

Access, Coverage, and the Role of Mobile Delivery

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KEY TAKEAWAYS

- Older adults in nursing homes, assisted living, and home-based settings have among the highest rates of untreated oral disease in the country, and the office-based dental system largely does not reach them. About 1.3 million people live in U.S. nursing homes, and an estimated 2 million older adults are completely or mostly homebound.
- Coverage gaps compound the access problem. Traditional Medicare excludes most dental care by statute, and adult dental coverage under Medicaid is optional and varies widely across states, from extensive to emergency-only.
- Untreated oral disease in this population is associated with aspiration pneumonia, poorer glycemic control, and malnutrition, and it shifts costs to emergency departments and inpatient care.
- Mobile dental programs operating under collaborative-practice arrangements can rotate through facilities and homes to provide preventive care, screening, and referral. The delivery model is established; the policies that govern it, scope of practice and Medicaid benefit design, are set largely by states.

Introduction

The United States has about 55.8 million residents ages 65 and older, a number the Census Bureau projects will reach roughly 95 million by 2060.[1] About 70 percent of people turning 65 today will need some form of long-term services and support during their lives.[2] A large share of that care is delivered in nursing homes, assisted living facilities, and private homes, settings where a conventional dental office is not a realistic option. For the older adults who live in these settings, oral health care is among the least accessible parts of the health system.

This brief examines why older adults in long-term care and home-based settings go without dental care, how Medicare and Medicaid shape the coverage available to them, the clinical and fiscal consequences of unmet need, and the role that mobile dental programs can play. It

also identifies the state policy levers, scope of practice and Medicaid benefit design, that determine whether mobile delivery can operate at scale.

Most older adults in long-term care and home-based settings cannot reach office-based dental care

About 1.3 million people live in U.S. nursing homes, and roughly 62 percent of them rely on Medicaid to pay for their care. An estimated 2 million older adults are completely or mostly homebound, meaning they never or rarely leave home, and another 5.3 million can leave only with difficulty or assistance.[3] As a result, this population sits functionally outside the office-based delivery system that serves everyone else.

Medicare and Medicaid leave much of this population without routine dental coverage

Medicare, which covers nearly all this population, excludes routine dental care by statute under Section 1862(a)(12) of the Social Security Act, an exclusion in place since the program began in 1965. Regulatory changes in the 2023 through 2025 Physician Fee Schedule rules extended Medicare payment to a narrow set of medically necessary dental services tied to cancer treatment, organ transplant, and dialysis, but these do not constitute a routine dental benefit.[4] About 47 percent of Medicare beneficiaries have no dental coverage of any kind, and roughly half had no dental visit in a recent measurement year.[4]

Medicaid is the other payer, and here coverage depends on the state. Adult dental coverage under Medicaid is optional, unlike the pediatric benefit, which is required. States place their adult benefit somewhere on a continuum that runs from extensive to limited to emergency-only to none. As of the end of 2024, 11 states and the District of Columbia met the criteria for an extensive adult benefit, up from four states in 2020.[5] The direction has been toward broader coverage, but the benefit remains uneven, and optional benefits are often among the first reduced when state budgets tighten. Between 2000 and 2025, at least 21 states cut or eliminated adult Medicaid dental benefits at least once.

Medicare and Medicaid set the terms for most of this population, but they are not the only financing paths. Some residents have dental coverage through a Medicare Advantage supplemental benefit, through the Programs of All-Inclusive Care for the Elderly (PACE) for enrolled frail elders, or through Veterans Affairs eligibility, and a smaller number retain private coverage or pay out of pocket. Nursing facilities also carry their own dental-access obligations, discussed below. For the low-income, long-stay, and dually eligible residents who make up much of the nursing home population, Medicaid remains the typical payer, which is why its benefit design most determines whether an on-site program is viable. Figure 1 summarizes the available pathways.

Figure 1. Pathways for Dental Coverage for Older Adults

Payer or pathway	Role in financing on-site dental care	Principal limit
Medicaid adult dental benefit	Primary payer for many long-stay and dually eligible residents	Optional and uneven by state; among the first benefits cut when budgets tighten
FQHC dental services	Health centers can deliver or partner to deliver on-site care on a sliding-fee basis	Capacity and geographic reach vary; not present in every area
PACE	Capitated programs include dental for enrolled frail elders	Limited to PACE enrollees within defined service areas
Medicare Advantage supplemental dental	Many MA plans add a supplemental dental benefit	Scope varies by plan; traditional Medicare excludes routine dental
Veterans Affairs	Covers eligible veterans	Eligibility is limited and reaches a small share of this population
Facility contracts, grants, and demonstrations	Facilities, philanthropy, or Section 1115 demonstrations can fund on-site care	Often time-limited and not a stable benefit

NOTES: Pathways are not mutually exclusive. Categories describe the role and principal limit of each source; they do not represent payment amounts. **SOURCE:** Mission Mobile Medical Policy Center analysis of Medicaid, Medicare, PACE, and Veterans Affairs dental coverage rules, 2025 through 2026.

Untreated oral disease carries both clinical and fiscal consequences

The oral health of long-term care residents is well documented and poor. Studies of nursing facility residents report untreated decay in the natural teeth of a substantial majority, gingivitis in roughly two-thirds to three-quarters, periodontal treatment need in a third to a half, and persistent dental pain in a meaningful minority. Ill-fitting or absent dentures are common, and root caries, the decay that forms on exposed root surfaces as gums recede, is a particular problem in older adults.

Untreated oral disease in this group is a whole-health problem rather than a quality-of-life footnote. Poor oral hygiene and periodontal disease are clinically relevant to aspiration pneumonia, a frequent and serious infection in long-term care that affects at least 250,000 nursing home residents a year.[7] Periodontal disease is associated with poorer glycemic control in residents with diabetes, and tooth loss and oral pain contribute to malnutrition through altered food selection and reduced intake.

The fiscal consequences of unmet need appear in where care defaults to when prevention is absent. When dental coverage is restricted, patients present instead at emergency

departments for nontraumatic dental conditions, meaning dental problems not caused by injury. Emergency departments can manage pain and infection but rarely deliver definitive dental treatment, so the visit treats the symptom and not the disease. Dental-related emergency department visits cost the health system an estimated 2.1 billion dollars a year, and the American Dental Association's Health Policy Institute estimates that close to 79 percent of those visits could have been handled in a dental office.[5]

State experience illustrates the cost shift: after California eliminated its adult Medicaid dental benefit, emergency department visits and associated costs for dental conditions rose,[6] and similar increases have been reported in other states following comparable reductions. For long-term care residents specifically, untreated oral disease also contributes to avoidable hospitalizations, including for aspiration pneumonia, each of which costs far more than the preventive care that might have averted it.

Mobile dental programs bring care to patients who cannot travel to it

A mobile dental program is built to address the central problem this population presents, which is that the patient cannot come to the care. A single clinic can rotate on a schedule through nursing homes, assisted living facilities, adult day programs, and homebound visits across a region, delivering a defined set of services on site and referring what falls outside them. The on-site set covers preventive hygiene such as cleanings and fluoride varnish, diagnostic examination and oral cancer screening, denture adjustment and education, and silver diamine fluoride, a topical agent that arrests existing decay without drilling and is well suited to frail patients. When combined with teledentistry, an on-site hygienist can connect the resident to a dentist for triage and treatment planning without moving the patient. Conditions that require a dentist's operatory, such as complex restorative or surgical care, are identified and referred.

For nursing facilities, on-site dental care also helps meet an existing legal duty rather than adding a discretionary amenity. Federal requirements for long-term care facilities direct them to assist residents in obtaining routine and emergency dental services (42 CFR 483.55), but thin adult Medicaid coverage and a shortage of dentists who will treat this population make that duty difficult to discharge through outside referral and transport. A program that brings care to the facility offers a workable way to satisfy the requirement and to document that residents have access.

The operational model is established rather than theoretical. Apple Tree Dental, a Minnesota nonprofit founded in 1985 to serve nursing home residents, delivers on-site and mobile care through ten dental centers and 150 community partner sites, including nursing facilities, assisted living, and group homes, and operates under a collaborative-practice model.[8] Researchers followed 1,159 older adult Apple Tree Dental patients (mean age 74) to see how much dental care they used and what it cost, comparing people living independently versus those in long-term care.[9] It found that the costs of comprehensive dental care were similar, modest, and declined over time across both settings, suggesting such care can be delivered

feasibly and affordably to aging populations. Versions of the model have been replicated in North Carolina, Louisiana, Massachusetts, Texas, and California.[10]

Measured outcomes from comparable programs show what regular on-site care produces. A longitudinal study of Gerodent, a mobile dental program serving nursing homes in Flanders, Belgium, found that the share of residents with an oral treatment need fell from 65.9 percent to 31.3 percent over follow-up, and that slightly more than half of residents reached a state of oral health stability with no further restorative or prosthetic treatment need.[11] The mechanism is unremarkable, and that is the point: regular, scheduled professional contact converts a backlog of accumulated disease into managed, preventable maintenance.

State policy determines whether mobile delivery can operate at scale

Three state policy levers determine whether the model can operate at scale. The first is scope of practice. A dentist's time is the scarce and expensive input in any dental program, and a model that requires a dentist to be physically present for every preventive service cannot reach a dispersed, low-density population affordably. Most states have addressed this through direct access, which allows a dental hygienist to provide preventive care based on the hygienist's own assessment without a dentist first examining the patient or being present. As of 2025, 42 states authorize some form of direct access, up from nine in 2000.[12] Many states implement it through collaborative practice, a defined arrangement in which a hygienist delivers care in facilities and community settings under a written agreement with a collaborating dentist who remains the clinical anchor and the destination for referrals. The arrangement expands the volume of care that can be delivered without expanding the number of dentists required, which is the constraint that otherwise caps any program serving this population.

The second lever is Medicaid benefit design. For the dually eligible residents who make up much of the long-term care population, Medicaid is the only realistic payer for dental care, because Medicare does not cover it. A state's decision about whether its adult dental benefit covers preventive and restorative services, and at what frequency, directly determines whether a mobile program serving that state's nursing homes is financially viable. The fiscal logic favors coverage: paying for scheduled preventive care delivered on site is consistently less expensive than absorbing the emergency department visits, avoidable hospitalizations, and complications that follow when care is absent. Several states have begun testing this proposition directly. Nevada's 2024 Section 1115 demonstration extends a limited adult dental benefit through federally qualified health centers in part to measure the return on investment for a high-risk diabetic Medicaid population.[5]

A third lever is teledentistry policy. Not every state has adopted rules governing how remote examination, diagnosis, and supervision may be delivered and reimbursed, and where such regulation is absent the modality simply goes unused. A mobile program does not need teledentistry regulation to operate, since much of its value comes from care that a hygienist

can provide on site. Where teledentistry rules exist, however, they have a practical effect on how a program is designed, because they shape workflows and staffing by allowing a dentist to examine, triage, and plan treatment remotely rather than requiring a dentist to travel to every site, which lets scarce dentist time reach more patients.

Considerations for state policymakers

State policymakers weighing whether and how to extend dental care to long-term care and homebound older adults face several related considerations:

- Whether the state's scope-of-practice framework permits collaborative-practice or direct-access delivery in nursing homes, assisted living, and home settings, which is the precondition for any mobile program to reach the population at sustainable cost.
- How the adult Medicaid dental benefit affects long-term care residents and the dually eligible, for whom Medicaid is the only dental payer. Coverage of preventive and restorative services, and their allowed frequency, shapes program viability.
- How formalizing teledentistry rules could increase access in mobile and fixed sites, especially in areas with serious dentist workforce shortages.
- Whether cost analyses account for the downstream spending that untreated oral disease shifts onto emergency departments and inpatient care, rather than scoring the dental benefit in isolation.
- Whether demonstration authority, such as a Section 1115 waiver, could test on-site mobile delivery and measure outcomes and cost for a defined high-need population before a permanent benefit change.

Looking ahead

The aging of the population will enlarge every number in this brief. The population ages 65 and older will nearly double by 2060, the long-term care and homebound populations will grow with it, and more older adults are keeping their natural teeth, which raises rather than lowers the volume of dental care this group will need. These residents will need oral health care; the open question is how a system that does not currently reach them will be built to do so. Mobile delivery operating under collaborative-practice arrangements is one of the few approaches with both a national base of operational experience and the structural fit to reach people where they live. States have the power to determine whether mobile dental programs can operate at scale and improve the quality of life and health for our nation’s older adults.

Endnotes

1. U.S. Census Bureau. 2023 National Population Projections. 2023.

2. U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation. Long-Term Services and Supports for Older Americans: Risks and Financing. 2022.

3. Ornstein KA, Leff B, Covinsky KE, et al. Epidemiology of the Homebound Population in the United States. JAMA Internal Medicine. 2015;175(7):1180 to 1186.

4. KFF. Coverage of Dental Services in Traditional Medicare; Drilling Down on Dental Coverage and Costs for Medicare Beneficiaries. 2025.

5. CareQuest Institute for Oral Health. Medicaid Adult Dental Benefits and Medicaid Adult Dental Coverage Checker (benefits as of December 31, 2024). 2025.

6. Singhal A, Caplan DJ, Jones MP, et al. Eliminating Medicaid Adult Dental Coverage in California Led to Increased Dental Emergency Visits and Associated Costs. Health Affairs. 2015;34(5):749 to 756.

7. Zimmerman S, et al. Effectiveness of a Mouth Care Program Provided by Nursing Home Staff vs Standard Care on Reducing Pneumonia Incidence: A Cluster Randomized Trial. JAMA Network Open. 2020;3(6).

8. Apple Tree Dental. Our Organization; Mobile Community Outreach. 2026. appletreedental.org

9. Smith BJ, Helgeson M, Prosa B, Finlayson TL, Orozco M, et al. Longitudinal Analysis of Cost and Dental Utilization Patterns for Older Adults in Outpatient and Long-Term Care Settings in Minnesota. PLOS ONE. 2020;15(5):e0232898.

10. Association of State and Territorial Dental Directors. Best Practices Report: Teledentistry and Mobile Care, Apple Tree Dental (Minnesota). 2021.

11. Janssens B, Vanobbergen J, Petrovic M, et al. The Impact of a Preventive and Curative Oral Healthcare Program on the Prevalence and Incidence of Oral Health Problems in Nursing Home Residents. PLOS ONE. 2018;13(6):e0198910.

12. American Dental Hygienists' Association. Direct Access States [State-by-state chart]. 2025.