Improving Pregnant Women's Access to Oral Health Care in Georgia

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Introduction

Oral health during and post pregnancy is essential to a woman's overall health. Yet, current policies in Georgia block pregnant and postpartum women from accessing adequate dental services, especially for the low-income population. Medicaid provides health insurance coverage for some of the nation's most vulnerable populations, including pregnant women but states have great flexibility in managing their Medicaid for Pregnant Women (MPW) programs. The purposes of the paper are to discuss the importance of comprehensive oral health care during pregnancy, to improve pregnant women's access to comprehensive dental services, and to describe the concrete recommendations of each policy option.

In the following sections, this paper first presents background on dental care for pregnant women in the US, summarizes different oral health coverage options for pregnant women among the US states, introduces the current Georgia Medicaid policies, and analyzes the root causes of these inadequate policies. Then, the paper describes the issue in more detail and clarifies the importance of solving this issue. The third section aims to discuss three policy options issued by the federal or other state governments. Draw from the experiences in the past, the final section provides specific recommendations based on the Georgia background.

Literature Review

Background on Dental Care for Pregnant Women in the US

In 2000, the US Surgeon General's report, Oral Health in America: A Report of the Surgeon General, was the first national policy report to call attention to the association between oral health and adverse pregnancy outcomes. Poor oral hygiene increases the risk of complications for the woman and her pregnancy. Periodontal disease occurs in up to 70% of

pregnant women (Sanz et al., 2013). A decade later, publications from the Institute of Medicine and others emphasized the importance of integrating oral health into primary care for pregnant woman. In 2012, a federally facilitated National Consensus Statement underlined the safety of dental care throughout pregnancy and provided guidance for obstetricians, midwives, and dental providers to meet the oral health needs of pregnant women. In 2014, the Integration of Oral Health and Primary Care report provided a guide for primary care providers to implement a set of interprofessional oral health competencies in primary care practice settings (Haber et al., 2019).

Oral Health Coverage Options for Pregnant Women in the US states

Several programs are aimed at addressing this issue. These include Medicaid, Children's Health Insurance Program (CHIP), and the Affordable Care Act (ACA) offer options for oral health coverage for low-income pregnant women.

Medicaid is an assistance program that serves low-income people of every age. Nearly half of all births in the U.S. are financed by Medicaid (Stephens, Quinonez, Boggess, & Weintraub, 2020). Patients usually pay no part of the costs for covered medical expenses. A small co-payment is sometimes required. Medicaid is a federal-state program. It is run by state and local governments within federal guidelines[1]. Subject to federal standards, states administer Medicaid programs and have the flexibility to determine covered populations, covered services, health care delivery models, and methods for paying physicians and hospitals[2]. To decide who is eligible for Medicaid in Georgia, the State government uses an important standard of the Federal

[1] Medicaid Definition. https://www.hhs.gov/answers/medicare-and-medicaid/what-is-the-difference-between-medicare-medicaid/index.html
[2] Rudowitz, R. (2019). 10 Things to Know about Medicaid: Setting the Facts Straight. https://www.kff.org/medicaid/issue-brief/10-things-to-know-about-medicaid-setting-the-facts-straight/

Poverty Level (FPL). FPL is a measure of income issued every year by the Department of Health and Human Services (HHS) and it is used to determine the eligibility for Medicaid, ACA's Medicaid Expansion and CHIP. The 2020 FPL is $12,760 for one person in Household[3]. If your income is below 100% FPL, you are eligible for the Medicaid program.

The Medicaid expansion program is a state-based program established under the Affordable Care Act in which eligibility for Medicaid services is expanded. The Affordable Care Act (ACA) created additional health coverage options for individuals and families, including pregnant women. First, the ACA expanded Medicaid eligibility criteria to low-income adults under age 65 with incomes up to 138% FPL. Second, the ACA established health insurance marketplaces, where uninsured individuals and their families can shop for and purchase health insurance at competitive prices. Third, the ACA introduced Basic Health Programs, state-based programs offering health benefits to individuals with household incomes of 133–200% FPL. Beyond the ACA Medicaid expansion to low-income adults, expansion states have options to increase the federal minimum income limit of 138% FPL. The income eligibility limit for pregnancy-related services must be at least 138% of the federal poverty level (FPL) - $17, 608 for an individual in 2020[4]. As of November 2020, 39 states plus the District of Columbia expanded Medicaid eligibility[5]. However, Georgia does not adopt the ACA Medicaid expansion[6].

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[3] Health and Human Services Department (HHS). (2020). HHS POVERTY GUIDELINES FOR 2020. https://aspe.hhs.gov/poverty-guidelines

[4] Miner, J. (2020). 2020 Federal Poverty Guidelines. https://www.peoplekeep.com/blog/2020-federal-poverty-guidelines

[5] Kaiser Family Foundation (KFF). Status of State Action on the Medicaid Expansion Decision. https://www.kff.org/health-reform/state-indicator/state-activity-around-expanding-medicaid-under-the-affordable-care-act/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D

[6] Kaiser Family Foundation (KFF). (2020). "Status of State Action on the Medicaid Expansion Decision", Status of State Medicaid Expansion Decisions: Interactive Map. https://www.kff.org/medicaid/issue-brief/status-of-state-medicaid-expansion-decisions-interactive-map/

Demand for Medicaid dental services among children is likely to increase moving forward, regardless of Medicaid expansion. The Children's Health Insurance Program (CHIP) provides health care coverage for children whose families earn too much to qualify for Medicaid. In some states, CHIP also provides coverage to parents and pregnant adults. More than half of states provide CHIP coverage for uninsured children with family incomes at or above 250% federal poverty level (FPL), and 19 states cover children with family incomes up to 300% FPL or higher (Stephens, Quinonez, Boggess, & Weintraub, 2020).

Current Situation with Georgia Medicaid

On March 27, 2019, Republican Governor Brian Kemp signed The Patients First Act, which aimed to address challenges in healthcare including the state's high uninsured rates (13.41% in 2020, which ranks 4th highest uninsured rates in the states[7]). On October 31, 2019, Kemp released a proposed 1332 waiver[8] seeking to implement a reinsurance program and make other changes to marketplace coverage. This proposal would decrease enrollment, raise premiums, and lead more Georgians to enroll in substandard plans rather than comprehensive coverage. On October 15, 2020, the Centers for Medicare & Medicaid Services (CMS) approved an 1115 waiver[9] called Georgia Pathways to Coverage which expands Medicaid coverage to 100% FPL (as opposed to 138%, as called for in the ACA), with initial and continued enrollment conditional on compliance with work and premium requirements (as long as they work at least

[7] Szilagyi, J. (2020). 2020 States with the Highest Uninsured Rates: Georgia Ranks 48th. All On Georgia. https://allongeorgia.com/national-news/2020-states-with-the-highest-uninsured-rates-georgia-ranks-48th/

[8] Through a waiver under Section 1332 of the Affordable Care Act (ACA), Georgia proposes to exit HealthCare.gov without creating a state-based marketplace to replace it.

[9] The Section 1115 Medicaid demonstration waivers offer states an avenue to test new approaches in Medicaid that differ from what is required by federal statute. https://www.kff.org/medicaid/issue-brief/the-landscape-of-medicaid-demonstration-waivers-ahead-of-the-2020-election/

80 hours per month[10]). And the Georgia Pathways to Coverage requested the enhanced ACA funding match despite a July statement from CMS indicating that it will not provide this match for partial expansions[11]. As of April 2020, criteria for enrollment in Georgia Medicaid are set for pregnant women is up to 220% of FPL with family income. Furthermore, Georgia Medicaid only provides topical application of fluoride (excluding prophylaxis) twice a calendar year and comprehensive periodontal evaluation for pregnant women[12].

Root Causes for the Current Situation

Low-income pregnant women in Georgia have difficulties to access oral health care because of the limited oral health coverage in Medicaid for pregnant women, inability to find more dental providers willing to treat pregnant women, and the lack of knowledge of safety and importance of getting dental care during pregnancy.

a. Limited oral health coverage in Medicaid for pregnant women.

Oral health coverage is often inaccessible for low-income pregnant women. Georgia Medicaid has inadequate dental coverage for pregnant women and the coverage ends too soon after birth. A coverage brief from the Children's Dental Health Project (2019), Improving Access to Oral Health Care in Pregnancy, classified dental health into three categories: Emergency, Limited and Extensive. Emergency covers only extractions and treatment necessary to relieve pain and eliminate infection. Limited covers basic preventive, diagnostic, and restorative services such as routine cleanings, fillings, and extractions and may have dollar limits on coverage up to

[10] Norris, L. (2020). Georgia and the ACA's Medicaid expansion. https://www.healthinsurance.org/georgia-medicaid/#:~:text=Georgia%20will%20partially%20expand%20Medicaid,go%20along%20with%20full%20expansion.&text=As%20of%20May%202020%2C%2023,not%20have%20health%20insurance%20coverage
[11] https://help.ihealthagents.com/hc/en-us/articles/225377107-What-are-the-2020-Federal-Poverty-Levels-
[12] CareSource. (2017). Georgia Medicaid Covered Dental Benefits Quick Reference. https://www.caresource.com/documents/ga-covered-dental-benefits-quick-reference-guide/

$1,000. Extensive covers most categories of routine and specialty dentistry and may have dollar limits above $1,000. It is common for state Medicaid programs to offer more comprehensive health coverage to pregnant women than to other adults, to ensure a mother's safety and viability of her pregnancy. As mentioned above in the "Oral Health Coverage Options for Pregnant Women" section, states can set higher Medicaid eligibility limits, with some over 300% FPL. Still, there is no federal requirement that Medicaid covers oral health care as part of pregnancy-related benefits. Further, there is no national standard for the duration of these optional benefits. Therefore, Georgia still does not have mandated requirements that Medicaid cover oral health care as part of pregnancy-related benefits.

Although pregnant women enrolled in Georgia Medicaid are entitled to "pregnancy-related services," oral care is not explicitly included as a pregnancy-related service. Furthermore, while federal law under Medicaid requires pediatric dental coverage, including coverage for pregnant adolescents, it leaves dental care for adults as a state option. Similarly, CHIP and the ACA mandate oral coverage for pregnant youth but not for pregnant adults. (Stohl & Chen, 2018).

Even if the Georgia state government would integrate oral care with primary care of pregnant women, a 60-day postpartum extension would not affect the unmet dental needs for postpartum women in years after giving birth. Post-pregnancy dental care is important because dentists need to observe chronic dental diseases for previously pregnant women over a longer time period than just the pregnancy. Sufficient time is needed to treat disease and establish long-term patterns of preventive care for the woman and her child. Therefore, the state government needs to extend the time related to dental benefits for postpartum women after birth.

b. Inability to find a dental provider willing to treat pregnant women.

Many dentists are unwilling to treat patients during pregnancy. They are often reluctant to provide oral health care during pregnancy due to fear of fetal risks. Dentists often defer treatment of pregnant women because of fears of anesthetics, radiographs, antibiotics, and analgesics causing fetal harm (Haber et al., 2019). Finding dentists who accept Medicaid is even more problematic in rural areas, where the overall number of dentists is already low. Patients in these areas often face long wait and/or drive times for dental appointments. Some pregnant women also experience delays in receiving eligibility for Medicaid benefits (Stephens, Quinonez, Boggess, & Weintraub, 2020).

c. Lack of knowledge of the safety and importance of getting necessary dental care in pregnancy.

During pregnancy, physiological changes may affect oral health negatively, such as dental cavities, pregnancy gingivitis, gum disease, and tooth erosion. While there is sufficient evidence that dental care is safe during pregnancy, more than 75% of obstetricians and gynecologists surveyed had patients who reported being declined dental services during pregnancy[13]. Although the mechanism of periodontal disease-associated adverse pregnancy outcomes remains uncertain, multiple studies indicate that treatment of maternal periodontal disease during pregnancy is safe and improves maternal oral health and general well-being (Boggess & Edelstein, 2006). The US and Georgia lack adequate data collection and reporting on pregnant women's oral health. Consequently, both the Georgia State government and Georgians

[13] Children's Dental Health Project. (2015). Oral Health & Pregnant Women Resource Center. https://www.cdhp.org/resources/320-oral-health-pregnant-women-resource-center

do not have a complete understanding of pregnant women's oral health status and how important it is.

Issue

Oral health care is a necessary and critical component of health care for pregnant women but pregnant women who are low-income also find it particularly difficult to access care in Georgia. Georgia does not have data to track pregnant women's oral health status but some studies at the federal level of pregnant women have shown that only 23–35% of pregnant women have a dental visit during pregnancy, and rates vary significantly by income (Stephens, Quinonez, Boggess, & Weintraub, 2020). Also, most low-income pregnant women in Georgia do not receive adequate oral care. According to postpartum survey data from the Pregnancy Risk Assessment Monitoring System, up to 66% of women had no oral health care during their most recent pregnancy. Women who have lower incomes are half as likely to obtain oral health care during pregnancy as compared to women who have higher incomes (Stohl & Chen, 2018).

Georgia is required to provide comprehensive oral health care to children in Medicaid but the dental benefits for including pregnant women are limited. The Georgia Medicaid for Pregnant Women (MPW) pays for medical care for pregnant women for up to 60 days after giving birth. Although pregnant women enrolled in Georgia Medicaid are provided "pregnancy-related services", oral care is not explicitly included as one of the pregnancy-related services. Georgia Medicaid only provides topical application of fluoride (excluding prophylaxis) twice a calendar year and comprehensive periodontal evaluation for pregnant women. Low-income individuals may be more responsive to seeking treatment for previously untreated dental problems right after gaining coverage, but less likely to change their use of preventive services

(Lyu, Shane, & Wehby, 2020). Therefore, current dental benefits do not help low-income pregnant women much.

Changing policies related to the MPW will lead to better oral health among pregnant women and their infants which may reduce pregnancy complications. Srinivas and Parry (2012) suggested that women with gum disease may be at greater risk for serious health conditions like pre-eclampsia, giving birth too soon, or having low birth-weight babies. Recent research suggests that poor oral health can lead to a number of complications and serious health concerns for pregnant women and young children. Regarding pregnant mothers, Kopycka-Kedzierawski et al. (2019) found that gum disease may also lead to postpartum depression. For children's health outcomes, Dye et al. (2011) found that children were more than three times as likely to have higher levels of caries (also known as cavities), treated or untreated, if their mothers had high levels of untreated caries.

Supporting pregnant women's good oral health boosts family financial security. Women with good oral health earn 4.5% more than their peers (Glied & Neidell, 2010). This increase makes a real difference for families, especially in households where mothers are the sole or primary breadwinner. As six in ten low-wage adults lacking dental coverage reported that their oral health impeded job prospects, helping them address their dental needs can boost employment and family incomes (American Dental Association Health Policy Institute, 2018). Additionally, providing dental benefits to Medicaid adults may lead to enhanced savings for states in other areas, such as hospital emergency department spending (Yarbrough, Vujicic & Nasseh, 2016).

Given the unprecedented scale of job loss during the COVID-19 pandemic, the Georgia state government plays a critical role in supporting access to health care for low-income pregnant

women. The state government's responsibility is to allocate high-quality health care for the public, especially for vulnerable people. The market alone cannot ensure all Georgians equal access to quality oral health care so the state government must preserve the interests of its citizens by supplementing the market where there are gaps and regulating the market where there is inefficiency or unfairness.

Discussion

This paper summarizes the literature on the current situation in the US and Georgia. Other states in the U.S. faced a similar issue that low-income pregnant women find it difficult to access dental care. We can refer to other states' cases to see how they developed their policies to solve this issue. Therefore, this paper provides three policy options as follows:

1. **Creating a practice guidance program for Georgia's pregnant women, prenatal care providers, and dental professionals to raise public awareness.** This option provides an opportunity to inform Medicaid-eligible women of the availability of dental benefits and accelerates developing reliable and consistent mechanisms for collecting and publishing data on pregnant women's health status, their access to dental care and coverage, and how many have coverage today. **Maine** published Tips for a Healthy Mouth for Mom and Baby[14] aiming to provide information about improving women's oral health education, collaboration, and integration of oral health care into prenatal care and primary care. **Maryland** designed a poster, The Health of Your Mouth Is Important During Pregnancy[15], which includes information about how the health of a pregnant

[14] Maine General Health. Tips for a Healthy Mouth for Mom and Baby. https://www.mchoralhealth.org/PDFs/tips-for-a-health-mouth-mom-baby.pdf
[15] The Health of Your Mouth is Important During Pregnancy. https://phpa.health.maryland.gov/oralhealth/Documents/OralHealthDuringPregnancyPoster.pdf

woman's mouth affect her infant's health, the safety of getting oral care during pregnancy, and the importance of making a dental appointment early in pregnancy. **New Mexico** provided online courses about improving the oral health of pregnant women, children, and families[16]. This course included six modules: oral health essentials, oral screening, oral health in pregnancy, oral health knowledge and skills for infants and small children, planning and making changes for good family oral health, and advocacy for oral health for mothers and babies: system access and change. **Virginia** issued a guidance program entitled Oral Health During Pregnancy: Practice Guidance for Virginia's Prenatal and Dental Providers[17]. Take some examples in this guidance program. It provided an oral heath during pregnancy infographic, which said "only 13.03% pregnant women went to a dentist or dental clinic about an oral health problem.[18]" For prenatal providers, the guidance program presented five oral health questions to ask pregnant women and oral health tips to share with pregnant women. For dental providers, the guidance program recommended establishing relationships and a referral process with prenatal providers in the community. **Texas** released a training website[19], Oral Health and Dental Services for Pregnant Women, which is designed to help health workers teach pregnant women about the importance of oral health, educate on the safety of receiving oral health care during pregnancy, and to provide pregnant

[16] Disability and Health Policy Division (DHPD). UNM Center for Development and Disability. Online Course about Improving the Oral Health of Pregnant Women, Children, and Families. http://www.cdd.unm.edu/other-disability-programs/disability-health-policy/nm-oral-health.html

[17] Virginia Department of Health. Oral Health During Pregnancy: Practice Guidance for Virginia's Prenatal and Dental Providers. https://www.vdh.virginia.gov/content/uploads/sites/30/2019/03/PracticeGuideforVirginiaPrenatalDentalProvidersWEB.pdf

[18] Data source: Virginia Prams Annual Report, 2016 Suvery. https://www.vdh.virginia.gov/prams/resources/

[19] Texas Health and Human Services. Oral Health and Dental Services for Pregnant Women. https://www.txhealthsteps.com/static/courses/oral/sections/index.html

women with resources to enable them to find affordable oral health care. For each topic, there are some suggestions and case examples about how to communicate effectively with pregnant women. For example, under the "Promoting Oral Health Habits and Dental Care to Pregnant Women" topic, the webpage provided the definitions of dental caries and pregnancy gingivitis they should be familiar with and listed three example cases of past patients to encourage women to have a dental checkup.

2. **Integrating oral health into primary care for prenatal women. Many maternal health care providers are not incorporating oral health into pregnancy care.** Adam, Gregorich, Rising, Hutchison and Chung (2017) reported that in a survey of 146 practicing maternal health care provider respondents (80 obstetrician-gynecologists and 66 certified nurse-midwives in Michigan), 80% of respondents acknowledged that oral health was important for their pregnant patients. However, only 29% reported performing an oral examination on their patients because of the lack of training (23%) or not feeling competent (24%). It is important for midwives and obstetrician-gynecologists who are primary care providers to be knowledgeable about the associations between oral health and chronic conditions such as diabetes, pneumonia, and celiac disease.

The Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services developed an initiative, Integration of Oral Health and Primary Care Practice (IOHPCP) in 2014. This initiative proposed creating a "starter set" of oral health competencies and designing a system for implementing the core competencies. HRSA developed five domains (risk assessment, oral health evaluation, preventive interventions, communication and education, interprofessional collaborative practice) and each domain contains a core set of competencies. "Risk

assessment" identified the factors that impact oral health and overall health. "Oral health evaluation" integrated subjective and objective findings based on completion of focused oral health history, risk assessment, and performance of oral screening. "Preventive intervention" recognized options and strategies to address oral health needs identified by a comprehensive risk assessment and health evaluation. "Communication and education" aimed to enhance the relationship between individuals and groups (dentists and primary care providers). For example, the competencies of the preventive intervention domain are: "implement appropriate patient-centered preventive oral health interventions and strategies" and "introduce strategies to mitigate risk factors when identified".

Interprofessional education and collaborative practice could be other ways for integration. Non-dental health providers can have a key role in improving oral health. Oral health integration throughout the existing primary care curriculum goes beyond just sitting in classrooms together; interprofessional education focuses on clinical activities with team-based learning among different types of professional students, establishing networks with local dentists for help with teaching and referrals, nondental oral health champions, university and institutional leadership, internal and external funding to initiate and sustain educational activities, and the growth of large-group, multidisciplinary delivery systems (Wojtowicz, Olson, & National Academies of Sciences, Engineering, and Medicine, 2019). A collaboration between the Harvard School of Dental Medicine (HSDM) and Northeastern University resulted in a manual turned into practice with the creation of the Nurse Practitioner & Dentist (NPD) Model for Primary Care. The NPD model promotes interprofessional collaborative practice (IPCP) and interprofessional education (IPE) by integrating primary care services

provided by a nurse practitioner (NP) into an academic dental practice environment. The NPD model brings NP and dental students together in interprofessional teams that are jointly responsible for providing primary care and dental services. During supervised clinical rotations, students learn how each profession formulates diagnoses, implements preventive interventions, and makes referrals within their scopes of practice. Students also develop interprofessional plans of care under the direct supervision of NP and dental faculty (Dolce, Parker, & Da Silva, 2018).

3. **Expanding Medicaid dental coverage for women or increasing the income eligibility for Medicaid.** Pregnancy-related coverage in Medicaid should include comprehensive oral health benefits. Some form of dental coverage is available to pregnant women in 48 states and the District of Columbia. Only two states, Tennessee and Alabama, do not offer any dental coverage to pregnant women over the age of 21. However, only 22 states offering extensive dental benefits (Children's Dental Health Project, 2019). Take Virginia for example. In March 2015, Virginia expanded comprehensive dental benefits to pregnant women in its Medicaid program, while still limiting non-pregnant adults in Medicaid to medically necessary oral surgical procedures (Stohl & Chen, 2018). Furthermore, states should consider extending postpartum dental benefits from 60 days to 2 years because pregnant women have higher rates of gingival inflammation than non-pregnant women (Ranji, Gomez, & Salganicoff, 2019).

This option could also take the form of the introduction of legislation to require oral health care as a mandatory component of pregnancy-related coverage in Medicaid. Overall, this issue needs more research. Examples of current research that could be used to model a more comprehensive plan of care include:

- Expanding Medicaid with extensive dental coverage for pregnant women. A recent study, Effects of the Recent Medicaid Expansions on Dental Preventive Services and Treatments, drew a result that expanding Medicaid with extensive coverage of dental services increased the likelihood of any dental visits in the past 12 months by over 5 percentage points in 2014 and 2015 but found no evidence of an impact in expanding states providing limited coverage. There is also evidence from earlier Medicaid expansions that offering dental benefits were associated with more dental visits, reduction in untreated caries, and greater dentist participation in Medicaid (Lyu, Shane, & Wehby, 2020). Therefore, providing comprehensive dental coverage can address unmet dental needs and improve oral health long-term among low-income adults.
- Separating dental visits into prevention and treatment categories can help to understand how the ACA Medicaid expansion affects each type of the dental visit of low-income women so that the government could reallocate funds among these two types of dental services. Preventive dental service is defined as receiving a dental exam or cleaning. And treatment services including cavity fillings, inlay, crown, root canal, periodontal scaling, implant, abscess treatment, oral surgery, bridges, dentures, orthodontics, temporomandibular disorders/temporomandibular joint treatment, whitening, or tooth extraction (Lyu, Shane, & Wehby, 2020).
- Identifying the effect from increasing income eligibility for a given set of dental benefits and increasing dental benefits for those already income eligible so that the research will discern which way could increase pregnant women’s dental visit better.

Recommendation

As part of the waiver proposal, Georgia asked CMS to provide the state with full Medicaid expansion funding (i.e., covering 90% of the cost), although the state would only be implementing a partial expansion of Medicaid. A similar request from Utah was rejected by the Trump Administration earlier in 2019[20], and CMS followed the same process for Georgia: The federal government will not provide the 90% funding match for Georgia's partial Medicaid expansion, but will instead pay the state's normal federal matching rate of 67%[21]. This means it will cost Georgia more to cover the expanded Medicaid population than it would if the state were to simply expand Medicaid fully, as called for in the ACA[22].

Therefore, based on the situation that the Georgia State Government does not have ACA's enhanced federal funding now, the paper recommends that:

- Some programs should be implemented to educate graduates of midwifery programs in Georgia public universities to enhance oral health integration in their standard of care, and
- Dental and nondental oral health experts collaborate in public hospitals to increase dialogue with professional colleagues about addressing oral health access barriers and disparities for pregnant women and others across vulnerable populations.

[20] Norris, L. (2020). Utah and the ACA's Medicaid expansion. https://www.healthinsurance.org/utah-medicaid/#CMS
[21] Georgia Department of Health & Human Services. (2020). Georgia Pathways to Coverage. https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ga/ga-pathways-to-coverage-ca.pdf
[22] Norris, L. (2020). Georgia and the ACA's Medicaid expansion. https://www.healthinsurance.org/georgia-medicaid/#:~:text=Georgia%20will%20partially%20expand%20Medicaid,go%20along%20with%20full%20expansion.&text=As%20of%20May%202020%2C%2023,not%20have%20health%20insurance%20coverage.

- The Georgia Department of Community Health needs to publish the first oral health guidance for the pregnant woman who enrolled in Medicaid because Georgia does not distinguish pregnant women from other adults for the purpose of qualifying for Medicaid dental benefits. These low-income women lack knowledge on the safety of dental care during pregnancy and even don't know they have a periodontal evaluation and fluoride benefits.
- The Georgia Medicaid should extend its dental benefits to the restorative services level (fillings and root canals) because low-income pregnant women may be more responsive to seeking treatment for previously untreated dental problems right after gaining coverage and less likely to change their use of preventive services.

Conclusion

Oral health is essential to the general health and well-being of pregnant women so this paper has focused on pregnant women's access to oral health in Georgia. While the different policy options may still have their defects in the implementation process, we hope the information in this paper can help the Georgia State government better understand the importance of providing adequate oral care coverage for low-income pregnant women and consider the recommendations that may benefit low-income pregnant women in Georgia.

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