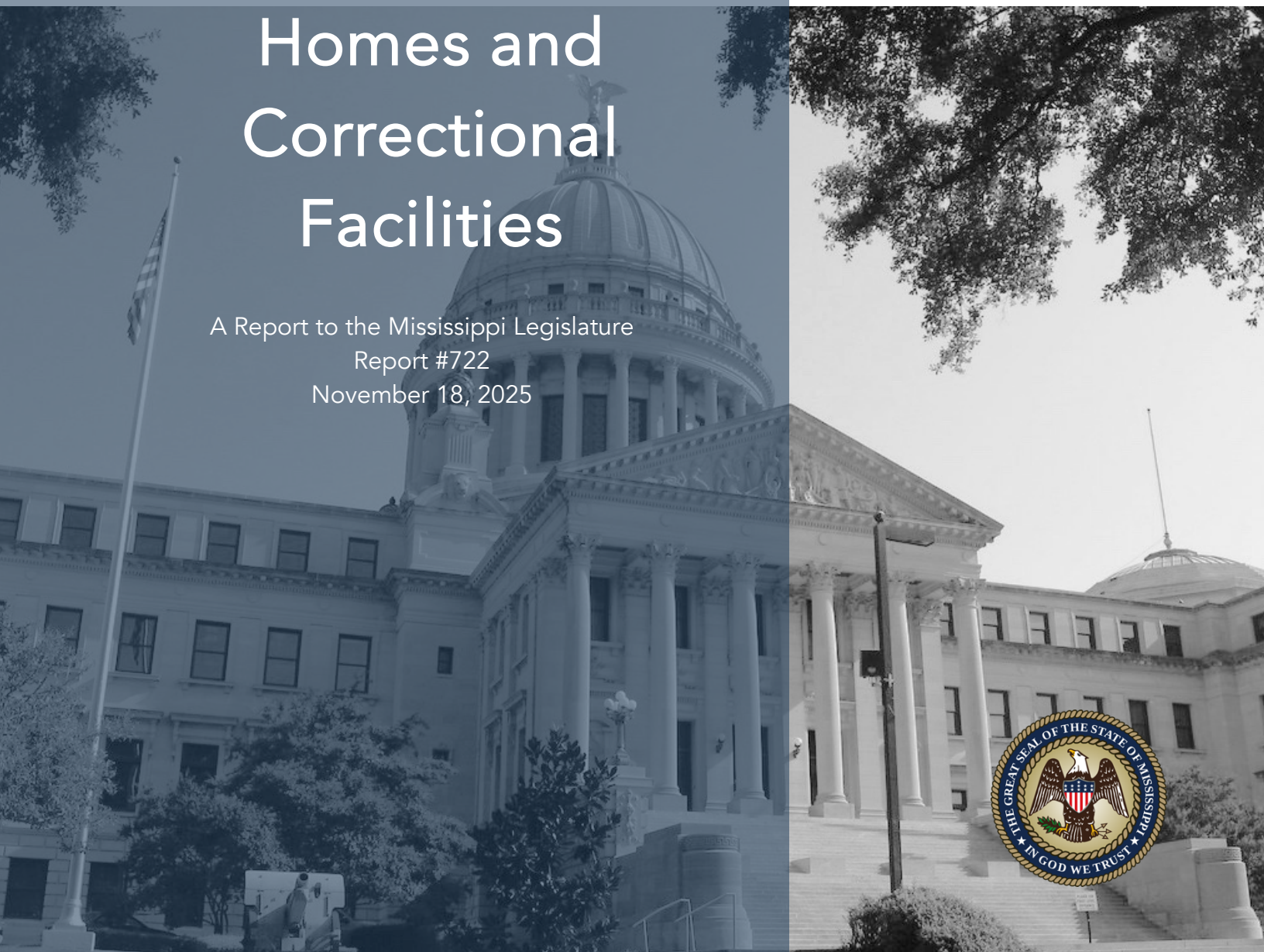
PEER MISSISSIPPI

Joint Legislative Committee on Performance Evaluation and Expenditure Review

A Review of the Provision of Routine Dental Hygiene Services in Mississippi Nursing Homes and Correctional Facilities

A Report to the Mississippi Legislature
Report #722
November 18, 2025



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Joint Legislative Committee on Performance Evaluation and Expenditure Review
PEER Committee

P.O. Box 1204 | Jackson, Mississippi 39215-1204

November 18, 2025

Honorable Tate Reeves, Governor
Honorable Delbert Hosemann, Lieutenant Governor
Honorable Jason White, Speaker of the House
Members of the Mississippi State Legislature

On November 18, 2025, the PEER Committee authorized release of the report titled ***A Review of the Provision of Routine Dental Hygiene Services in Mississippi Nursing Homes and Correctional Facilities.***

Kevin W. Felsher

Representative Kevin Felsher, Chair

This report does not recommend increased funding or additional staff.

Phone: (601) 359-1226 | Fax: (601) 359-1420 | www.peer.ms.gov
Woolfolk Building | 501 North West St, Suite 301-A | Jackson, MS 39201

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List of Exhibits

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PEER MISSISSIPPI
Joint Legislative Committee on Performance Evaluation and Expenditure Review

A Review of the Provision of Routine Dental Hygiene Services in Mississippi Nursing Homes and Correctional Facilities

Report Highlights

November 18, 2025

CONCLUSION: Receiving routine dental hygiene services leads to better oral health outcomes, reduces medical costs, and lowers the risk of developing chronic diseases. Despite the benefits of routine dental hygiene services, nursing home residents and inmates in Mississippi face barriers that affect their ability to receive routine dental care. One of the avenues to expand access to dental care could be to authorize dental hygienists to provide low-risk, routine dental services in public health settings including nursing homes and correctional facilities.

BACKGROUND

Over the course of recent decades, research has emerged establishing a link between oral health and overall health. Poor oral health leads to diseases of the mouth such as cavities and periodontal disease and increases the risk for other chronic diseases such as diabetes, cardiovascular disease, and Alzheimer's disease. Oral disease also takes an economic toll, with approximately $134 billion in direct costs expended on oral conditions in the United States in 2019, according to the World Health Organization.

One of the remedies to poor oral health, along with healthy lifestyle choices, includes routine dental care. Studies have found that receiving preventative dental care leads to better oral health, including fewer cavities, plaque buildup, and tooth loss. It also results in a lower incidence and cost of non-preventative dental care and other medical visits.

KEY FINDINGS

Provision of Routine Dental Hygiene Services in Mississippi Nursing Homes

The Mississippi State Department of Health has licensed 209 nursing homes in the state, which provide care to more than 15,000 individuals. Overall, state and federal regulations impose only limited requirements for providing routine dental hygiene care to nursing home residents.

- **61% of nursing home administrators licensed in Mississippi who responded to PEER's survey reported that 60% or fewer nursing home residents receive routine dental hygiene services at least once a year.**

  Similar results have been reported nationally, indicating that many nursing home residents go without routine dental services. Contributing factors include a lack of Medicaid coverage for dental services, a lack of dental insurance, and a shortage of dental professionals.

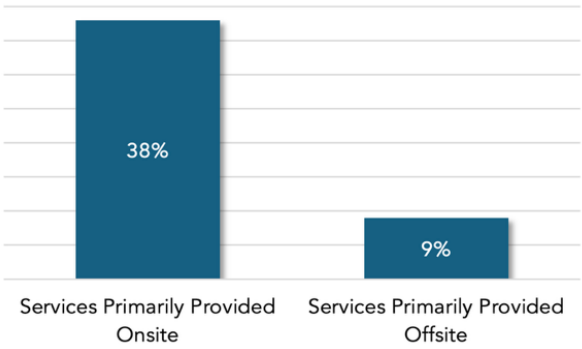
- **In Mississippi, 89% of responding nursing home administrators who confirmed that residents receive a dental assessment upon admission to the facility reported that a nurse conducts the dental assessment, compared to only 5% who reported that a dentist conducts the assessment.**

  Multiple studies and narrative reviews have concluded that nurses underreport issues with oral health when compared to assessments conducted by dental professionals.

- **Approximately 50% of responding nursing home administrators reported that dental services for nursing home residents are primarily provided offsite.**

  Nursing home residents without access to onsite dental care are less likely to receive dental services.

Percentage of Nursing Home Administrators Who Reported that More than 60% of Nursing Home Residents Receive Dental Services at Least Once a Year by Site of Service Provision



- **Some nursing facilities and residents may not be aware that the cost of dental insurance can be reduced from the residents' Medicaid liability at no cost to the resident.**

  These deductions could help allay the financial obstacles to receiving dental services.

Provision of Routine Dental Hygiene Services in Mississippi Correctional Facilities

In FY 2025, MDOC administered a correctional system comprised of 35 correctional facilities and approximately 19,000 inmates.

- **The insufficient data collection and record-keeping methods utilized by the Mississippi Department of Corrections' (MDOC) medical services contractor VitalCore do not allow for independent analysis of the adequacy of the dental care MDOC and its contractor are offering to inmates.**

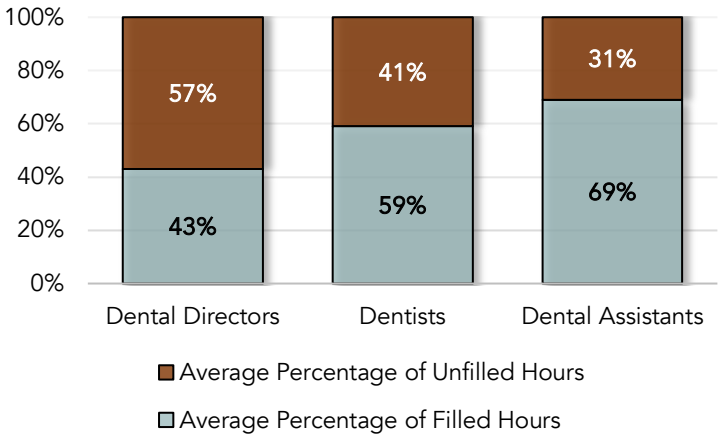
  A lack of data on the types of dental services (e.g., routine, emergency) and issues with interpreting the available data prevented PEER's analysis of the quality of dental care for inmates.

- **MDOC could produce limited documentation to PEER showing that it had completed contract monitoring activities.**

  The lack of monitoring lowers MDOC's ability to hold VitalCore accountable for providing services and increases the possibility for inmates to receive insufficient care.

- **VitalCore's staffing hours for dental professionals fell below its contractual requirements each month from January to June 2025, with unfilled staffing hours ranging from 31% to 57% across the dental positions.**

  These staffing shortages decrease the likelihood of high-quality dental care for inmates and increase the likelihood of overworking the dental professionals on staff.



Levels of Supervision for Dental Hygienists in Mississippi and Other States

- **While Mississippi does not allow dental hygienists to operate without a dentist onsite in most public health settings, 43 states do permit hygienists to practice without dentist supervision in public health settings.**

  Of the 43 states permitting direct access for dental hygienists, at least 15 states specify that hygienists may practice in nursing homes and correctional facilities.

RECOMMENDATIONS

The following provides a summary of the report recommendations. Refer to the report, beginning on page 47, for a complete list.

Improving Dental Hygiene Services in Correctional Facilities

- MDOC and VitalCore should improve their data collection system, including standardization of records, storage of data in an analyzable file format, and tracking all data points pertinent to compliance with established standards of dental care.
- MDOC should maintain documentation for all activities related to monitoring the medical services contract.
- MDOC should work with VitalCore to resolve the shortages in dental staffing.

Improving Dental Hygiene Services in Nursing Homes

- The Mississippi State Department of Health (MSDH) should educate nursing homes about permissible Medicaid patient liability deductions.
- MSDH should amend its regulations governing nursing homes to require nursing homes to arrange for a dental screening by a dental professional, arrange for dental professionals to offer training to nursing staff, and ensure availability of onsite dental care for residents who request or require it in areas of the state where onsite providers are accessible.
- MSDH should consult with the Mississippi State Board of Dental Examiners to develop oral hygiene policies that shall be incorporated in residents' care plans.

Lowering Supervision Requirements for Dental Hygienists

- The Legislature should consider amending MISS. CODE ANN. §73-9-5 (1972) to allow dental hygienists to provide low-risk, non-invasive services in public health settings under general supervision or collaborative agreement with a licensed dentist.

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November 18, 2025
For more information, contact: (601) 359-1226 | P.O. Box 1204, Jackson, MS 39215-1204
Representative Kevin Felsher, Chair | James F. (Ted) Booth, Executive Director

A Review of the Provision of Routine Dental Hygiene Services in Mississippi Nursing Homes and Correctional Facilities

Introduction

Authority

The PEER Committee, under the authority granted by MISS. CODE ANN. § 5-3-51 (1972) et seq., conducted a review of the provision of routine dental hygiene services in Mississippi nursing homes and correctional facilities.

Scope and Purpose

In conducting this review, PEER sought to:

- provide an overview of the benefits and barriers to receiving routine dental hygiene services;
- describe the regulatory environment surrounding the provision of routine dental services in Mississippi nursing homes and correctional facilities;
- determine the current process for providing and receiving routine dental hygiene services in Mississippi nursing homes and correctional facilities;
- determine if the nursing homes and correctional facilities are fulfilling their statutory mandates and abiding by best practices when providing routine dental hygiene services; and,
- compare Mississippi's laws establishing supervisory requirements for dental hygienists with the laws in other states to assess the level of clinical autonomy for dental hygienists in Mississippi and other states.

Method

To conduct this analysis, PEER reviewed:

- applicable state and federal laws and regulations;
- relevant data and documents provided by the Mississippi State Department of Health, including nursing home census numbers and compliance survey procedures; and,
- relevant data and documents provided by the Mississippi Department of Corrections, including medical services contracts, dental staffing records, and dental services logs.

PEER also:

- submitted questions and received responses from several industry experts, including the Mississippi Dental Hygienists' Association, the University of Mississippi Medical Center School of Dentistry, the Special Care Dentistry Association, and others, regarding best practices for providing services to nursing home residents and/or inmates;

Method (cont.)

- created and conducted a survey to nursing home administrators licensed in Mississippi;
- obtained the number of graduates from dental and dental hygiene programs in Mississippi for the past 10 years;
- completed 50-state reviews of nursing home regulations, dental hygienist supervision levels, and frequency of routine dental care in correctional facilities; and,
- researched academic studies for evidence related to the benefits of and barriers to routine dental hygiene services in nursing homes and correctional facilities.

Overview of the Benefits and Barriers to Routine Dental Hygiene Services

Over the course of recent decades, research has emerged establishing a link between oral health and overall health. The importance of preserving oral health elevates the role that dental care can play in protecting individuals' overall health and wellbeing. Routine dental hygiene services offer one of the first lines of defense in sustaining a healthy mouth. The level of need and access to routine dental hygiene services differs among people groups, which introduces special considerations for vulnerable populations like nursing home residents and incarcerated individuals.

Overall Benefits and Barriers to Routine Dental Hygiene Services

Maintaining oral health promotes healthy teeth, enhances quality of life, and reduces the risk of developing chronic diseases. One of the keys to maintaining a healthy mouth involves reception of routine dental services, which have been shown to produce better health outcomes and generate cost savings. According to the National Institutes of Health and the National Conference of State Legislatures, some of the most common barriers to receiving dental care include low income, racial and ethnic minority status, and rurality.

Link Between Oral Health and Overall Health

In its comprehensive 2021 report *Oral Health in America*, the National Institutes of Health (NIH) concluded that oral health plays a vital role in individuals' physical, mental, social, and economic well-being, with implications for people's ability to communicate, take in nutrients, and make a good impression. A sizable corpus of academic studies corroborates NIH's conclusion, backed by evidence linking oral health to overall health.

The definition of *routine dental hygiene* used throughout this report, as adapted from MISS. CODE ANN. § 73-9-5 (1975), is preventive care services typically performed by a dental hygienist including, but not limited to, cleaning and polishing teeth.

Maintaining oral health promotes healthy teeth, enhances quality of life, and reduces the risk of developing chronic diseases. Poor oral health, on the other hand, can lead to diseases of the mouth such as cavities and periodontal disease and increases the risk for other chronic diseases such as diabetes, cardiovascular disease, and Alzheimer's disease. Although direct causation between oral and chronic diseases has been difficult to establish, researchers have found a distinct correlation between the two types of ailments, likely due to their shared features of inflammation, bacterial presence, and a weakened immune system.

Along with the detriments to physical health, oral diseases also take an economic toll, with an estimated $134 billion in direct costs expended on oral conditions in the United States in 2019 according to the World Health Organization. Accounting for indirect costs such as missed workdays, lowered productivity, and premature mortality would put the economic burden even higher.

In order to prevent the negative effects of oral disease, experts recommend a series of lifestyle choices to preserve oral health. These practices include abstaining from tobacco, drinking less alcohol, avoiding sugary foods and drinks, and practicing daily hygiene tasks such as brushing and flossing one's teeth. Another major component of oral care is routine dental appointments, which have been found to lead to better health outcomes and cost savings.

Benefits of Routine Dental Services

A systematic review of longitudinal studies performed in Australia, Brazil, China, New Zealand, and Sweden identified quality evidence demonstrating that regular dental attendance is associated with fewer cavities, fewer missing teeth, and better oral health-related quality of life.[1] Other studies have reached similar conclusions, finding that professional dental hygiene treatment reduces plaque, gingivitis, cavities, and tooth loss.[2]

Routine or preventive dental treatment has also been found to lower the incidence and cost of non-preventive (e.g., restorative, prosthodontic) dental care and other medical visits. Two retrospective studies on Medicaid expenditures published in 2018 and 2022 found that preventive dental visits were associated with lower instances of non-preventive treatment and lower total dental expenditures.[3] Another two studies published in 2022 similarly determined that preventive dental visits resulted in lower overall healthcare costs for Medicaid enrollees with diabetes or coronary heart disease.[4]

Although the academic literature offers conclusive findings on the positive effects of routine dental visits on oral and overall health outcomes, research on the ideal frequency of dental visits is less definitive. The traditional recommendation that all adults should attend a routine dental visit every six months has not been substantiated through academic studies. Multiple systematic reviews of

[1] Aina Najwa Mohd Khairuddin, et al., "Impact of Dental Visiting Patterns on Oral Health: A Systematic Review of Longitudinal Studies," *BDJ Open*, 10, 18 (2024).

[2] Elena Figuero, et al., "Mechanical and Chemical Plaque Control in the Simultaneous Management of Gingivitis and Caries: A Systematic Review," *Journal of Clinical Periodontology*, 44, 18 (2017); Soren Jepsen, et al., "Prevention and Control of Dental Caries and Periodontal Diseases at Individual and Population Level: A Consensus Report of Group 3 of Joint EFP/ORCA Workshop on the Boundaries Between Caries and Periodontal Diseases," *Journal of Clinical Periodontology*, 44, 18 (2017); W.V. Giannobile, et al., "Patient Stratification for Preventive Care in Dentistry," *Journal of Dental Research*, 92, 8 (2013); Attawood Lertpimonchai, et al., "The Association Between Oral Hygiene and Periodontitis: A Systematic Review and Meta-Analysis," *International Dental Journal*, 67 (2017).

[3] Naderah Pourat, Moonkyung Kate Choi, and Xiao Chen, "Evidence of Effectiveness of Preventive Dental Care in Reducing Dental Treatment Use and Related Expenditures," *Journal of Public Health Dentistry*, 78, 3 (2018); Heather Taylor, et al., "Does Preventive Dental Care Reduce Nonpreventive Dental Visits and Expenditures among Medicaid-Enrolled Adults?," *Health Services Research*, 57, 6, (2022).

[4] Ira B. Lamster, et al., "Preventive Dental Care is Associated with Improved Health Care Outcomes and Reduced Costs for Medicaid Members with Diabetes," *Frontiers in Dental Medicine* (2022); Bijan J. Borah, et al., "Association Between Preventive Dental Care and Healthcare Cost for Enrollees with Diabetes or Coronary Artery Disease: 5-Year Experience," *Compendium of Continuing Education in Dentistry*, 43, 3 (2022).

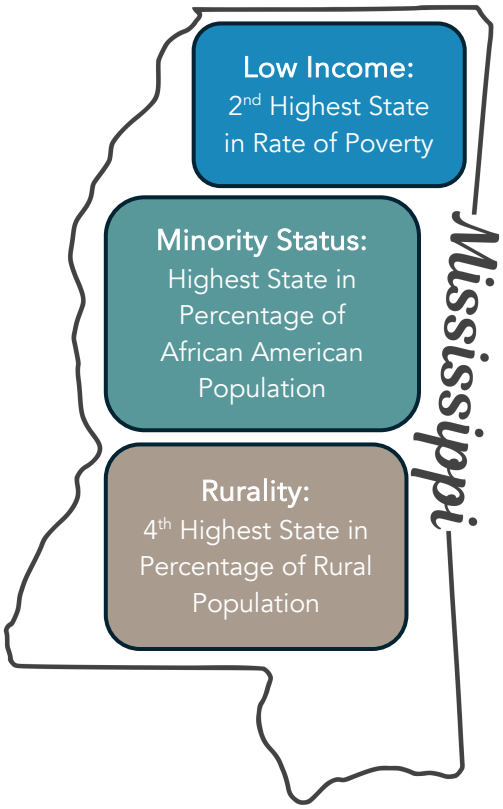
studies related to dental visit frequency have concluded that there is little to no evidence supporting the efficacy of six-month dental visits over yearly or biennial visits.[5]

Instead of setting a universal six-month standard, researchers advise dentists to create personalized treatment plans for their patients based on their unique health conditions, risk factors, and medical histories. Risk factors that may warrant more frequent routine dental appointments include preexisting oral diseases, tobacco usage, high-sugar diet, excessive alcohol consumption, diabetes, and certain genetic variations.

Common Barriers to Accessing Dental Services

According to NIH and the National Conference of State Legislatures, three factors that contribute to disparities in access to dental care include low income, racial and ethnic minority status, and rurality. Individuals who fall into these demographic categories experience poorer oral health outcomes than their counterparts, resulting primarily from lack of access to dental providers and an inability to afford services. Since Mississippi contains a comparatively high population in each of these demographic categories according to US Census Bureau data, citizens of the state have a greater likelihood of facing barriers to dental care.

Exhibit 1: Mississippi Rankings in Demographics Associated with Low Access to Dental Care



SOURCE: PEER analysis of US Census Bureau data as reported by the US Census Bureau and the Kaiser Family Foundation.

[5] Patrick Fee, et al., "Recall Intervals for Oral Health in Primary Care Patients," *Cochrane Database of Systematic Reviews*, 10 (2020); Seena Patel, R Curtis Bay, and Michael Glick, "A Systematic Review of Dental Recall Intervals and Incidence of Dental Caries," *Journal of American Dental Association*, 141, 5 (2010); National Institute for Health and Care Excellence, "2020 Exceptional Surveillance of Dental Checks: Intervals Between Oral Health Reviews (NICE Guideline CG19)," NICE (2020).

Oral Health and Barriers to Dental Care for Nursing Home Residents

Due to their age and physiological frailty, nursing home residents live with a higher risk and prevalence of oral diseases. Some of the hindrances to accessing professional dental care include residents' resistance to services, cost of services, difficulty in making visits to dentists, and unavailability of dentists who provide services onsite at the facility.

Oral Health Condition of Nursing Home Residents

The population of adults aged 65 and older is one of the fastest growing demographics worldwide. According to data from the 2020 United States (US) census, approximately 1 in 6 citizens are 65 years or older, with projections forecasting the number to rise to 1 in 5 by 2030.

Due to improvements in oral health in recent decades, NIH reports that older adults are more likely to retain their natural teeth than previous generations, with rates of tooth loss (i.e., edentulism) in the US declining from 50% in the 1960s to 13% in 2014. However, even with advancements in oral health, older adults remain at high risk for oral diseases, including tooth decay, gum disease, and oral cancer. According to NIH, about 80% of older Americans live with at least one chronic disease, which can lead to physical and cognitive impairments that affect their ability to provide oral self-care. Another leading factor that contributes to oral health issues for older adults is lowered saliva production, or xerostomia, which is a common development of aging and a side effect of many medications.

Already predisposed to many of the conditions that bear negatively on oral health, nursing home residents—the majority of whom fall in the 65 and older age group—fare poorly in assessments of oral hygiene. A screening survey in North Dakota, for example, determined that 34% of all nursing home residents needed early or urgent dental care.[6] In North Carolina, a random sample of nursing home residents revealed high levels of plaque on residents' teeth and dentures as well as mild gingival irritation.[7] A 2019 systematic review of oral health among older institutionalized residents similarly concluded that the institutionalized elderly population was at increased odds for poor oral health across a variety of assessment metrics.[8]

Common Barriers to Accessing Dental Services for Nursing Home Residents

Though nursing home residents face a higher probability of developing oral conditions, residents do not always receive regular dental services. While percentages vary by research parameters and location, a systematic review of the academic literature in the United States and other nations found that 20% to 75% of nursing home residents had a dental visit within the past 12 months, with even fewer visiting the dentist more than once per year.[9] Some of the hindrances to accessing

[6] Center for Rural Health, "Dental Screenings and Daily Care for North Dakota nursing Home Residents: A Promising Practice," University of North Dakota School of Medicine and Health Services (2018).
[7] Sheryl Zimmerman, et al., "Readily Identifiable Risk Factors of Nursing Home Residents' Oral Hygiene: Dementia, Hospice, and Length of Stay," *Journal of American Geriatric Society*, 65, 11 (2017).
[8] Florence M. F. Wong, Yannies T. Y. Ng, and W. Keung Leung, "Oral Health and its Associated Factors Among Older Institutionalized Residents—A Systematic Review," *International Journal of Environmental Research and Public Health*, 16 (2019).
[9] Ibid.

professional dental care include residents' resistance to services, cost of services, difficulty in making visits to dentists, and unavailability of dentists who provide services onsite at the facility.

Oral Health and Barriers to Dental Care for Inmates

The oral health condition of inmates is generally worse than the noninstitutionalized population. Though incarceration may increase access to dental services for some inmates, the lack of legal standards and national data on inmates' dental health limits public knowledge about the condition of correctional dental services.

Oral Health Condition of Inmates

According to the Bureau of Justice Statistics, the number of individuals incarcerated under state and federal correctional authorities in the US totaled 1.3 million at the end of 2023. Following the trend of the broader population, the population of incarcerated adults is aging rapidly.

The oral health status of inmates is generally worse than the noninstitutionalized population. Inmates' poor oral health stems from a series of risk factors that increase the probability of oral disease. For one, a significant proportion of inmates come from low socioeconomic backgrounds, which hinders access to dental care prior to incarceration. Inmates also demonstrate high rates of substance abuse, psychological disorders, and chronic and communicable diseases—all of which yield unfavorable consequences for oral health. As a result, NIH reports that inmates have higher rates of tooth decay, worse periodontal health, and a higher prevalence of urgent dental needs than the noninstitutionalized population.

Common Barriers to Accessing Dental Services for Inmates

For some inmates, the access to dental services afforded through the correctional system provides the first dental care they have ever received. While inmates have the benefit of access to dental services, the quality of those services may be lacking. The federal standard for the quality of medical care requires that inmates should merely be free from "deliberate indifference" to their medical needs. States can impose more specific policies of their own, but the focus of those policies is often on emergent rather than preventive needs.

Another hindrance to assessing the quality of care for inmates is the lack of data on the oral health of incarcerated individuals. Inmates are excluded from most nationally representative datasets such as the National Health Interview Survey, and there are limited alternative datasets from which to draw conclusions about the incarcerated population. Without adequate data to guide policymakers' decisions, inmates' dental needs may go unnoticed and underserved.

Provision of Routine Dental Hygiene Services in Mississippi Nursing Homes

More than 15,000 individuals reside in one of Mississippi's 209 nursing homes. The provision of routine dental hygiene services to Mississippi nursing home residents is currently limited due to a variety of factors, as discussed in the chapter below.

Overview of Mississippi Nursing Homes

The Mississippi State Department of Health has licensed 209 nursing homes in the state, 96% of which are certified to receive compensation through Medicare and/or Medicaid. Mississippi's nursing homes provide care, on average, to more than 15,000 individuals.

Mississippi contains 209 licensed nursing homes distributed across every county of the state except for Issaquena County. Though the number of residents can fluctuate from month to month, Mississippi's nursing homes provide care, on average, to more than 15,000 individuals.

See Exhibit 7 on page 19 for a map of Mississippi's nursing home facilities in relation to counties designated by the US Health Resources and Services Administration as health professional shortage areas for dental providers.

Exhibit 2: Mississippi Nursing Home Certification Status as of September 2025

Certification Status	Number of Nursing Homes
Dually Medicare and Medicaid-Certified	172
Medicaid-Certified Only	23
Medicare-Certified Only	6
State Licensure Only	8

SOURCE: PEER analysis of the Mississippi State Department of Health facility directory.

Nursing homes in Mississippi are licensed through the Mississippi State Department of Health's (MSDH) Division of Health Facilities Licensure and Certification. As the state survey agency, MSDH also verifies compliance with federal regulations for nursing homes that participate in Medicare or Medicaid programs through the Centers for Medicare and Medicaid Services (CMS).

As shown in Exhibit 2 on page 8, while most nursing homes in the state are either Medicare or Medicaid-certified, eight nursing homes, do not participate in the CMS programs and are considered state licensure only facilities.

Appendix C on pages 53-59 contains a complete list of Mississippi nursing homes.

Medicare and Medicaid-Certified Facilities

CMS provides insurance coverage for two different types of facilities that offer nursing services: skilled nursing facilities covered under Medicare and non-skilled nursing facilities covered under Medicaid. MSDH classifies the facilities according to their Medicare and Medicaid certification status, which means that Mississippi contains 172 dually skilled and non-skilled facilities, 23 non-skilled nursing facilities, and 6 skilled nursing facilities. Both types of facilities must be licensed and certified by the state survey agency, i.e., MSDH.

Skilled Nursing Facilities

A skilled nursing facility provides transitional rehabilitative care for patients after release from the hospital with the ultimate goal of enabling the patients to return home. Skilled nursing care must be provided by or under the direct supervision of licensed health professionals, such as registered nurses (RNs), licensed practical nurses (LPNs), speech-language pathologists, physical therapists, and occupational therapists.

Medicare Part A covers all or part of the cost for skilled nursing facility care for up to 100 days for eligible recipients who meets certain qualifying conditions (e.g., has a qualifying inpatient hospital stay). To be eligible for Medicare, individuals must be 65 or older, disabled, diagnosed with end-stage renal disease, or diagnosed with ALS. With Medicare coverage, the patient pays the following based on the length of his or her stay at the skilled nursing facility:

- Days 1-20: $0;
- Days 21-100: $209.50 per day; and,
- Days 101 and beyond: all costs.

If the patient still requires nursing home services after Medicare coverage ends, the individual may pay privately or transition into a longer-term facility.

Non-Skilled Nursing Facilities

While a skilled nursing facility is intended for a short-term stay, a non-skilled nursing facility serves as a more permanent residence for individuals in need of long-term care. Non-skilled nursing facility care is provided mostly by LPNs and nurse aides under the supervision of an RN and includes assistance with everyday activities such as dressing, bathing, and eating.

Medicare continues to pay for the medical needs of beneficiaries residing in non-skilled nursing facilities, but it does not cover the overall cost of care in the facility. To bridge the coverage gap, Medicaid helps to pay for non-skilled nursing facility services when other payment options are unavailable and the individual is eligible for the Medicaid program based on monthly income and personal resources. With certain exclusions for property and possessions, individuals must have $4,000 or less in total resources and a monthly income less than the private pay rate of the nursing facility to be eligible for Medicaid benefits.

State Licensure Only Facilities

The eight state licensure only facilities in Mississippi include one proprietary nursing home, two non-profits, and five state veterans homes. Residents in these nursing homes rely on alternative

means of payment to cover the cost of their care, such as private pay, long-term care insurance, or assistance from the US Department of Veterans Affairs (VA).

State Veterans Homes

Unique among Mississippi's nursing homes, the state veterans homes operate under the administration of the Mississippi Veterans Affairs Board (VAB) and the broader jurisdiction of the federal VA. Mississippi's VAB staffs and oversees the facilities while the federal VA certifies the state veterans homes, conducts annual site visits, and pays a per diem for each resident's care. Residents must contribute a daily charge for their care, which ranges from $75 to $85 depending on the facility, but veterans with a service-connected disability rating of 70% or greater face no extra charge unless they reside in a single-occupancy room. The spouses of veterans residing in a state veterans home may be admitted into the facility at a higher rate of $215 per day.

In addition to these federal and resident contributions, the state of Mississippi also assists with the cost of operating the homes. In fiscal year (FY) 2026, VAB received $6.4 million in state funds for operating expenses and salaries, including contractual obligations and supplies, for the state veterans homes.

Cost of Nursing Home Care

According to an extensive cost of care survey conducted by the financial company Genworth, the annual median cost for a semi-private nursing home room in the United States totaled $111,000 in 2024.[10] The annual median cost reported for Mississippi was slightly higher, at $116,000.

Estimates from the Mississippi Health Care Association and a PEER-conducted survey to Mississippi-licensed nursing home administrators, which will be discussed later in this report, suggest that as many as 80% of residents in Mississippi rely on Medicaid to cover the cost of nursing home services. Other means for covering the cost of care include private pay, long-term care insurance, VA benefits, and Medicare.

All but eight of the nursing homes in Mississippi are privately or locally operated and funded. The only state-operated facilities identified by MSDH staff include the five state veterans homes and the three Jaquith Nursing Home facilities located within the Mississippi State Hospital. These state facilities function through a combination of state and non-state funds. The non-state funds include federal VA per diem payments allotted to the state veterans homes and Medicaid compensation paid to the Jaquith Nursing Homes. On the state funding side, the amount appropriated from the General Fund included $6.4 million for operating expenses for the state veterans homes in FY 2026 and $19.8 million for a range of care services for the Jaquith Nursing Home facilities in FY 2025.

[10] Genworth Financial, Inc. is a Fortune 500 company focused on empowering families to navigate the aging journey. Genworth provides guidance, products, and services that help people understand their caregiving options and fund their long-term care needs. The company has been conducting a cost of care survey since 2004. To complete the 2024 cost of care survey, Genworth and its affiliate CareScout contacted more than 140,000 long-term care providers nationwide to complete more than 15,000 surveys for nursing homes, assisted living communities, adult day health facilities, and home care providers from July to December 2024.

Regulatory Environment for Dental Care in Mississippi Nursing Homes

In Mississippi, state licensure only nursing homes must adhere to state regulations, while nursing facilities that receive Medicare or Medicaid funding must adhere to both state and federal regulations. Overall, the state and federal regulations impose only limited requirements for providing routine dental hygiene care to nursing home residents. As the licensing agency, MSDH is responsible for conducting onsite surveys (i.e., inspections) to ensure that the facilities maintain regulatory compliance.

State Regulations for Nursing Homes

MISS. CODE ANN. Section 43-11-13 (1972) instructs MSDH to adopt, amend, promulgate and enforce rules, regulations, and standards for nursing homes in the state. MSDH's regulations establish comprehensive standards that facilities must meet to ensure the safety and wellbeing of their residents. These standards include requirements for proper sanitation, staffing ratios, amenities, record-keeping, medical services, and resident activities, among others. All nursing homes in Mississippi—both state licensure only and Medicare and Medicaid-certified facilities—must provide reasonable evidence of the ability to comply with MSDH's standards in order to obtain a license.

MSDH's regulations do not contain any specific mandates related to the provision of dental services. The only standard pertaining to the oral health of residents stipulates that each resident shall receive assistance as needed with activities of daily living, including personal and oral hygiene.

Federal Regulations for Medicare and Medicaid-Certified Nursing Homes

The regulations governing Medicare and Medicaid-certified nursing facilities are contained in 42 C.F.R. Part 483, Subpart B. Similar to Mississippi's state regulations, the federal regulations outline a comprehensive set of standards pertaining to facility operations and resident well-being, ranging from the provision of daily services to specifications for the physical environment. Facilities must meet the requirements detailed in the federal regulations in order to participate in the Medicaid and Medicare programs and are subject to review for compliance of the requirements by the state survey agency—a role held by MSDH in Mississippi.

The federal regulations contain slightly different requirements for skilled and non-skilled nursing facilities regarding the provision of dental care. Both types of facilities must fulfill the following responsibilities:

- provide or obtain emergency dental services (e.g., services to treat acute oral pain or broken or damaged teeth);
- promptly refer residents with lost or damaged dentures for dental services; and,
- assist the resident in making appointments and arranging transportation to and from dental services locations, if necessary or requested.

While skilled facilities must additionally provide or obtain routine dental services for residents, non-skilled nursing facilities must only provide or obtain routine dental services to the extent covered under the state Medicaid plan.

Based on the definitions established by federal regulation and CMS guidance, the requirements for skilled and non-skilled nursing facilities to provide routine dental services are limited in Mississippi for two main reasons. First, because residents must transition out of skilled nursing facilities after 100 days unless they pay the full cost of the facility's services, a skilled nursing facility would not be required to provide routine dental services under CMS's definition—i.e., an annual examination and cleaning—except for services requested by the resident or under rare circumstances when a resident pays the full cost for facility care extending beyond 100 days. Secondly, the stipulation requiring non-skilled nursing facilities to provide routine dental services to the extent covered under the state Medicaid plan does not apply because Mississippi's Medicaid plan does not cover routine dental services for adults.

> In its guidance document for facility inspectors, CMS defines routine dental services as an annual inspection of the oral cavity for signs of and diagnosis of disease, dental radiographs as needed, dental cleaning, fillings, denture adjustments, smoothing broken teeth, and limited prosthodontic procedures.

In sum, federal regulations mandate that skilled and non-skilled nursing facilities in the Medicaid and Medicare programs provide emergency dental services and transportation to dental services upon request, but they do not require the facilities to plan and effectuate routine dental hygiene services for each resident.

MSDH Survey Process

To fulfill MSDH's duties as the licensing and certifying agency for nursing homes, MSDH staff conducts annual onsite surveys, i.e., inspections, to ensure compliance with state and federal regulations. All nursing homes receive an annual state survey, and CMS-certified facilities receive an additional survey pertaining to federal regulations every 11 to 15.99 months. MSDH tries to complete the surveys concurrently for facilities receiving both the state and the federal survey.[11]

All surveys occur unannounced. The surveys entail a comprehensive review of the nursing homes, including an evaluation of resident care, medication administration, kitchen sanitation, medical waste disposal, and financial records. Surveyors complete interviews with a selected sample of nursing home residents, observe the residents' health status, and review facility records.

The survey process typically lasts a week, beginning with onsite fieldwork conducted by a team of four to five MSDH nurse surveyors and concluding with a written report of the surveyors' findings. If the surveyors' report reveals deficiencies, the nursing home must respond with a plan of corrective action within ten calendar days. If the facility has repeated findings of deficiencies, the facility will enter a deficiency period where corrective action must be taken.

In addition to the annual surveys, MSDH also conducts site visits in response to complaints. MSDH staff triages complaints based on a tiered system determined by the severity of the complaint. A complaint determined to be a case of immediate jeopardy where the resident is at risk of injury, abuse, or neglect will receive first priority. Surveyors may enter the facility at all times of the day or night to assess how the facility is functioning.

[11] The monitoring of state veterans homes' compliance with VA regulations falls under separate federal VA jurisdiction and thus did not fit within the purview of this review.

According to MSDH staff, nursing homes are rarely cited for deficiencies in providing dental care. Though dental care is part of the survey process and covered under two CMS-designated compliance codes, MSDH reported that only one facility has been cited under these codes from 2021 to 2025. Deficiencies in activities of daily living such as grooming and tooth brushing are more common.

Overview of Dental Services in Mississippi Nursing Homes

There are no uniform procedures for providing dental services to nursing home residents in Mississippi. The method and frequency of dental services vary by nursing home and may be affected by certain impediments that hinder accessibility to services such as a lack of Medicaid coverage, lack of dental insurance, and lack of onsite services.

Input from Professional Organizations and Institutions

PEER contacted several professional organizations and institutions with expertise in nursing home administration or dental care over the course of its review, including the following:

- MSDH Division of Health Facilities Licensure and Certification;
- Mississippi Dental Association;
- Mississippi Dental Hygienists' Association;
- Mississippi Health Care Association;
- Mississippi State Board of Dental Examiners;
- Mississippi State Board of Nursing Home Administrators;
- University of Mississippi Medical Center School of Dentistry;
- Independent Nursing Home Association; and,
- Special Care Dentistry Association.

These expert organizations provided insight into the process, best practices, and standards for providing routine dental hygiene services in nursing homes.

Survey to Mississippi Nursing Home Administrators

To further assess the process and frequency of providing routine dental hygiene services in Mississippi nursing homes, PEER sent a digital survey to all Mississippi-licensed nursing home administrators (NHAs) with the assistance of the Mississippi State Board of Nursing Home Administrators. The survey contained a total of 27 possible questions, with some questions programmed to skip if inapplicable based on respondents' answers to preceding questions. Out of approximately 405 NHAs, PEER received 93 anonymized responses over a two-week span, resulting in a 23% response rate.

There are some limitations to these survey results. First, the responses represent less than a quarter of NHAs and thus cannot be taken to reflect the majority perspective of NHAs. Secondly, some nursing facilities employ more than one licensed NHA, either as assistant administrators or in other

staff positions, which could result in multiple responses from the same facility. Lastly, not all licensed NHAs are currently working in a Mississippi nursing facility.[12] Although PEER outlined the survey's intent to review the provision of dental services in Mississippi nursing homes and all the questions targeted that topic, the possibility exists that errant responses could have been submitted.

Taking the survey's limitations under advisement, PEER's interpretation of the survey results is all corroborated by national trends, the statements of other experts in the field, or both. The NHA survey responses offer supporting, not solitary, evidence for the findings outlined in the following sections.

Summary of the Process for Providing Dental Services to Nursing Home Residents

Based on the responses PEER obtained from industry experts, there are no uniform procedures for providing dental services to nursing home residents in Mississippi. Some nursing homes offer services onsite while others primarily offer transportation to offsite locations. Some nursing homes initiate the scheduling of dental appointments while others arrange appointments only upon request. A few facilities have a dedicated room for dental services and a dentist on staff, but most facilities do not. Overall, without explicit requirements outlined in state or federal regulations for the provision of routine dental services, nursing homes currently function autonomously and diversely in their methods for arranging residents' dental services.

Extent of Routine Dental Care for Nursing Home Residents

Similar to the percentages of dental visits recorded among nursing home residents in the United States and other nations, 61% of nursing home administrators licensed in Mississippi responding to PEER's survey reported that 60% or fewer nursing home residents receive routine dental hygiene services at least once a year. Some of the leading factors that contribute to residents not receiving routine dental hygiene services include a lack of Medicaid coverage for dental services, a lack of dental insurance, and a shortage of dental professionals. Leaving oral health unattended can lead to several negative consequences for residents' oral health, overall health, and social wellbeing.

As discussed in the first chapter, many nursing home residents across the nation and around the globe go without routine dental services. Medicare does not cover dental services, so nursing home residents must secure other means of affording routine dental care, whether through alternate insurance options or out-of-pocket payments. Shortages in dental providers, especially those able and willing to see geriatric patients, create another obstacle for residents' accessibility to dental services.

Amidst these obstacles to accessing dental care, nursing home residents are more likely to exhibit risk factors, such as chronic disease and lowered saliva production, that make them susceptible to oral disease and more inclined to need dental care. While dental professionals tailor the frequency

[12] A small percentage of respondents indicated that they work in an Intermediate Care Facility for Individuals with Intellectual Disabilities. The federal regulations for the provision of dental services in these facilities are stricter than for nursing homes, so these responses would skew toward higher rates of service provision rather than fewer rates of service provision.

of dental appointments based on the unique needs of each patient rather than establishing a set frequency for all patients, experts in the field, including the Association of State and Territorial Dental Directors, Mississippi Dental Hygienists' Association, and the Centers for Disease Control and Prevention, advise that older adults should receive a dental checkup at least once a year. Taking into account the compounding risk factors that make nursing home residents vulnerable to poor oral health, residents may need professional dental care more than once a year.

A lack of routine dental hygiene services can lead to several negative consequences for nursing home residents, including a decline in oral health, overall health, and social wellbeing. Leaving oral health unattended increases the likelihood of tooth loss, tooth decay, weight loss, difficulty communicating, disease progression, and undiagnosed ailments.

The following sections examine the three main barriers to accessing routine dental care for nursing home residents in Mississippi, which include a lack of Medicaid coverage for adults, a lack of dental insurance, and a shortage of dental professionals.

Lack of Medicaid Dental Coverage for Adults in Mississippi

While states are required to provide dental benefits to children covered by Medicaid and the Children's Health Insurance Program (CHIP), they have flexibility to determine what, if any, dental benefits are provided to adult Medicaid enrollees. Because the states determine their own policies for Medicaid dental coverage for adults, the scope of coverage varies by state. Many states offer a comprehensive range of diagnostic, restorative, and preventive services while a few states, like Mississippi, only offer coverage for emergency services such as extractions and problem-focused evaluations.

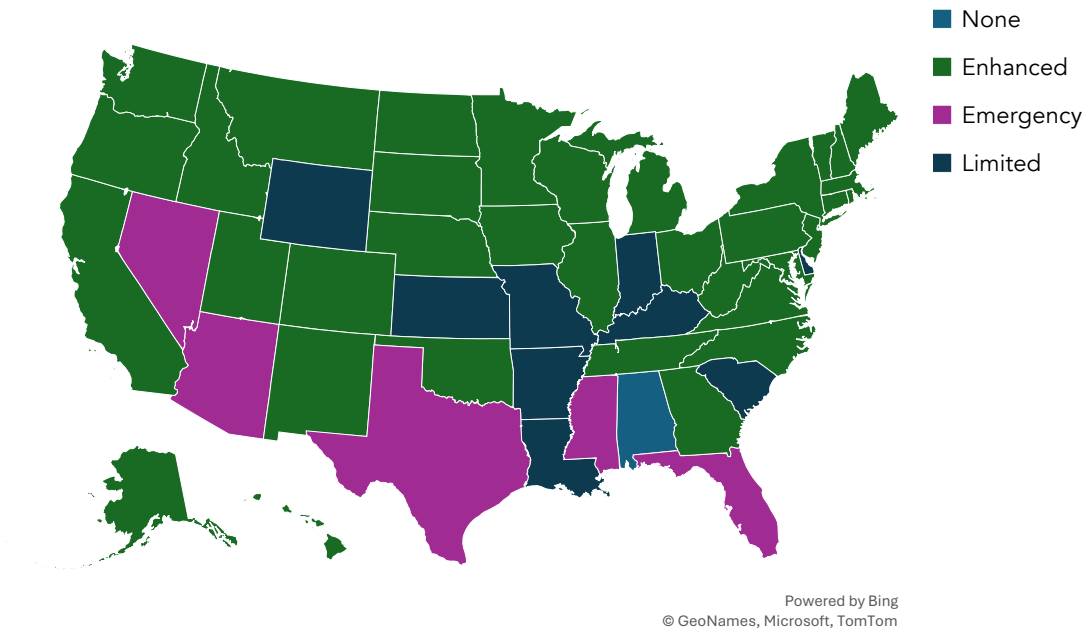
In 2024, the American Dental Association Health Policy Institute (HPI) concluded that 41 states offered limited or enhanced dental coverage for Medicaid adult enrollees while the remaining nine states, including Mississippi, offered no coverage or emergency-only coverage. In 2024 and 2025, Georgia, Missouri, and Utah expanded their dental coverage, raising the number of states with limited or enhanced coverage to 44. As shown in Exhibit 3 on page 16, based on HPI's analysis and recent state actions to increase coverage, Mississippi joins Alabama, Arizona, Florida, Nevada, and Texas as the only six states that do not offer non-emergency dental coverage to adult Medicaid enrollees.[13]

Some states implement unique coverage policies for certain enrollee groups that exceed the benefits offered to the general adult population. According to the CareQuest Institute for Oral Health—a nonprofit oral health advocacy group—21 states, not including Mississippi, offer enhanced dental coverage to specific beneficiaries, including pregnant adults, adults utilizing long-term care, and adults with intellectual or developmental disabilities.

> Arizona is the only state offering emergency-only Medicaid dental coverage to the general adult population while offering broader coverage to nursing home residents.

[13] Louisiana offers denture services to the adult Medicaid population but no other diagnostic, restorative, or preventive services.

Exhibit 3: Medicaid Coverage for Adult Enrollees



Note: PEER estimated the coverage levels for the states that recently expanded coverage, i.e., Georgia, Missouri, and Utah. All other coverage assignments come from the Health Policy Institute.

SOURCE: PEER analysis of data from the Health Policy Institute and recent state legislative action.

Finally, according to data published by CareQuest in 2024 and recent state actions to increase coverage, Mississippi is one of only twelve states that does not provide denture services to the adult Medicaid population. Of the twelve states that do not provide dentures to the general adult population, three states (i.e., Arizona, Missouri, New Hampshire) provide coverage of denture services for nursing home residents only.[14] Overall, the lack of Medicaid coverage for adult enrollees resulted in 71% of nursing home administrators who responded to PEER's survey identifying the lack of Medicaid coverage as a moderate or major barrier to the provision of routine dental services in nursing homes.

Extending diagnostic, restorative, and preventive dental services to the adult Medicaid population in Mississippi would cost an estimated $2.6 million to $2.9 million annually. The lower-end estimate is based on the per capita cost incurred by the expansion of dental services in Georgia in 2024, adjusted for Mississippi's federal medical assistance percentage (i.e., FMAP, or the federal share of Medicaid costs based on each state's per capita income compared to the national average).[15] The higher-end estimate comes from an analysis conducted by HPI in 2021 on the net costs for each state to expand dental coverage.

[14] The cost for dentures is an allowable deduction from nursing home residents' Medicaid patient liability in Mississippi.
[15] Georgia provides the best comparison for Mississippi because it is one of two non-Medicaid expansion states to extend dental coverage to adult enrollees in the past two years. The other non-Medicaid expansion state to increase dental coverage—Tennessee—offers a less useful comparison because it expanded from no coverage to enhanced coverage while Georgia expanded from emergency-only coverage to enhanced coverage.

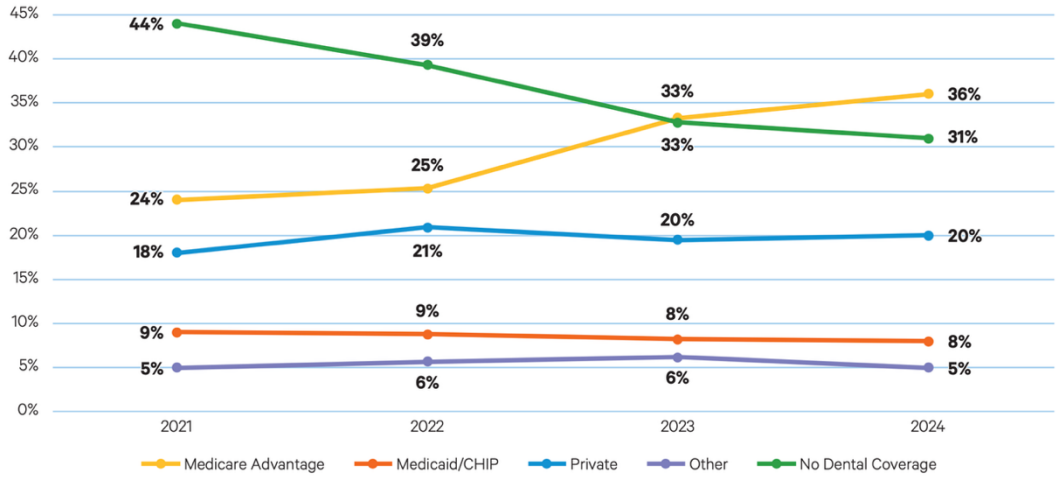
If Mississippi decided to offer dental coverage to nursing home residents only, the annual cost would be approximately $1.6 million, based on the per capita cost for expansion of coverage in Arizona in 2016 and adjusted for Mississippi's FMAP.

Lack of Dental Insurance

Two separate reviews of nationally representative surveys completed by Charm Economics (i.e., an analytics research firm) in 2025 and by CareQuest in 2024 found that 31% of adults over the age of 55 or 60 lack dental insurance. The results from PEER's survey to NHAs indicate an even lower percentage of dental insurance holders in Mississippi nursing homes, with 61% of NHA respondents reporting that 40% or fewer nursing home residents have dental insurance.

According to CareQuest, the percentage of adults on Medicare—the majority of whom are 65 or older—who do not have dental insurance has declined over the past four years, falling from 44% in 2021 to 31% in 2024, as illustrated in Exhibit 4 on page 17. During the same time period, the percentage of adults with dental coverage through a Medicare Advantage plan increased from 24% to 36%. Even with the increase in coverage, adults aged 60 or older are still uninsured at a higher rate than adults aged 30-59 (21%) though at a lower rate than adults aged 18-29 (34%).

Exhibit 4: Type of Dental Insurance Held by Adults with Medicare Health Insurance from 2021 to 2024



SOURCE: "Out of Pocket: A Snapshot of Adults' Dental and Medicare Care Coverage," CareQuest Institute for Oral Health, Inc., 2025.

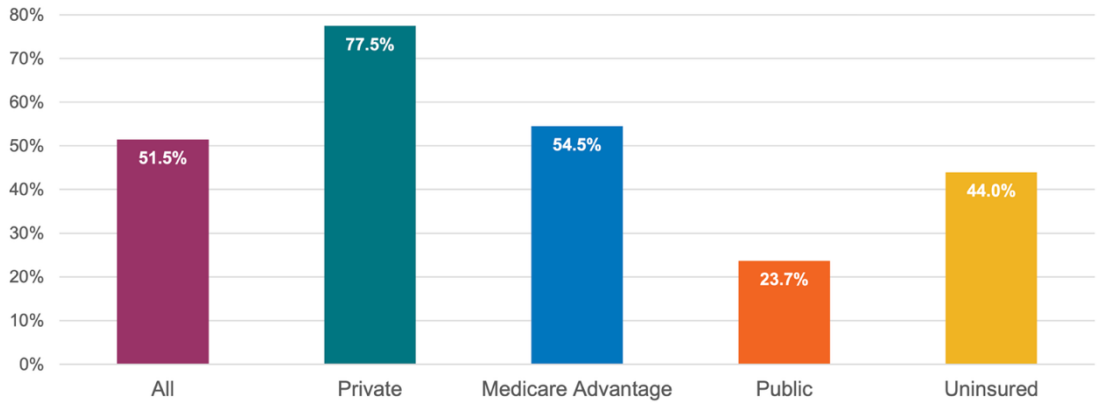
Research has shown a strong association between having dental insurance and recording a dental visit among older adults. A study published in 2019 on the demand for preventive and restorative dental services among adults aged 65 and over found that holders of private dental insurance were 25% more likely to use preventive dental services and that beneficiaries of Medicaid dental benefits were 23% and 36% more likely to utilize basic and major restorative services, respectively.[16] Another study published in 2016 concluded that adults in the United States aged

[16] Chad D. Meyerhoefer, et al., "The Demand for Preventive and Restorative Dental Services Among Older Adults," *Health Economics*, 28, 9 (2019).

51 and over with dental coverage were significantly more likely to record dental attendance than those without dental coverage.[17]

The results of the nationally representative Medical Expenditure Panel Survey, interpreted by HPI, revealed similar findings about the effect of dental insurance on dental visits. As shown in Exhibit 5 on page 18, HPI found that adults aged 65 and older with private insurance or a Medicare Advantage plan were more likely to have visited the dentist in the past year than those who were uninsured or on public insurance. Adults aged 65 or older on public dental insurance were the least likely to have visited the dentist in the past year, which can be attributed to the effect of states' differing levels of Medicaid dental coverage and other correlating factors such as low income and provider availability.

Exhibit 5: Percentage of Seniors Ages 65+ with a Dental Visit in the Past Year by Insurance Status in 2022



SOURCE: "National Trends in Dental Care Use, Dental Insurance Coverage, and Cost Barriers," American Dental Association Health Policy Institute, 2024.

Across age groups, adults are approximately three times more likely to lack dental insurance than they are to lack health insurance. As a result, cost barriers for dental services are higher than for other types of healthcare services, with 17% of all adults and 11% of seniors reporting on the National Health Interview Survey in 2023 that they did not obtain needed dental services in the past 12 months due to cost.

Shortage of Dental Professionals in Mississippi

Mississippi ranks among the lowest in the nation in provider-to-population ratio for dentists and dental hygienists, which has led to provider shortages in the state.

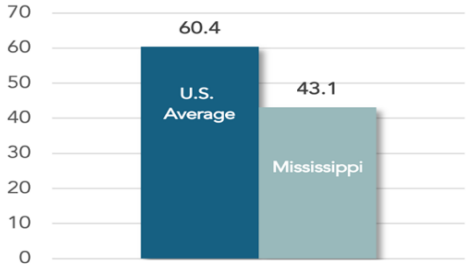
Dentists

According to data collected by the American Dental Association in 2023, Mississippi ranked third lowest in the US behind Arkansas and Alabama in terms of the number of dentists practicing in the state per 100,000 residents. With 43 dental professionals per 100,000 citizens, Mississippi had 17 fewer dentists per capita than the national average of 60 dentists per 100,000 citizens, as shown in Exhibit 6 on page 19.

[17] Richard Manski, et al., "Disparity in Dental Attendance Among Older Adult Populations: A Comparative Analysis Across Selected European Countries and the USA," *International Dental Journal*, 66 (2016).

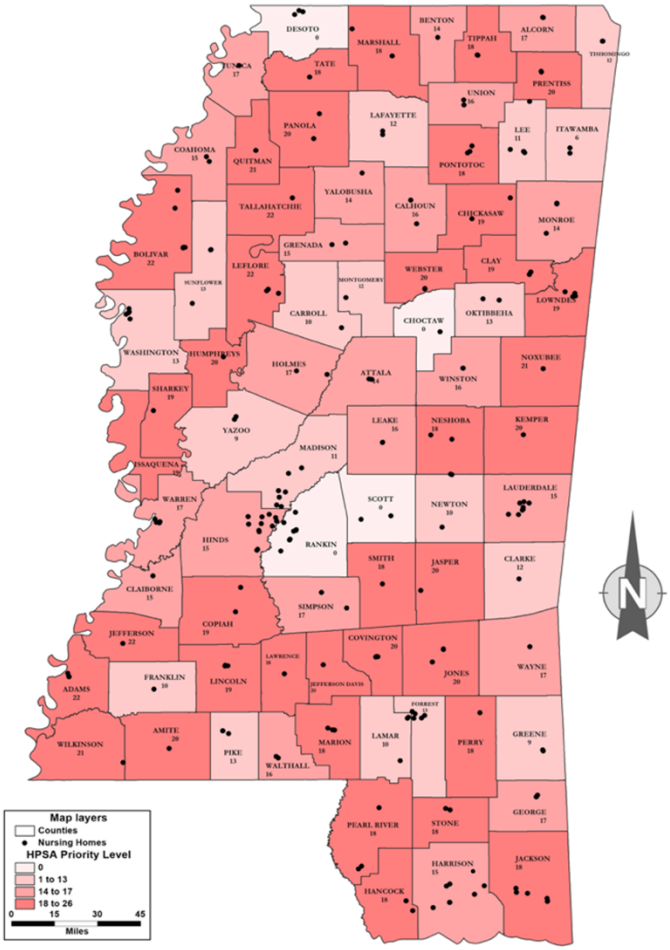
The dearth of dental professionals and other factors such as poverty level and distance to the nearest dental provider resulted in the designation of 78 of Mississippi's 82 counties as health professional shortage areas according to the Health Resources and Services Administration in 2024. As shown in Exhibit 7 on page 19, 38 counties containing 36% of the state's nursing homes score within the highest HPSA priority level range, i.e., the greatest level of need for dental providers.

Exhibit 6: Number of Dentists per 100,000 Citizens in 2023



SOURCE: PEER analysis of American Dental Association data.

Exhibit 7: Nursing Home Locations in Mississippi in Relation to Dental Health Professional Shortage Areas



HPSA Priority Level	Number of Counties	Number of Nursing Homes
0	4	15
1-13	18	59
14-17	22	59
18-26	38	76
Total	**82**	**209**

Note: Health Professional Shortage Area scores are assessed based on population-to-provider ratio, percent of the population below 100% Federal Poverty Level, water fluoridation status, and travel time to nearest source of care outside the HPSA designation area. A higher number indicates a greater level of need.

SOURCE: PEER analysis of data from the Health Resources and Services Administration reported by the Mississippi State Department of Health (MSDH) in 2024 and MSDH's directory of nursing home facilities.

The challenge of retaining dental professionals in the state contributes to these provider shortages. The University of Mississippi Medical Center (UMMC) School of Dentistry—the only dental school in the state—has graduated an average of 37 dentists each year over the past decade. However, approximately 37% of graduates over the past three years moved out of the state after graduation to pursue better career opportunities, including a considerable increase of 25% more students in the class of 2025 leaving than in the class of 2024. UMMC expects graduating students will continue to leave the state at a rate of 30% to 40% in the coming years.

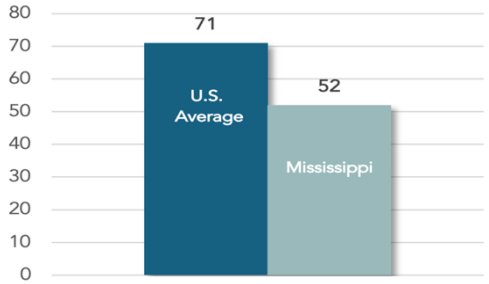
UMMC projects that the state needs to introduce 30 new dentists into the state each year to address the present provider gaps, assuming an adequate distribution of dentists across the state. The school anticipates that the expansion of its dental programs and class sizes with the addition of the new clinical building funded by the Legislature in 2023 will help meet the dental needs of Mississippi's residents.

Until then, some sources in the state, including MSDH and UMMC, have cited issues with provider shortages and the effect of those shortages on the accessibility of dental services. In contrast, however, the majority of nursing home administrators who responded to PEER's survey rated the scarcity of dental providers as only a minor issue or no issue at all.

Dental Hygienists

Similar to the rates of availability of dentists in Mississippi, the number of dental hygienists per 100,000 residents in Mississippi ranks among the bottom five in the nation based on Bureau of Labor Statistics data. With 52 dental hygienists per 100,000 citizens, Mississippi has 19 fewer dental hygienists than the national average of 71 per 100,000 citizens, as shown in Exhibit 8 on page 20.

Exhibit 8: Number of Dental Hygienists per 100,000 Citizens in 2024



SOURCE: PEER analysis of Bureau of Labor Statistics and US Census Bureau data.

The outlook for educating and retaining dental hygienists in the state is more favorable than for dentists. UMMC estimates that approximately 70 dental hygienists graduate each year from Mississippi's five accredited programs, with approximately 75% of dental hygiene students remaining in Mississippi after graduation. In 2026, Mississippi Gulf Coast Community College plans to launch a new dental hygiene program, adding a sixth accredited program alongside UMMC, Meridian Community College, Mississippi Delta Community College, Northeast Mississippi Community College, and Pearl River Community College.

Potential Unfamiliarity with Permissible Medical Expense Deductions

Responses from nursing home administrators in Mississippi suggest that some nursing facilities and residents may not be aware that the cost of dental insurance can be reduced from the residents' Medicaid patient liability at no cost to the resident. With 61% of responding NHAs reporting that 40% or fewer nursing home residents have dental insurance and that 60% or fewer receive a dental appointment at least once a year, ensuring that nursing homes, residents, and the residents' families are aware of the permissible medical expense deductions could help allay the financial obstacles to receiving dental services.

In order to be eligible to receive Medicaid coverage for nursing home care, a person's monthly income (e.g., Supplemental Security Income, Social Security) must be below the private pay rate for the nursing facility. If eligible for Medicaid, residents must pay their income to Medicaid to help cover the cost of their care, which is called their patient liability.[18] However, residents may make certain deductions from their patient liability, including a personal needs allowance of $44 and medically necessary expenses not subject to payment by the Division of Medicaid or other third-party insurance, such as eyeglasses, hearing aids, and dentures. Health insurance premiums, including charges for dental insurance, are also permissible medical expenses that can be deducted from the resident's liability. At least two companies operating in Mississippi offer dental insurance policies tailored to nursing home residents that charge a monthly premium that may be deducted from the residents' patient liability with no additional copays or out-of-pocket charges.

Responses from NHAs suggest that some nursing facilities and residents may not be aware that the cost of dental insurance can be deducted from the residents' liability at no cost to the resident. One NHA mentioned the benefits of one of the companies that provides dental insurance to nursing home residents but explained that the coverage options were confusing to the facility and to the residents. Another NHA stated that some family members do not understand that the services will be provided at no cost to the resident. Furthermore, 80% of NHAs who responded to PEER's survey identified the cost of dental services as a moderate or major barrier for nursing home residents, and twelve NHAs mentioned financial resources and insurance coverage as an area for needed improvement.

Since approximately 80% of nursing home residents utilize Medicaid to cover the cost of their care in Mississippi, knowledge about the opportunity to deduct dental insurance expenses from their patient liability could affect the residents' access to dental services. With 61% of responding NHAs reporting that 40% or fewer nursing home residents have dental insurance and that 60% or fewer record a dental visit once a year, ensuring that nursing homes, residents, and the residents' families are aware of the permissible medical expense deductions could help allay the financial obstacles to receiving dental services.

[18] If an individual's monthly income is more than the per diem payment the Division of Medicaid makes to the facility each month, the income in excess of the Medicaid payment may be placed in an Income Trust overseen by a court-appointed conservator.

Lack of Onsite Dental Services

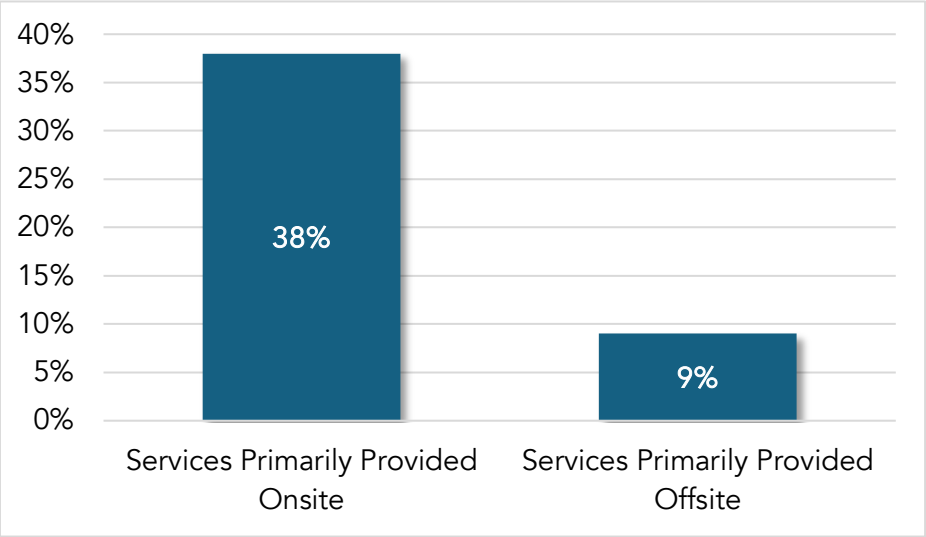
Approximately 50% of licensed nursing home administrators in Mississippi who responded to PEER's survey reported that dental services for nursing home residents are primarily provided offsite. However, due to limited mobility issues, nursing home residents without access to onsite dental care are less likely to receive dental services.

Under federal regulations, Medicare and Medicaid-certified nursing facilities must assist residents in arranging for dental services, as necessary or requested, and provide transportation to offsite dental locations. Although the facilities must ensure the availability of transportation to dental appointments, the physical and mental frailty of many residents make travel difficult, if not prohibitive. These mobility issues lower accessibility to dental services for physiologically vulnerable residents for whom offsite appointments are the only option for receiving dental care.

Approximately 50% of NHAs who responded to PEER's survey reported that dental services for nursing home residents are primarily provided offsite. The same percentage of responding NHAs considered difficulty arranging for dentists to see residents onsite a moderate or major barrier to the provision of routine dental hygiene services in their facility. At least 20% of the responding NHAs reiterated the need for onsite dental services when asked what resources or policy changes would help improve access to routine dental hygiene services in their facility.

The concerns expressed by responding NHAs about the lack of onsite services are substantiated by a considerable decrease in the percentage of residents who receive dental services if those services are primarily provided offsite rather than onsite. As shown in Exhibit 9 on page 23, NHAs who reported that the provision of dental services primarily occurred onsite were nearly 30% more likely to indicate that more than 60% of residents receive dental care at least once a year than those who reported that the provision of dental services primarily occurred offsite.

Exhibit 9: Percentage of Nursing Home Administrators Who Reported that More than 60% of Nursing Home Residents Receive Dental Services at Least Once a Year by Site of Service Provision



SOURCE: PEER analysis of results from the survey sent by PEER to Mississippi-licensed nursing home administrators in August 2025.

Onsite Service Delivery Options

The accessibility issues for nursing home residents in obtaining dental care are well-acknowledged in academic and professional literature. To resolve the barriers posed by nursing home residents' limited mobility, organizations such as the Association of State and Territorial Dental Directors, the Special Care Dentistry Association, and the National Institutes of Health (NIH), propose the integration of mobile dentistry and teledentistry into nursing homes. These modes of service delivery allow nursing home residents to receive needed dental care without the disturbance or distress of being transported to an offsite clinic.

Mobile Dentistry

As defined by contributors to the clinical reference book *Oral Healthcare and the Frail Elder*, mobile dental care entails a mix of in-home and portable services using specially equipped vans or mobile clinics by which dental personnel can offer convenient and flexible care directly to people in diverse settings. Mobile dental units are equipped to set up a dental clinic within the nursing facility, ideally in a dedicated space where residents receive other services, such as a beauty parlor. If circumstances necessitate, dental personnel may also provide services bedside.

Based on survey responses from NHAs, at least two mobile healthcare companies—Aria Care Partners and 360care—are currently providing dental services for some Mississippi nursing homes. Both companies offer comprehensive dental care for nursing home residents, including preventive, restorative, and denture services.

One of the potential drawbacks to mobile dentistry is the cost. Although mobile services can reduce the cost of transporting residents offsite and the expense of medical care for

untreated dental conditions, researchers acknowledge that the cost for mobile staff, equipment, and supplies is high and may be more expensive than offsite visits.

Teledentistry

Teledentistry provides another alternative to offsite dental services that offsets some of the financial concerns associated with mobile dentistry. The American Dental Association defines teledentistry as the use of telehealth systems and methodologies in dentistry. The implementation of teledentistry can occur synchronously with a live videoconference between the patient and a dental provider or asynchronously with the digital transmission of health information for later review by the dentist. In the nursing home setting, teledentistry could facilitate virtual dental examinations and the submission of dental records and photographs without needing to move residents out of their living environment or arranging for dental personnel to come onsite.

According to NIH, studies have concluded that telehealth interventions appear generally equivalent to in-person care. While teledentistry cannot replace dental services that require physical procedures, it can offer a substitute for some in-person dental visits.

PEER's survey to NHAs did not include a question about teledentistry, so the current use of teledentistry in Mississippi nursing homes is unclear. Preliminary research indicates that some private practices in Mississippi offer teledentistry options, but the extent to which these services reach nursing homes residents is not certain. Other states, including Iowa, Idaho, New York, Minnesota, and Missouri have launched pilot or permanent teledentistry programs to provide dental services to nursing home residents through partnerships with universities, community health centers, and nonprofits.

Throughout the process of determining the best method for providing services, residents' preferences should be respected. Some residents may prefer to continue visiting a local dentist, even if that requires offsite transportation. The facilitation of onsite dental services in nursing homes ought to complement, not hinder, the provision of transportation to offsite locations for residents who appreciate and utilize the offsite option.

Lack of Participation by Dental Professionals in Resident Assessments

Since federal regulations do not stipulate which healthcare professional should conduct dental assessments for nursing home residents, the responsibility typically falls to nursing staff who are not as equipped as dental professionals to recognize issues with oral health. In Mississippi, 89% of the nursing home administrators responding to PEER's survey who confirmed that residents receive a dental assessment upon admission to the facility reported that a nurse conducts the dental assessment, compared to only 5% who reported that a dentist conducts the assessment. The lack of participation by dental professionals in the resident assessment could result in residents' oral health issues going undetected.

The federal regulations governing nursing facilities certified to receive Medicare and Medicaid reimbursement require that the facilities conduct initial and periodic comprehensive assessments for each resident in the facility. Pursuant to 42 CFR § 483.20, nursing facilities must conduct an assessment within 14 calendar days of the resident's admission into the facility, within 14 calendar days after determination of a significant change in the resident's condition, and not less than once

every 12 months. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.

One component of the comprehensive assessment involves determining the resident's oral and dental status. The oral assessment involves asking the resident or representative about the resident's dental status and conducting a thorough examination of the resident's mouth, checking for ill-fitting dentures, abnormal mouth tissue, cavities, broken teeth, inflamed or bleeding gums, loose natural teeth, and mouth or facial pain. Federal regulations do not specify which healthcare professional should conduct the oral component of the comprehensive resident assessment.

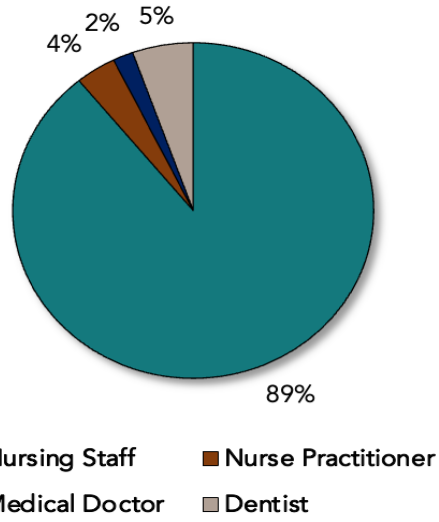
The Role of Nursing Staff in Residents' Oral Assessments

According to the National Academies of Sciences, Engineering, and Medicine, the responsibility for conducting the oral health assessment for nursing home residents typically falls on nursing staff who may lack the requisite training to identify oral health concerns. The responses from nursing home administrators in Mississippi align with this conclusion, as 89% of administrators who confirmed that residents receive a dental assessment upon admission to the facility reported that a nurse conducts the assessment. Of those who reported that a nurse conducts the assessment, 18% said that the nursing staff does not receive training to help them recognize issues with dental health.

Multiple studies and narrative reviews have concluded that nurses underreport issues with oral health when compared to assessments conducted by dental professionals. A 2023 study on nursing home residents in Canada, for example, found that a dental hygienist detected significantly more debris, tooth loss, and tooth decay than nurses.[19] Another two studies completed in the United States likewise determined that nursing staff reported less oral conditions, including pain and gingivitis, than dental professionals.[20]

Increased training for nursing staff on recognizing issues with oral health, though helpful, may not be sufficient to improve the

Exhibit 10: Survey-Reported Percentage of Professionals Who Perform the Initial Oral Assessment for Nursing Home Residents in Mississippi



SOURCE: PEER analysis of results from the survey sent by PEER to Mississippi-licensed nursing home administrators in August 2025.

[19] Nelly Villacorta-Siegal, et al., "Integration of a Dental Hygienist into the Interprofessional Long-Term Care Team, *Gerodontology*, 41 (2024).

[20] Jiska Cohen-Mansfield and Steven Lipson, "The Underdetection of Pain of Dental Etiology in Persons with Dementia," *American Journal of Alzheimer's Disease and Other Dementias*, 17, 4 (2002); Zimmerman, "Readily Identifiable Risk Factors."

oral health outcomes of nursing home residents. While some studies have shown improvement in residents' oral health status after the provision of education to nursing staff, two systematic reviews of the academic literature published in 2016 and 2025 did not find quality evidence to suggest that nurse training leads to long-term benefits for nursing home residents.[21] As the 2025 review concluded, implementation strategies positively affected the knowledge and attitudes of nursing staff, but the oral health of older people did not necessarily improve.

The Role of Dental Professionals in Residents' Oral Assessments

Though not mandated by law, academic researchers and professional organizations recommend the involvement of dental professionals in the initial and ongoing oral assessments of nursing home residents. Integrating dental professionals into residents' care teams increases the likelihood of detecting oral health concerns and establishes oversight by professionals best equipped to advise on dental matters.

Some states have taken steps to ensure the participation of dental professionals in assessing nursing home residents. State regulations in Colorado, Minnesota, New York, and Wisconsin, for example, require that a dentist or dental hygienist perform an initial dental examination for each nursing home resident. Minnesota and New York require access to further examinations by dental professionals on at least an annual basis.

Other strategies states utilize to encourage the involvement of dental professionals include mandating that nursing homes receive consultation from dentists or dental hygienists and provide in-staff training conducted by dental professionals. Fourteen states (e.g., Arkansas, Georgia, and Kentucky) require nursing homes to appoint an advisory dentist or dental professional to assist with developing the facility's oral hygiene policies, and at least 12 states (e.g., Arkansas, Iowa, and Wisconsin) require nursing homes to arrange for dental professionals to offer professional development to staff regarding oral health issues.

Mississippi's regulations do not contain any requirements for the participation of dental professionals in the assessment of nursing home residents or the advisement of nursing home staff. As a result, only 26% of responding NHAs reported that a dentist assists in conducting the comprehensive resident assessment, and only 5% who confirmed that residents receive an oral assessment reported that a dentist performs the assessment. Without the participation of dental professionals in the resident assessment, oral health issues in nursing home residents may go undetected.

[21] Martina Albrecht, et al., "Oral Health Education Interventions for Nursing Home Staff and Residents, Cochrane Database of Systematic Reviews, 9, (2016); Lina F. Weening-Verbree, et al., "Oral Health Care in Older People in Long-Term Care Facilities: An Updated Systematic Review and Meta-Analyses of Implementation Strategies, *International Journal of Nursing Studies Advances*, 8 (2025).

Provision of Routine Dental Hygiene Services in Mississippi Correctional Facilities

Pursuant to the duties established in MISS. CODE ANN. § 47-5-10, the Mississippi Department of Corrections (MDOC) has the responsibility to provide care, custody, training, supervision, and treatment for adult offenders committed for incarceration in the state of Mississippi. MDOC currently contracts with the correctional healthcare services company VitalCore Health Strategies, LLC (VitalCore) to provide comprehensive healthcare services to all inmates in MDOC custody. A lack of sufficient data and contract monitoring by MDOC and VitalCore hinder the ability to assess the quality of dental services provided to inmates although considerable shortages in VitalCore's staffing of dental personnel suggest that the provision of care may be subpar.

Overview of Mississippi Correctional Facilities

In FY 2025, MDOC administered a correctional system comprised of 35 correctional facilities and approximately 19,000 inmates.

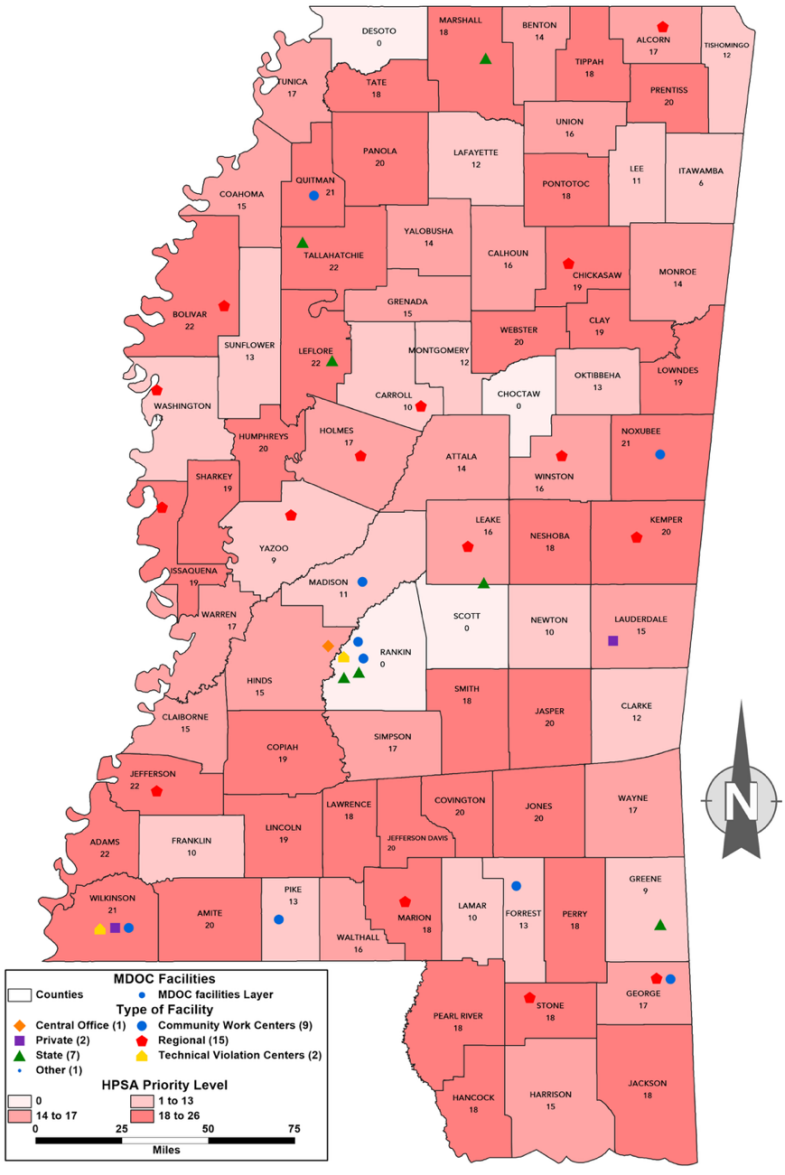
Pursuant to the duties established in MISS. CODE ANN. § 47-5-10, MDOC has the responsibility to provide care, custody, training, supervision, and treatment for adult offenders committed for incarceration in the state of Mississippi. MDOC oversees a total of 35 inmate facilities across the state, some of which are solely administered by MDOC and some of which are jointly administered by MDOC and local governments or private companies.[22] Altogether, MDOC supervises the following, as illustrated in Exhibit 11 on page 28:

- seven state correctional facilities;
- fifteen regional facilities;
- two private facilities;
- nine community work and transitional centers; and,
- two technical violation centers.

Inmates are assigned to a housing location at MDOC's discretion based on classification status, space availability, level of care, and eligibility. The community work centers, for example, house minimum custody inmates within eight years of their earliest release date while Central Mississippi Correctional Facility—one of the state facilities—can house inmates with a minimum, medium, or close custody level.

[22] The number of facilities is based on the list of facility locations provided by MDOC staff. Two of the state facilities and one of the community work centers are attached to Central Mississippi Correctional Facility.

Exhibit 11: MDOC Correctional Facilities in Relation to Dental Health Professional Shortage Areas



Name of Facility
Central Office
The Central Office is located in Jackson, Mississippi
State Facilities
Central Mississippi Correctional Facility
Delta Correctional Facility
Marshall County Correctional Facility
Mississippi Correctional Institute for Women
Mississippi State Penitentiary
South Mississippi Correctional Institution
Walnut Grove Correctional Facility
Regional Facilities
Alcorn County Regional Correctional Facility
Bolivar County Correctional Facility
Carroll/Montgomery County Regional Correctional Facility
Chickasaw County Regional Correctional Facility
George/Greene County Correctional Facility
Holmes/Humphreys County Correctional Facility
Issaquena County Correctional Facility
Jefferson/Franklin County Correctional Facility
Kemper/Neshoba County Regional Correctional Facility
Leake County Correctional Facility
Marion/Walthall County Correctional Facility
Stone County Correctional Facility
Washington County Regional Correctional Facility
Winston/Choctaw County Correctional Facility
Yazoo Regional Correctional Facility
Private Facilities
East Mississippi Correctional Facility
Wilkinson County Correctional Facility
Community Work/Transitional Work Centers (CWC/TWC)
Central Mississippi Correctional Facility TWC
Forrest County CWC
George County CWC
Madison County CWC
Noxubee County CWC
Pike County CWC
Quitman County CWC
Rankin County CWC
Wilkinson County CWC
Technical Violation Centers
Flowood TVC
Wilkinson TVC

Note: Health Professional Shortage Area scores are assessed based on population-to-provider ratio, percent of the population below 100% Federal Poverty Level, water fluoridation status, and travel time to nearest source of care outside the HPSA designation area. A higher number indicates a greater level of need.

SOURCE: PEER analysis of data from the Health Resources and Services Administration reported by the Mississippi State Department of Health in 2024 and facility locations provided by the Mississippi Department of Corrections.

Approximately 7% of the inmate population resides in county jails rather than MDOC facilities. An inmate may be housed in a county jail if the individual is awaiting transfer to an MDOC facility, if the county has contracted with MDOC to house state inmates, or if the sheriff of the county has submitted a formal request for the inmate to reside at the county jail. The care and expenses for inmates whom a sheriff requests to reside in a county jail fall on the responsibility of the county while MDOC maintains responsibility for the expenses of inmates housed in county jails due to lack of space at the state correctional facilities.

Overall, as shown in Exhibit 12 on page 29, the number of inmates in the MDOC correctional system as of June 30, 2025 totaled 19,091. The majority of inmates resided in a state (57%) or regional (23%) correctional facility while the remaining 20% of inmates resided in other types of facilities.

Exhibit 12: Mississippi Department of Corrections Inmate Demographics in June 2025

Total Population
19,091

Age Range		
13 to 17	46	<1%
18 to 19	186	1%
20 to 29	3,682	19%
30 to 39	5,917	31%
40 to 49	5,034	26%
50 to 59	2,738	14%
60 to 69	1,193	6%
70 to 79	269	1%
>80	24	<1%
Unknown	2	<1%
Total	**19,091**	**100%**

Population by Type of Facility		
Community Work Center	335	2%
County Jail	1,241	7%
Private	2,197	12%
Regional	4,450	23%
State	10,822	57%
Technical Violation Center	-	0%
Transitional Work Center	46	<1%
Total	**19,091**	**100%**

Gender		
Female	1,588	8%
Male	17,501	92%
Unknown	2	<1%
Total	**19,091**	**100%**

Note: The inmate population numbers reflect the count on June 30, 2025.

SOURCE: PEER analysis of data provided by the Mississippi Department of Corrections.

Regulatory Environment for Dental Care in Mississippi Correctional Facilities

Inmates are the only individuals in the United States with a constitutional right to medical and dental care. Bound by federal law not to withhold needed medical or dental care from inmates, MDOC has adopted standards established by two national correctional associations to ensure the adequate provision of services.

Federal and State Regulations

The legal protection for the right to suitable healthcare for incarcerated individuals begins at the federal level, enshrined within the Eighth Amendment of the US Constitution, which prohibits the infliction of "cruel and unusual punishments." In 1976, the Supreme Court ruled in *Estelle v. Gamble* that the protections outlined in the Eighth Amendment apply to the provision of inmates' healthcare, concluding that the "deliberate indifference to serious medical needs of prisoners" constitutes the kind of treatment proscribed by the Constitution. Subsequent appellate court cases, including *Ramos v. Lamm* and *Hoptowit v. Ray*, determined that the right to adequate healthcare extended to dental care as well. These court rulings affirmed inmates' right to access necessary dental services, making inmates the only individuals in the United States with a constitutional right to dental and medical care.

In Mississippi, the duty to provide custody and care for inmates rests with MDOC. Pursuant to MISS. CODE ANN. § 47-5-901 (3) (a), MDOC also bears the responsibility to cover the financial cost of medical services "for any and all incarcerated persons from a correctional or detention facility."

National Correctional Association and MDOC Standards

The American Correctional Association (ACA) and the National Commission on Correctional Health Care (NCCHC) serve as two of the leading national associations in setting standards for correctional facilities and inmate healthcare. Over 1,300 correctional facilities across the nation and around the world, including in Mississippi, have attained ACA accreditation, and thousands of health care professionals have participated in NCCHC educational training opportunities.

According to its medical services contract with VitalCore, MDOC abides by ACA, NCCHC, and internal standards for the appropriate provision of dental services. Based on the standards set by ACA, NCCHC, and MDOC, all inmates should receive an intake dental screening, an intake dental examination, oral hygiene training, and routine and emergency dental care within specific timeframes.

Exhibit 13 on page 32 provides a summary of the required services and timelines discussed in the following sections.

Intake Dental Screening

An intake dental screening should occur no later than seven days after admission into the correctional system. A qualified healthcare professional or dental assistant should conduct the screening, which includes visual observation of the mouth and identification of any abnormalities that warrant immediate dental care. According to VitalCore, nurses who are specially trained by a dentist to provide oral screenings conduct the initial screening upon an incarcerated individual's admission to an MDOC intake facility.

Intake Dental Examination and Classification

An intake dental examination should occur no later than 30 days after admission into the correctional system. A licensed dentist should conduct the examination, which involves a comprehensive review of the patient's oral history, a head and neck exam, charting of teeth, digital x-rays, cancer screenings, and an exam of the hard and soft tissue of the oral cavity. According to MDOC policy, inmates will be placed in a dental classification system

based on their initial dental examination. The classification system places inmates into one of the following categories based on level of need:

- Class I (Elective) - Inmates require no dental treatment, request ongoing prevention measures as indicated.
- Class II (Corrective) - Inmates require treatment not of an urgent nature. Restoration of essential function and treatment for chronic oral pathosis is indicated.
- Class III (Interceptive) - Inmates with sub-acute conditions likely to become acute without prompt treatment.
- Class IV (Urgent/Emergent) - Inmates who require urgent/emergent dental treatment.

An inmate's dental classification determines his or her individual treatment plan and scheduling for dental services. MDOC staff explained that dental needs are assessed on a case-by-case basis, with the frequency of services determined by an inmate's oral health status as determined by the dental staff.

Oral Hygiene Training

Oral hygiene training should occur within 30 days of admission into the correctional system. A qualified healthcare professional should offer the training, which includes instruction on proper brushing of teeth and other dental hygiene matters.

Routine and Emergency Dental Services

After receiving the initial intake screening, examination, and training, inmates may request routine and emergency dental services on an ongoing basis by submitting a sick call request using tablets or physical forms in their housing unit. These requests must be triaged within 24 hours of receipt of the request by qualified healthcare professionals and prioritized for care based on level of need, with dental emergencies addressed within 12 hours of the original complaint. If a dental appointment is required, the scheduled time must be within seven working days of the triage date.

ACA and NCCHC do not establish a set standard for the frequency of routine dental hygiene services, but MDOC policies dictate that inmates will receive a routine dental exam every two years—a timeframe generally comparable to the timeframes established in other states. The two-year examination includes dental cleaning, plaque removal, a periodontal exam, reviewing and updating the patient's dental record and related history, examination of the hard and soft tissues of the oral cavity, and dental radiographs if deemed necessary for proper diagnosis.

Record-Keeping

Both ACA and NCCHC advise correctional facilities to maintain proper dental records. The associations recommend that the records be entered uniformly across the correctional system, with standardized procedures for the format, basic content, and charting of patient information. MDOC's policies, likewise, state that inmates' health record files should be complete and filed in a uniform manner.

Exhibit 13: Dental Services and Timeliness Standards Outlined in National Correctional Association and MDOC Policies

Dental Services Provided Upon Admission into the Correctional System	
Type of Service	Required Timeliness of Service
Intake Dental Screening	Within seven days of admission
Intake Dental Examination	Within 30 days of admission
Oral Hygiene Training	Within 30 days of admission

Routine and Emergency Dental Services Provided on an Ongoing Basis	
Type of Service	Required Timeliness of Service
Routine Dental Examination	Every two years
Dental Sick Call Requests	Triaged within 24 hours of receipt of the request
Dental Appointments	Scheduled within seven working days of the triage date
Dental Emergencies	Addressed within 12 hours of the original complaint

SOURCE: PEER analysis of standards and policies set by the American Correctional Association, National Correctional Commission on Health Care, and the Mississippi Department of Corrections.

Overview of MDOC's Medical Services Contract

Since October 2020, MDOC has contracted with VitalCore to provide comprehensive healthcare services to inmates in MDOC custody.

MDOC currently contracts with the correctional healthcare services company VitalCore to provide comprehensive healthcare services to inmates in MDOC custody. Under the terms of the contract, VitalCore must deliver all medical, dental, pharmaceutical, and mental health services to MDOC inmates at a level of quality that meets the standards of efficacy and timeliness outlined in ACA, NCCHC, and MDOC policies and protocols. The contract tasks VitalCore with a range of administrative and logistical functions necessary to manage inmates' healthcare, including staffing of personnel, maintenance of medical records, triaging of inmate needs, and coordinating onsite and offsite appointments.

MDOC first contracted with VitalCore under an emergency contract in October 2020 after parting ways with its former contractor, Centurion Health, over concerns with the quality of service and disputes over financial compensation. MDOC signed three subsequent one-year emergency contracts with VitalCore before signing the company to a longer-term contract in October 2024 following a formal Request for Proposals (RFP) process. The current contract secures VitalCore's services through September 30, 2027, with two optional one-year renewal terms if MDOC decides to extend the contract beyond 2027.

The total amount of the contract from October 2024 to September 2025 equaled $115 million. The amount will increase to $119 million for the second year of the contract and to $124 million

for the third year of the contract. The contract includes an annual cap of $25 million to pay for medical services that cannot be provided onsite, such as hospital care or specialty physician appointments.

Overview of Dental Services in MDOC Facilities

VitalCore's contract provides for comprehensive onsite dental care to MDOC inmates according to ACA, NCCHC, and MDOC standards and arranges for offsite dental services as necessary.

According to its contract, VitalCore provides comprehensive onsite dental care to MDOC inmates, including preventive, diagnostic, restorative, and rehabilitative care, and contracts with offsite healthcare providers and facilities for the provision of specialty care, emergency room visits, and hospital services. To ensure access to dental services, MDOC's contract with VitalCore establishes minimum staffing levels for the number of full-time equivalent dental personnel required in the state, regional, and private facilities. In total, the contract requires VitalCore to staff the facilities with 4.40 dental directors, 9.20 dentists, and 18.30 dental assistants.

According to responses from VitalCore staff, VitalCore personnel utilize the dental operatories installed in each MDOC facility to provide onsite dental services, including routine dental exams and procedures, less complicated oral surgery, and the management of minor trauma. Although the state facilities maintain a full-time dental staff, dental professionals are not permanently stationed in the regional facilities, community work centers, and technical violation centers. For these facilities, VitalCore coordinates dental providers to travel to the location or arranges transportation for inmates to receive care at one of the state facilities. For more complicated procedures that exceed the capabilities of onsite dentists, VitalCore provides referrals to other specialists in the community.

As outlined in ACA, NCCHC, and MDOC standards, each MDOC inmate receives an intake dental screening, intake dental examination, and oral hygiene training upon admission into the correctional system. All subsequent routine and emergency dental appointments are arranged through the sick call request system. To submit a request for dental services, inmates may fill out an electronic or paper form indicating the nature of their request, which is then triaged by medical staff and assigned to the dental sick call log according to level of need.[23] VitalCore also schedules inmates' two-year routine exams through the dental sick call log.

A typical clinical schedule for the dental staff is compiled from the dental sick call requests and other scheduled examinations, which are prioritized according to the severity of the patients' condition and complaints. The inmates are then called up to the clinic and seen individually by a dentist and dental assistant. For after clinic hours, each facility has a dentist on-call to manage dental emergencies 24 hours per day, seven days per week.

[23] Pursuant to the authority granted by MISS. CODE ANN. §47-5-179 (1972) to charge inmates for nonemergency care, MDOC assigns a $6.00 fee for inmate-initiated sick call requests. This fee may be deducted from the inmate's commissary account. However, the fee may be waived for several reasons, including for issues related to chronic conditions, emergencies, or follow-up visits. Inmates who cannot afford the fee are also not charged nor are they denied services due to their inability to pay.

Insufficient Data on MDOC Dental Services

Although MDOC purports to adhere to established standards for the provision of dental services, VitalCore's insufficient data collection and record-keeping methods do not allow for independent analysis of the adequacy of the dental care MDOC and its contractor offer to inmates. This lack of data quality casts uncertainty on the quality of dental care VitalCore is providing to inmates.

In its medical services contract with VitalCore, MDOC requires VitalCore to abide by the standards of care established by ACA, NCCHC, and MDOC. As discussed earlier in this report, the requirements for dental care instituted by these organizations include an intake screening, intake examination, oral hygiene training, and routine and emergency services offered within set timeframes.

In order to assess VitalCore's compliance with the established standards for providing dental services, PEER requested data through MDOC indicating inmates' dates of admission into the correctional system and dates of service for the required dental care for each inmate from the beginning of VitalCore's contract relationship with MDOC in October 2020. PEER also requested the dental sick call log for calendar year 2025 and the number of inmates in each dental classification level.

Although VitalCore was able to report the total number of dental services provided to inmates, it does not track dental services by type (e.g., intake examination, routine examination, emergency appointment), which prevented PEER from assessing whether or not VitalCore is providing the services outlined by the required standards. Furthermore, a review of VitalCore's dental sick call log for 2025 where all examinations, routine requests, and emergency requests are entered revealed critical issues that prevented analysis. While PEER originally considered taking a sample from the log to assess compliance with timeliness standards, the state of the data rendered the sample impractical. The main issues included the following:

- The sick call data was recorded in a PDF format that does not easily transfer into a data processing system like Microsoft Excel. Importing the data as currently presented into a processor capable of broad analysis would require manual counting and inputting that would introduce the chance for human error.
- The data files exhibited inconsistencies in formatting from facility to facility and from month to month. In 51 different data files, there are 17 different methods of recording and titling information, which differ not only from institution to institution but also from month to month within the same institution.
- The data is often unlabeled or mislabeled (e.g., text entered in columns labeled as a date, or vice versa).
- Some of the data fields contained missing values.

Altogether, these issues resulted in concerns over the ability to adequately interpret the data.

Lastly, although MDOC policy states that each inmate will receive a dental classification level indicating his or her oral health status and needs, VitalCore reported that it does not currently document a dental classification in patients' charts and was thus unable to provide the number of inmates in each classification level.

Overall, VitalCore's current data collection and record-keeping methods do not allow for an independent assessment of compliance with the required standards of dental care set out by ACA, NCCHC, and MDOC nor do they meet with standards of maintaining complete and uniform health records. PEER acknowledges that ACA and NCCHC have reviewed MDOC's facilities as part of their triennial reaccreditation process and found them to be in compliance with the necessary standards to retain accreditation with the associations. Nevertheless, the lack of interpretable dental records still prevents external analysis. This insufficient data quality casts uncertainty on the quality of dental care VitalCore is providing to inmates and the internal mechanisms VitalCore utilizes to ensure quality control.

Appendix A on page 50 contains examples of the issues with MDOC's dental sick call logs.

Deficiencies in Contract Monitoring

Under the terms of the contract with VitalCore and its own internal policies, MDOC commits to performing contract monitoring to ensure VitalCore adequately fulfills its contractual responsibilities. However, MDOC could produce limited documentation to PEER showing that it had completed contract monitoring activities, which lowers its ability to hold VitalCore accountable for providing required healthcare services and increases the possibility for inmates to receive insufficient care without detection or resolution.

MDOC's contract with VitalCore and internal MDOC policies state that MDOC will perform contract monitoring to ensure VitalCore's compliance with the terms of the contract. According to the terms of the contract, MDOC's monitoring activities entail several tasks, including, among others, assessing quality of care, meeting with VitalCore representatives to address any issues, and reviewing documentation and records.

The contract provides that MDOC's designated contract monitoring staff will monitor VitalCore's service delivery at each MDOC facility through announced and unannounced visits to determine if VitalCore has achieved compliance with the performance indicators outlined in the contract. Among a variety of performance indicators contained within the contract monitoring program, ranging from proper documentation to infection control, the contract includes dental services as one of the contract requirements subject to performance indicators.[24]

In conjunction with MDOC's on-the-ground monitoring, MDOC's policies provide for the establishment of a comprehensive quality improvement program in accordance with ACA and NCCHC standards. The purpose of the program is to monitor and evaluate the delivery of healthcare to inmates and to identify, analyze, and correct problems which may potentially impede the quality of healthcare. The program's primary functions are to establish measurable criteria for monitoring quality of care, evaluate high-risk aspects of healthcare, and develop corrective action

[24] On a quarterly basis, MDOC may impose non-performance penalties in the amount of $10,000 per violation, per day for each applicable performance indicator that demonstrates less than 90% compliance. Though the contract outlines the areas subject to performance indicators, it does not specify the criteria and measurements corresponding with each indicator.

plans. The committee overseeing the program is tasked to meet quarterly and produce an annual report on the effectiveness of the healthcare system and an assessment of expected outcomes as they relate to the quality of patient care. According to MDOC policy guidelines, one of the focal areas for the quality improvement program includes dental care.

During the course of its review, PEER requested reports completed by the MDOC contract monitoring program for the review of the medical services contract pertaining to dental care, including any performance indicators or findings of deficiencies from FY 2021 to FY 2025. MDOC staff reported that it cannot locate any documents showing internal contract monitoring conducted by MDOC for the requested period except for a review of VitalCore's staffing levels. MDOC staff attests that staff members are performing site visits and reviewing VitalCore's records, but they cannot identify documentation demonstrating their monitoring activities beyond their monthly analysis of VitalCore's filled and unfilled staffing hours.[25] MDOC staff attributed the lack of documentation, in part, to high turnover in the medical department.

MDOC's deficiencies in documenting its contract monitoring activities lowers its ability to hold VitalCore accountable for providing required healthcare services and increases the potential for inmates to receive insufficient care without detection or resolution. MDOC reported that it is in the process of finalizing a contract through the State Personnel Board to acquire an external contract monitor to assist with monitoring VitalCore.

Appendix B on pages 51-52 contains a full list of the areas subject to performance indicators included in MDOC's contract with VitalCore.

Dental Professional Staffing Shortages in MDOC Facilities

VitalCore's staffing hours for dental professionals fell below its contractual requirements each month from January to June 2025, with unfilled staffing hours ranging from 31% to 57% across the dental positions. These staffing shortages decrease the likelihood of adequate dental care for inmates and increase the likelihood of overworking the dental professionals on staff.

MDOC's contract with VitalCore establishes minimum staffing requirements for the healthcare personnel deemed necessary to provide comprehensive medical services to inmates. If VitalCore fails to meet the staffing requirements outlined in the contract, MDOC may seek paybacks for unfilled hours worked for all positions except for support position classifications at the regional level. MDOC seeks paybacks if the required number of staffing hours falls below 90% for physicians, dentists, psychologists, nurse practitioners, and physician assistants and below 85% for of all other staff positions. These thresholds serve to accommodate staff vacation time, sick time, holidays, or paid time off. If VitalCore falls below the staffing thresholds for any quarter, the contractor shall credit MDOC at a rate equal to the average hourly wage of the unfilled position plus 20% (i.e., hourly rate X 1.20).

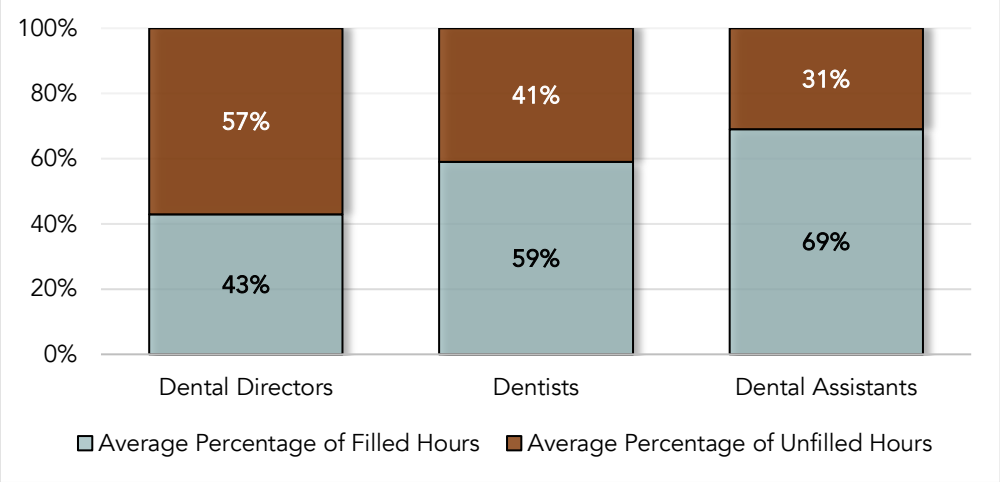
[25] MDOC did provide a dental chart review conducted by VitalCore for some of the correctional facilities in July 2024. However, this review does not assess all of the facilities in MDOC's correctional system, and it reflects self-reported data that has not been substantiated by MDOC staff or any other external auditor.

For each of the position categories subject to payback penalties, VitalCore must provide MDOC with an itemized list of hours worked at each MDOC facility by position on a monthly and quarterly basis. VitalCore must also provide supporting payroll and automated time-keeping information that demonstrates and verifies filled and unfilled hours for each position and MDOC facility.

MDOC determined that VitalCore's staffing hours fell below the contract's staffing requirements each month from January to June 2025 for each of the dental staff positions, which include dental directors, dentists, and dental assistants. As illustrated in Exhibit 14 on page 37, the dental director position fared the worst across the months under review, filling an average of only 43% of the required hours. Dentists filled an average of 59% of the required hours, and dental assistants filled an average of 69% of the required hours—all well below the compliance thresholds outlined in the medical services contract.

Due to the staffing shortages across all medical personnel, MDOC sought paybacks from VitalCore for the first and second quarters of 2025 totaling $2.1 million and $2.3 million respectively.[26] The amount owed for dental professionals, specifically, totaled $260,000 and $240,000. MDOC received the paybacks for the first quarter as a credit on its monthly invoice to VitalCore in June 2025. As of October 8, 2025, PEER is awaiting documentation for credits for staffing shortages in the second quarter.

Exhibit 14: Average Percentage of Required Hours Filled by VitalCore Dental Professionals, January through June 2025



Note: The Mississippi Department of Corrections' contract with VitalCore requires 90% of hours filled for dental directors and dentists and 85% of hours filled for dental assistants.

SOURCE: PEER analysis of Mississippi Department of Corrections data.

[26] The contract granted VitalCore a staffing payback requirement suspension for a 120-day period from the effective date of the contract on October 6, 2024. The start-up period suspension ended February 3, 2025.

Upon request for a response for the reason for the dental staffing shortages, VitalCore stated that the unfilled staffing hours are due to variety of reasons, including paid time off, sick time, military leave, staffing vacancies, and statewide dental professional shortages. VitalCore explained that it has implemented an "aggressive" recruitment strategy to improve the staffing shortages going forward.

As discussed on pages 18-20, Mississippi faces shortages in dental providers and ranks among the lowest in the nation in terms of the ratio of dental providers to citizens in the state.

VitalCore believes that there has been no reduction in dental services or any delay in providing medically necessary dental services in the midst of the staffing shortages. VitalCore expressed that it has navigated the staffing shortages through efficient triaging, an improved scheduling process, and the utilization of telehealth.

Despite VitalCore's statement about the quality of dental services, the high percentages of unfilled staffing hours for dental professionals puts the contractor's ability to provide quality dental care for inmates in question. Even if the inmates have not experienced a reduction in care, the adjustments necessary to sustain the dental program at limited capacity has likely multiplied the workload for the current dental staff. Though the lack of interpretable data on dental services prevents a definitive conclusion on the effect of the staffing shortages on quality of care, the shortages, at the very least, make adequate dental care for inmates less likely and the possibility of overworking the dental professionals on staff more likely.

Levels of Supervision for Dental Hygienists in Mississippi and Other States

Across the nation, dental hygienists operate under different levels of dentist supervision as set by each state. Mississippi recently loosened some of its regulations on the required level of supervision for dental hygienists, but Mississippi's law is still one of the most restrictive in the nation.

Types of Supervision Levels for Dental Hygienists

Each state establishes the level of dentist supervision required over the practice of dental hygienists, ranging from no dentist oversight to a high level of dentist oversight.

Across the nation, dental hygienists operate under different levels of supervision, i.e., the degree of oversight that dentists maintain over the provision of dental services by dental hygienists. Each state, as the American Dental Hygienists' Association (ADHA) explains, enacts its own laws determining the services dental hygienists can provide, the settings in which they can practice, and the supervision under which they practice.

The primary levels of supervision for dental hygienists, adapted from the Center for Health Workforce Studies and Utah State University, include the following:

- Direct Supervision: The dental hygienist's practice is mandated under the direct supervision of a dentist with specified supervision requirements. A dentist must be present when the dental hygienist is performing authorized tasks.
- General Supervision: A dental hygienist practicing under the general supervision of a licensed dentist shall have a written agreement with the supervising dentist that clearly sets forth the terms and conditions under which the dental hygienist may practice. A dentist needs to authorize services prior to their initiation but need not be present while the hygienist provides the services.
- Collaborative Practice: A dental hygienist may practice without the supervision of a dentist pursuant to a collaborative agreement between the hygienist and a licensed dentist.
- Full Independence: There is no requirement that a dentist must authorize or supervise most dental hygiene services. The dental hygienist is allowed to work without the supervision of a dentist.

Under any of these levels of supervision except for direct supervision, states may permit dental hygienists to practice with direct access, which ADHA defines as "the ability of hygienists to initiate treatment based on their assessment of a patient's needs without the specific authorization of a dentist, treat the patient without the presence of a dentist, and maintain a provider-patient relationship." Often permitted under a collaborative agreement with a supervising dentist, direct

access allows dental hygienists to offer a set of authorized services, such as oral prophylaxis and fluoride application, in non-clinical settings without requiring the presence of a dentist onsite.

Level of Supervision and Practice Settings for Dental Hygienists in Mississippi

As of July 2025, dental hygienists in Mississippi may operate under general supervision for a fixed number of days in the year in specified settings if they meet certain experience and certification requirements. Hygienists who do not meet the requirements or who have reached the limit on the number of days practicing under general supervision must provide services under direct supervision.

Until July 2025, dental hygienists in Mississippi worked strictly under direct supervision, with limited exceptions for the provision of oral hygiene instruction and screening under general supervision in public health settings. With the passage of House Bill 1062 during the 2025 Regular Session, which went into effect on July 1, 2025, dental hygienists now have the opportunity to provide services under general supervision for a fixed number of days in the year in specified settings if they meet certain experience and certification requirements.

In order to be eligible to practice under general supervision, a dental hygienist must have practiced in the state of Mississippi for a minimum of five years, or 6,000 practice hours, and possess current CPR certification. Dental hygienists may not practice under general supervision for more than ten consecutive business days or for more than 24 total days in the calendar year. Hygienists who do not meet the experience requirements or who have reached the limit on the number of days practicing under general supervision must provide services under direct supervision.

Additional provisions and considerations must be made for patients receiving dental hygiene services under general supervision. The patient:

- must be notified in advance of the appointment that the supervising dentist will be absent from the location;
- must have been seen by the supervising dentist no more than seven months prior to the appointment;
- must not be seen twice consecutively under general supervision;
- must not be charged an examination fee;
- must be a minimum of 18 years of age; and,
- must not be ranked with a worse health status than "a patient with a mild systemic disease," according to the American Society of Anesthesiologists Physical Status Classification System.

Pursuant to MISS. CODE ANN. §73-9-5 (1972) and the Mississippi State Board of Dental Examiners' regulations, dental hygienists may only operate under general supervision in a dental office owned by a Mississippi-licensed dentist or in a setting operated by a nonprofit entity meeting requirements for grantees supported by the Public Health Service. As the statute and regulations are currently constructed, dental hygienists are not allowed to provide services

through direct access and are prohibited from offering services in nursing homes and correctional facilities under general supervision.[27]

Level of Supervision and Practice Settings for Dental Hygienists in Other States

While Mississippi has expanded the ability for dental hygienists to practice under general supervision, Mississippi's law remains one of the most restrictive in the nation.

According to an analysis of legislation conducted by ADHA, states impose different levels of supervision for dental hygienists based on the types of services provided and the setting where the services are rendered. More complicated procedures like the administration of anesthesia and nitrous oxide require direct supervision while less complicated procedures like oral prophylaxis, x-rays, and the application of fluoride and sealants are permitted under general supervision or collaborative agreement in most states. Several states require higher levels of supervision in private dental offices than in public health settings while some states set the same level of supervision regardless of the setting.

Although states impose their own regulations outlining which public health settings are permissible for the practice of dental hygienists, the term *public health setting* generally refers to a setting outside of a private dental office, such as a school, community health center, nursing home, or correctional facility.

With the passage of House Bill 1062 in 2025, Mississippi joined all the other states in the nation except for Alabama in allowing dental hygienists to provide services under general supervision. Mississippi's general supervision law, however, remains one of the most restrictive in the country due to its limitations on patient eligibility criteria and permitted practice locations. Mississippi's restrictive supervision requirements limit the delivery of preventative dental hygiene services in public health settings like nursing homes and correctional facilities, thereby lowering accessibility to dental care for institutionalized individuals.

Contrary to Mississippi's laws and regulations, most states allow dental hygienists to provide low-risk procedures like oral prophylaxis, fluoride treatments, sealants, screenings, and patient education in both private and public health settings under minimal dentist supervision. According to ADHA and NCSL, 43 states currently allow dental hygienists to perform routine services through direct access in public health settings.[28]

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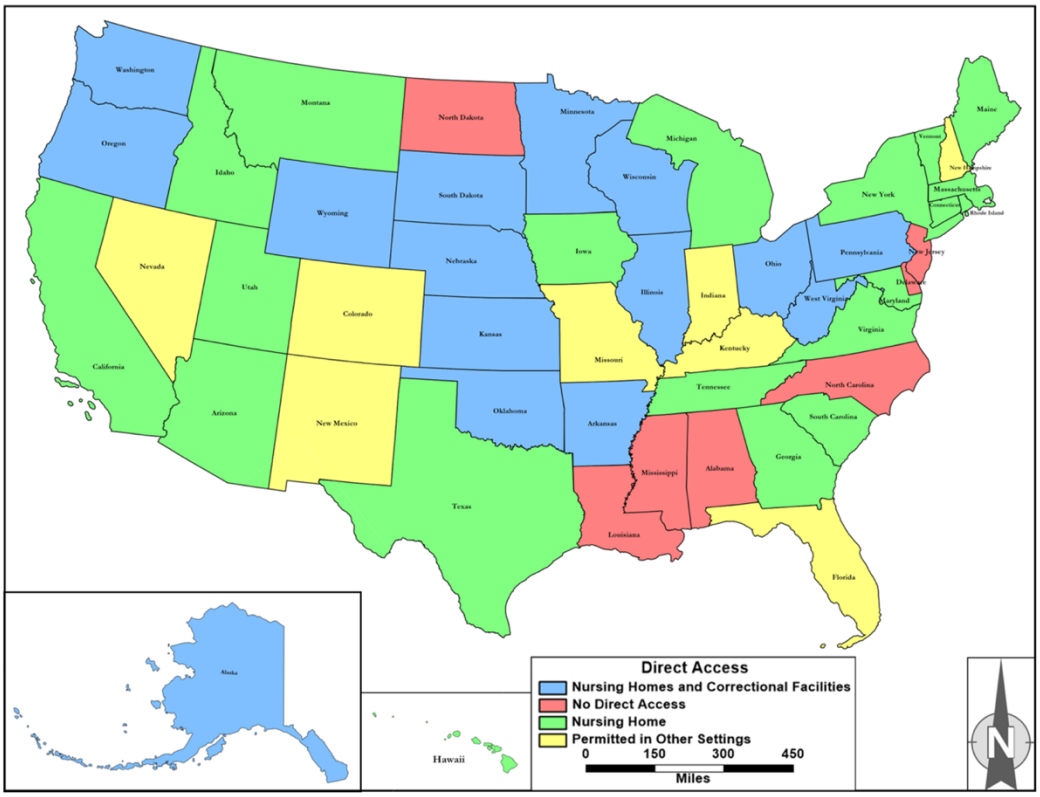
[27] House Bill 1062 authorizes the Mississippi State Board of Dental Examiners to assess the need for and authorize dental hygiene services in nursing homes and correctional facilities. As of August 2025, the Board had not completed a needs assessment. This PEER report serves as an independent needs assessment for dental hygiene services in nursing homes and correctional facilities.

[28] Although both ADHA and NCSL report that 43 states allow dental hygienists to work through direct access, they disagree slightly in which 43 states permit the practice. ADHA reports that North Carolina permits direct access and Hawaii does not while NCSL reports that Hawaii permits direct access and North Carolina does not. PEER opted to utilize NCSL's designations in Exhibits 15 and 16 on pages 42 and 43.

States Permitting Direct Access in Nursing Homes and Correctional Facilities

As shown in Exhibit 15 on page 42, 35 direct access states specify that dental hygienists may provide services in nursing homes, and 15 of those states specify that hygienists may also provide services in correctional facilities.[29] Of the 15 states that permit hygienists to provide services through direct access in both nursing homes and correctional facilities, none of the states impose a limit on the number of days that the hygienists may practice without direct supervision except that West Virginia does not allow hygienists to practice under general supervision for more than 15 consecutive business days. Of the same 15 states, Illinois and Ohio do not permit hygienists to provide services to the same patient consecutively without a dentist examining the patient while West Virginia does not permit hygienists to provide services to a patient more than two times consecutively without a dentist's examination.[30] An additional seven states require patients to be seen or referred to a dentist on a regular basis.

Exhibit 15: Permissible Practice Settings in Dental Hygienist Direct Access States



SOURCE: PEER analysis of state statutes and regulations.

Levels of Supervision and Educational Requirements in Direct Access States

As shown in Exhibit 16 on page 43, the level of supervision required for dental hygienists to work through direct access varies by state. Of the states that allow direct access:

[29] Additional states may permit direct access in nursing homes and correctional settings. PEER opted for a conservative estimate based on the facilities that were explicitly outlined in state statute and regulations.

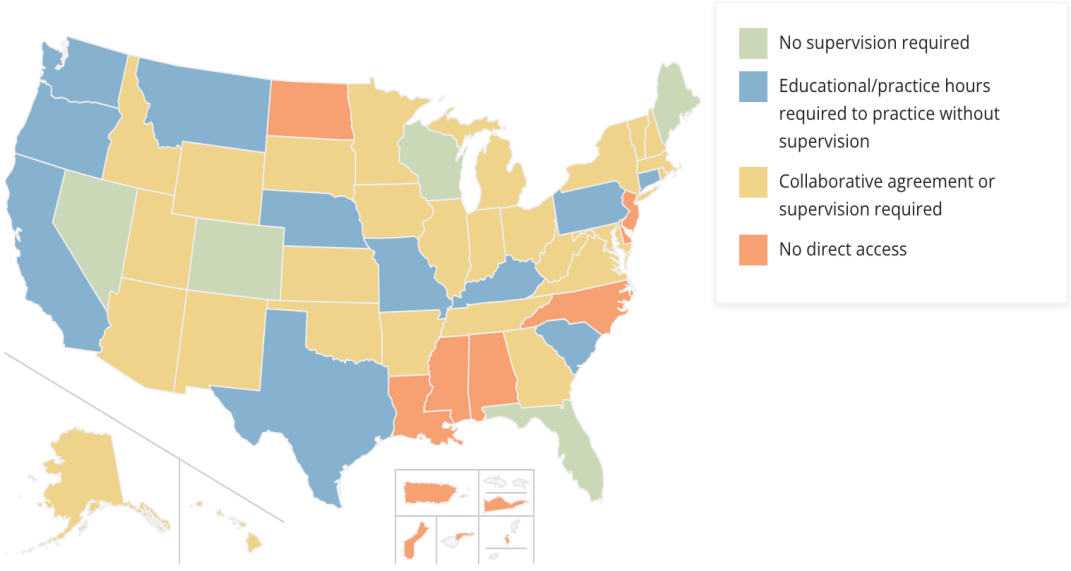
[30] Oklahoma does not allow a dental hygienist to see a patient consecutively under general supervision if the patient has not been examined and accepted for dental care by a dentist.

- 27 states require a dental hygienist practicing with direct access to have a collaborative agreement with a supervising dentist or to work under general supervision;
- 11 states allow hygienists to practice in direct access settings without supervision provided they meet certain educational and experience requirements.; and,
- 5 states do not require supervision by a dentist when dental hygienists are practicing in direct access settings.

Around half of the direct access states (e.g., Arkansas, Illinois) have created a separate license or supervision designation specific to providing dental hygiene services in public health settings while the other half of states (e.g., Wyoming, West Virginia) integrate public health settings into the broader regulations overseeing dental hygienists. While most states implement a single license or category for public health settings, Arkansas and Kansas have instituted one or more tiers of permits with escalating certification requirements and permissible practice settings. In Arkansas, for example, a hygienist with 1,200 clinical hours may provide services to children in a public setting under a "Collaborative Care Permit I" while a hygienist with 1,800 clinical hours may provide services to children, senior citizens, and persons with developmental disabilities in public settings under a "Collaborative Care Permit II."

Most of the states that permit dental hygienists to provide services through direct access require the hygienists to have a certain number of hours of clinical practice and an appropriate level of education. In Maryland, for example, hygienists working in a public setting must have at least 3,000 hours of clinical practice and a healthcare provider proficiency certification. A dental hygienist in California, meanwhile, must have 2,000 hours of clinical practice in the 36 months immediately preceding public practice, possess a bachelor's degree or its equivalent, complete 150 hours of an approved educational program, and pass a written examination.

Exhibit 16: State Supervision Levels for Dental Hygienists Practicing with Direct Access



SOURCE: National Conference of State Legislatures.

Advantages and Disadvantages of Lowering Supervision Requirements for Dental Hygienists

Lowering supervision requirements for dental hygienists can lead to increased access to preventive care, reduced cost of services, and professional satisfaction, but it may also lead to potential risks to patient safety and misdiagnosis of oral conditions. A compromise between these positives and negatives could involve lowering the required level of supervision for dental hygienists in public health settings for a limited set of non-invasive, low-risk routine services, such as oral prophylaxis and x-rays, that would act as a supplement to, but not as a replacement for, ongoing examinations by a dentist.

Advantages of Lowering Supervision Requirements

Recent research and policy analyses highlight the potential benefits of lowering supervision requirements for dental hygienists.

1. Increased access to preventive care and reduced cost of services

Research conducted by The Center for Growth and Opportunity at Utah State University analyzed national data from 2001-2014 exploring how regulatory changes affecting dental hygienists' scope of practice influence dental care utilization in areas with a shortage of dental care providers.[31] The study suggests that states allowing less restrictive dentist supervision may see increased preventive dental visits (e.g., cleanings, fluoride treatments, and sealant applications) in dental provider shortage areas. Lower supervision levels were also linked to a reduction in dental treatment visits, suggesting that preventive care may reduce the need for problem-focused procedures.

In addition to the potential for increased access to preventive care, the study as suggests that lowered supervision levels may reduce third-party and out-of-pocket costs. The writers found that lowering supervision for dental hygienists to general supervision or independent practice could result in a decrease in expenditures between 37 and 57 percent for third-party payments and between 49 and 74 percent for out-of-pocket payments among regular users of dental care.

The findings presented by Utah State University are backed by a collection of studies reviewed by the *British Dental Journal Team* (BDJT) in 2014. In its literature review, BDJT found seven studies with moderate or good quality evidence indicating that allowing hygienists to practice with direct access resulted in greater access to care and two studies of moderate or good quality indicating that direct access may produce cost savings.[32]

2. Enhanced workforce stability, efficiency, and professional satisfaction

According to the 2025 quarter 3 report on the economic outlook and emerging issues in dentistry provided by the American Dental Association Health Policy Institute (HPI), 32.5% of dentists reported that they have been recruiting dental hygienists over the past 3 months, with 90.8%

[31] Jie Chen, Chad D Meyerhoefer, and Edward Timmons, "The Effects of Dental Hygienist Autonomy on Dental Care Utilization," *Health Economics*, March 27, 2024, https://doi.org/10.1002/hec.4832.
[32] Steve Turner, Sheela Tripathee, and Steve Macgillivray, "The Risks and Benefits of Direct Access," BDJ Team, 1, no. 14025 (2015).

indicating that recruitment has been very or extremely challenging. In a separate report completed in 2022, HPI concluded that factors associated with the attrition of dental hygienists included negative workplace culture, insufficient pay, lack of growth opportunities, inadequate benefits, and feeling overworked.

The 2014 literature review published by BDJT identified two studies from the United States and the United Kingdom which found that dental care professionals (DCPs), including dental hygienists and dental therapists, reported higher job satisfaction when permitted to work to the full extent of their education and training, with both studies rated as having moderate-quality evidence.[33]

3. Feelings of competence and preparedness among dental hygienists to perform preventive dental hygiene services without dentist supervision

According to a study published in the *Journal of Dental Hygiene,* registered dental hygienists generally felt favorably about working without mandatory dentist supervision.[34] The cross-sectional study, which reviewed a survey completed by 360 hygienists across eight states with varying supervision levels, found that dental hygienists felt prepared and competent to perform preventive dental hygiene services without dentist supervision.

Disadvantages of Lowering Supervision Requirements

Along with its examination of the positive effects of allowing DCPs to practice with direct access, the BDJT literature review published in 2014 also identified the potential negative impacts of lowering supervision requirements. The review, which contains a synthesis of findings from 35 studies conducted in the US and other nations, identified four potential drawbacks to permitting DCPs to work with direct access.[35]

1. Potential risks to patient safety

Seven of the studies included in the review examined aspects of patient safety. Two of the studies mentioned evidence of deficiencies in facilities and equipment, but none of the studies provided any evidence of increased risk to patient safety. The review concluded that there was no evidence of significant issues related to patient safety resulting from the clinical activity of DCPs.

2. Risks relating to diagnosis and referral decision-making

Eleven of the studies included in the review evaluated the quality of DCPs' referral decision-making. Overall, the studies found that DCPs tended to over-refer patients, resulting in unnecessary consultations. Two of the studies found knowledge and training deficiencies regarding oral cancer among dental hygienists while another study reported a lack of confidence among hygienists and therapists in their ability to detect possible oral cancer.

3. Issues with support to patients

Seven studies looked at aspects of DCPs' knowledge or support to patients regarding smoking cessation, diabetes, child abuse, and domestic violence. All but one found deficiencies in DCPs' knowledge or support to patients, but there is no evidence from these studies to suggest that dentists were any better in these respects.

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[33] Turner, Tripathee, and Macgillivray, "The Risks and Benefits of Direct Access."

[34] April Catlett, "Attitudes of Dental Hygienists towards Independent Practice and Professional Autonomy," *Journal of Dental Hygiene: JDH* 90, no. 4, (August 1, 2016):249–56, pubmed.ncbi.nlm.nih.gov/27551146/.

[35] Turner, Tripathee, and Macgillivray, "The Risks and Benefits of Direct Access."

4. Concerns with and lack of knowledge among professionals and patients regarding direct access

Both dentists and patients in several studies have shown mixed views about the possibility of DCPs providing treatment, although studies involving patients who have actually received treatment from DCPs demonstrate patient satisfaction. The studies under review conclude that the introduction of direct access will require education and the preparation of information for health professionals, patients, and parents regarding lowered supervision requirements for dental hygienists.

Implications of the Advantages and Disadvantages of Lowering Supervision Requirements

In sum, lowering supervision requirements for dental hygienists can lead to increased access to preventive care, reduced cost of services, and professional satisfaction, but it may also lead to potential risks to patient safety and misdiagnosis of oral conditions. A compromise between these positives and negatives could involve lowering the required level of supervision for dental hygienists in public health settings for a limited set of non-invasive, low-risk routine services, such as oral prophylaxis and x-rays, that would act as a supplement to, but not as a replacement for, ongoing examinations by a dentist.

Recommendations

Improving Dental Hygiene Services in Mississippi Nursing Homes

1. MSDH should educate nursing homes about the opportunity for Medicaid-eligible residents to deduct the cost of medically necessary services and insurance premiums, including dental insurance premiums, from their patient liability. Nursing homes should, in turn, educate residents and the residents' responsible parties about this provision.
2. MSDH should amend the regulations governing nursing homes to require nursing homes to:
    a. arrange for a dental screening by a dentist or dental hygienist for each resident upon admission into the facility and on a periodic basis, either in conjunction with the comprehensive resident assessment or as a separate assessment; and,
        i. in cases when a dentist or dental hygienist is not available to conduct the screening, the facility should require that the oral component of the resident assessment be conducted by a physician (e.g., the nursing home's medical director) in lieu of nursing staff;
    b. arrange for dental professionals to offer professional development to nursing staff regarding oral health issues on an annual basis through in-person, virtual, and/or asynchronous trainings; and,
    c. ensure the availability of access to onsite dental care for residents who request or require it, whether through a written agreement or contract with an onsite provider, in areas of the state where onsite providers are accessible; and,
        i. for areas of the state with an appreciable shortage of dental providers, MSDH should conduct a study to determine strategies to enable access to onsite dental care for nursing home residents.
3. MSDH should consult with the Mississippi State Board of Dental Examiners to develop oral hygiene policies that shall be implemented in each nursing home resident's plan of care;
4. MSDH should educate nursing homes about the availability and benefits of mobile dentistry and teledentistry alternative care practices.

Improving Dental Hygiene Services in Mississippi Correctional Facilities

5. MDOC and VitalCore should utilize a standardized data-keeping system that remains consistent across facilities for all health records, including dental records.

6. MDOC and VitalCore should utilize a file format for storing health records that enables the data to be easily analyzed, such as a CSV or Excel file.
7. MDOC and VitalCore should record all data points pertinent to tracking compliance with established standards of dental care, including, but not limited to, the following for each inmate:
    a. date of intake dental screening;
    b. date of intake dental examination;
    c. date of oral hygiene training;
    d. date(s) of sick call requests;
    e. nature of the sick call request(s);
    f. date(s) of triage of sick call requests;
    g. summary of response to sick call requests (e.g., no appointment needed, dental appointment scheduled);
    h. date(s) of response to dental emergencies;
    i. date(s) of dental appointments subsequent to sick call requests;
    j. date(s) of two-year routine dental examinations; and,
    k. dental classification level.
8. MDOC should maintain documentation for all activities related to monitoring the medical services contract, including, but not limited to:
    a. any findings of deficiencies with the provision of medical services;
    b. an ongoing record of the contractor's level of compliance with established performance indicators;
    c. reports on facility visits;
    d. minutes from the quarterly Comprehensive Quality Improvement Committee meetings; and,
    e. annual reports and reviews completed by the Comprehensive Quality Improvement Committee related to the effectiveness of the healthcare delivery system, assessment of outcomes, and review of the committee's activities.
9. MDOC should work with VitalCore to resolve the shortages in dental staffing by identifying the root causes of the shortages and developing strategies to combat them, including, but not limited to, advertising and recruitment efforts.

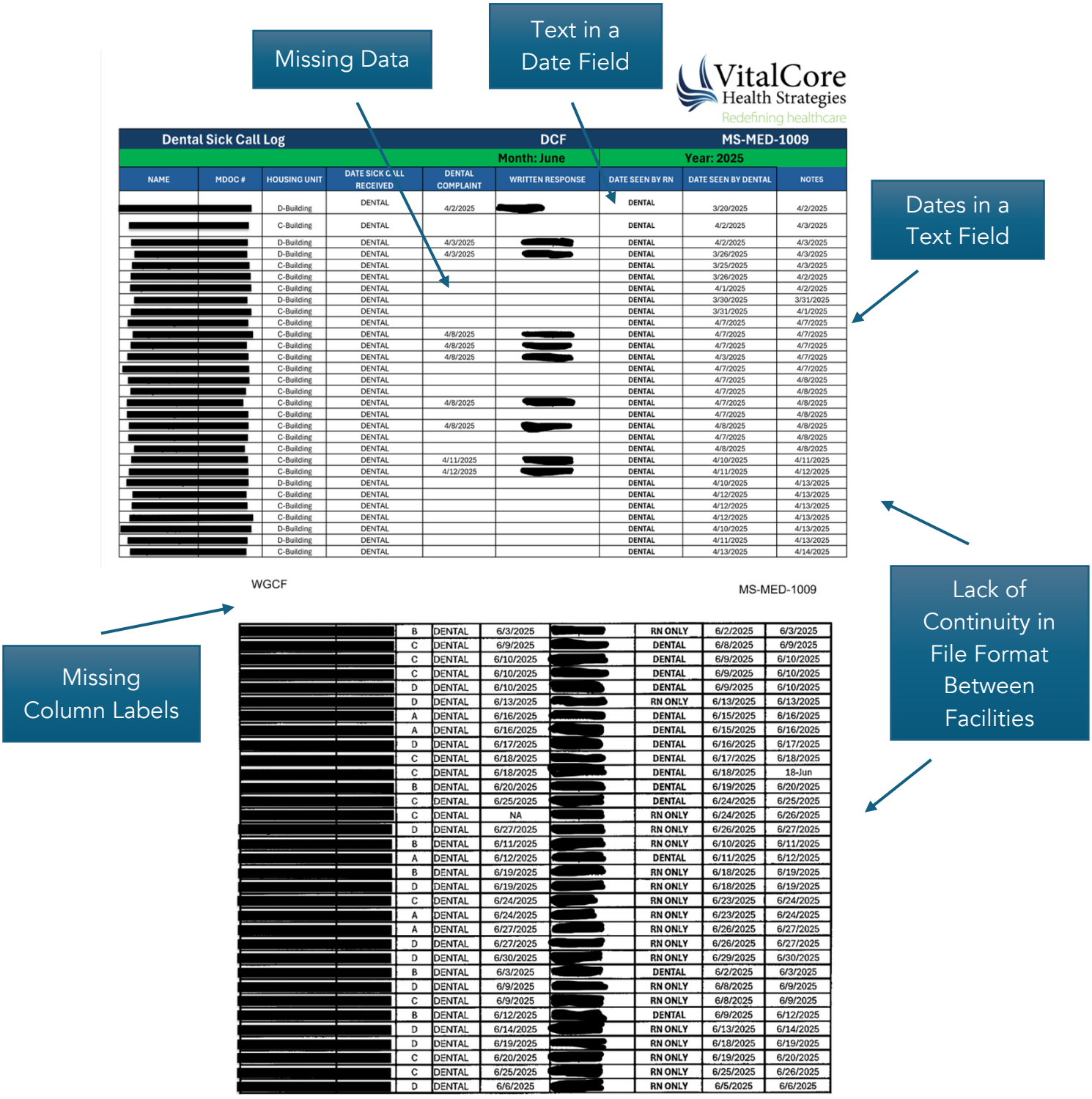
Lowering Supervision Requirements for Dental Hygienists

10. The Legislature should consider amending MISS. CODE ANN. §73-9-5 (1972) to allow dental hygienists to provide low-risk, non-invasive routine services, such as oral prophylaxis, fluoride treatments, sealants, screenings, and patient education in public health settings, including nursing homes and correctional facilities, if they meet reasonable experience and certification requirements. The Legislature could choose to authorize dental hygienists to operate in public

health settings under general supervision or a collaborative agreement with a licensed dentist, as implemented in other states.

11. If the Legislature lowers the supervision requirements for dental hygienists, the Mississippi State Board of Dental Examiners should consider and adopt regulations in accordance with state law authorizing dental hygienists to operate under lowered supervision requirements.
12. If the Legislature lowers the supervision requirements for dental hygienists, MSDH and MDOC should adopt regulations and/or policies to enable and promote the utilization of dental hygienists' services in nursing homes and correctional facilities.

Appendix A: Sample of Issues with MDOC Dental Sick Call Logs



Note: The names of inmates and dental professionals have been redacted.

SOURCE: PEER analysis of MDOC dental sick call logs for 2025.

Appendix B: Performance Indicators Included in MDOC's Contract with VitalCore

EXHIBIT H

Contract Requirements Subject to Performance Indicators in accordance with Section X: Contract Management – Subsection;C Performance Criteria

General Administrative Requirements:

1. Response time to general Information request from identified MDOC Executive Staff .
2. Compliance with Healthcare Records and Access Request
3. Required timeframes of daily, monthly and quarterly required Healthcare services reports.
4. Financial and Claims reporting due monthly, quarterly and annually.
5. Submission of quarterly staffing paybacks and reconciliation within required time frames.
6. Timely payment of non-Medicaid third-party community facility and provider claims.
7. Breach of Security protocols, rules and regulations
8. Response time to a requested for a Corrective Action Plan
9. Current licensure and/or certificates of facility staff
10. Training for Healthcare and Security Staff

Medical - Clinical Access, Response and Intervention:

1. Intake Screening Male and Female
2. Intake Health Assessment
3. Sick Call
4. Chronic Care Clinics and Referrals
5. On-site Specialty Care
6. Specialty Care Referrals
7. Infirmary Care
8. Treatment Plans
9. Inmate Preventative Health and Disease Management Education
10. Intra-system Transfer Screening
11. Facility Pharmaceutical Distribution Center
12. Medication Administration
13. Healthcare Records
14. Hepatitis C Treatment
15. Infectious Disease
16. Infection Control
17. Infectious Disease - HIV
18. TB Therapy
19. Healthcare coding
20. Dental Services
21. Grievances
22. Periodic Health Assessment
23. Restrictive Housing
24. Telemedicine
25. KOP renewal and access
26. Emergency Response – 'Man down drills'
27. CQI Program
28. Diagnostic Services
29. Hospice
30. Discharge Planning
31. Medical Equipment and Supplies
32. Specialty Diets
33. Grievances
34. Prosthetics

EXHIBIT H

Contract Requirements Subject to Performance Indicators in accordance with Section X: Contract Management – Subsection;C Performance Criteria

Mental Health Administrative Requirements:

1. Required timeframes of daily, monthly and quarterly required Mental Health specific services reports.
2. Response time to a requested for a Corrective Action Plan related to Mental Health services
3. Training specific to, but not limited to; Mental Health referrals, assessment and crisis intervention for security and healthcare staff.
4. Emergency Response – 'Man down drills' in Mental Health housing units
5. Mental health request and referral slips available in housing units and common areas
6. Observer training and certification for staff and inmate Observers
7. Current licensure and/or certificates of Mental Health facility staff
8. Annual evaluation and verification of individual practitioner's skills in the provision of mental health care

Mental Health - Clinical Access, Response and Intervention:

1. Intake Mental Health Reception Screening
2. Intake Mental Health Assessment
3. Intake Psychiatric Evaluation
4. Suicide Risk Assessment
5. Social Risk Assessment
6. Treatment Plans
7. Involuntary and Emergency Medications
8. Communication of Referrals
9. Mental Health Services in Restrictive Housing.
10. RDU Intake
11. Transfer and Receiving Screening
12. Constant Observation/Suicide Watch and Mental Health Observation.
13. Court Ordered Community Inpatient Services.
14. Mental Health Consultation to the Disciplinary Process.
15. Social History Assessment and Testing
16. Co-Occurring Disorders and Substance Abuse Treatment
17. Mental Health Coding
18. Individual Counseling
19. Treatment Plans
20. Outpatient Treatment
21. Inpatient Admissions
22. Discharge Planning
23. Medication Administration
24. Group Therapy
25. Activity Groups
26. Community Discharge Planning at EOS and/or Parole
27. Healthcare Records Mental Health Documentation
28. Grievances

SOURCE: Exhibit H of the Mississippi Department of Corrections' contract with VitalCore.

Appendix C: List of Mississippi Nursing Homes by Location and Certification Status

County	Nursing Home *(City)*	Total Capacity	Certification Type		
			Medicaid	Medicare	State Licensure Only
Adams	Adams County Nursing Center *(Natchez)*	100	√	√	
	Natchez Rehabilitation and Healthcare Center *(Natchez)*	58	√	√	
	Grand Trace Health Care and Rehabilitation *(Natchez)*	96	√	√	
Alcorn	Cornerstone Rehabilitation and Healthcare Center *(Corinth)*	95	√	√	
	Mississippi Care Center of Alcorn County *(Corinth)*	119	√	√	
Amite	Liberty Community Living Center *(Liberty)*	80	√	√	
Attala	Attala County Nursing Center *(Kosciusko)*	120	√	√	
	MS State Veterans Home-Kosciusko *(Kosciusko)*	150			√
Benton	Ashland Health & Rehabilitation *(Ashland)*	60	√	√	
Bolivar	Bolivar Medical Center- LTC Facility *(Cleveland)*	35	√		
	Cleveland Nursing and Rehabilitation Center *(Cleveland)*	120	√	√	
	Delta Rehabilitation and Healthcare Center *(Cleveland)*	75	√	√	
	Oak Grove Retirement Home *(Duncan)*	60	√		
	Diversicare of Shelby *(Shelby)*	60	√	√	
Calhoun	Bruce Community Living Center *(Bruce)*	35	√	√	
	Baptist Nursing Home- Calhoun *(Calhoun City)*	120	√		
Carroll	Vaiden Community Living Center *(Vaiden)*	60	√	√	
Chickasaw	Trend Health & Rehab of Houston, LLC *(Houston)*	60	√	√	
	Shearer Richardson Memorial Nursing Home *(Okolona)*	73	√		
Choctaw	Choctaw Nursing and Rehabilitation Center *(Ackerman)*	60	√		
Claiborne	Claiborne County Senior Care *(Port Gibson)*	75	√	√	
Clarke	Diversicare of Quitman *(Quitman)*	120	√	√	
Clay	Dugan Memorial Home *(West Point)*	60	√	√	
	West Point Community Living Center *(West Point)*	100	√	√	
Coahoma	Clarksdale Nursing Center *(Clarksdale)*	60	√	√	
	Greenbough Health and Rehabilitation Center *(Clarksdale)*	66	√	√	
Copiah	Copiah Living Center *(Crystal Springs)*	60	√	√	
	Pine Crest Guest Home *(Hazlehurst)*	55	√	√	
Covington	Arrington Living Center *(Collins)*	60	√	√	
	Landmark of Collins *(Collins)*	60	√	√	
	MS State Veterans Home-Collins *(Collins)*	150			√

County	Nursing Home *(City)*	Total Capacity	Certification Type		
			Medicaid	Medicare	State Licensure Only
DeSoto	Landmark of DeSoto *(Horn Lake)*	60	√	√	
	DeSoto Healthcare Center *(Southaven)*	120	√	√	
	Diversicare of Southaven *(Southaven)*	140	√	√	
Forrest	Bedford Alzheimer's Care Center *(Hattiesburg)*	60	√		
	Bedford Care Center of Hattiesburg *(Hattiesburg)*	120	√	√	
	Bedford Care Center-Monroe Hall *(Hattiesburg)*	80	√	√	
	Forrest General Hospital SNF *(Hattiesburg)*	20		√	
	Hattiesburg Health & Rehab Center *(Hattiesburg)*	184	√	√	
	Windham House of Hattiesburg *(Hattiesburg)*	60	√	√	
	Bedford Care Center of Petal *(Petal)*	60	√	√	
Franklin	Meadville Convalescent Home *(Meadville)*	58	√	√	
George	Glen Oaks Nursing Center *(Lucedale)*	45	√	√	
	George Regional Health & Rehabilitation Center *(Lucedale)*	59	√	√	
Greene	Leakesville Rehabilitation & Nursing Center *(Leakesville)*	60	√	√	
	Greene County Health & Rehabilitation *(Leakesville)*	60	√	√	
Grenada	Grenada Rehabilitation and Healthcare Center *(Grenada)*	116	√	√	
	Grenada Living Center *(Grenada)*	90	√	√	
Hancock	Dunbar Village Terrace *(Bay Saint Louis)*	60	√	√	
	Memorial Woodland Village Nursing Center *(Diamondhead)*	132	√	√	
Harrison	The Pillars of Biloxi *(Biloxi)*	180	√	√	
	Greenbriar Nursing Center *(D'Iberville)*	103	√	√	
	Coastal Health & Rehabilitation Center *(Gulfport)*	180	√	√	
	Driftwood Nursing Center *(Gulfport)*	151	√	√	
	Gulfport Care Center *(Gulfport)*	90		√	
	Lakeview Nursing Center *(Gulfport)*	105	√	√	
	MS State Veterans Home-Traditions *(Biloxi)*	100			√
	Pass Christian Health & Rehabilitation Center *(Pass Christian)*	60	√	√	
Hinds	Edgewood Health & Rehabilitation *(Byram)*	119	√	√	
	Willow Creek Retirement Center *(Byram)*	88	√	√	
	Clinton Healthcare *(Clinton)*	121	√	√	
	Woodlands Rehabilitation and Healthcare Center *(Clinton)*	145	√	√	
	Chadwick Nursing and Rehabilitation Center *(Jackson)*	102	√	√	
	Compere's Nursing Home *(Jackson)*	60	√	√	
	Lakeland Nursing & Rehabilitation Center *(Jackson)*	105	√	√	
	Magnolia Senior Care *(Jackson)*	60	√	√	

County	Nursing Home *(City)*	Total Capacity	Certification Type		
			Medicaid	Medicare	State Licensure Only
Hinds	Manhattan Nursing and Rehabilitation Center *(Jackson)*	180	√	√	
	MS State Veterans Home-Jackson *(Jackson)*	100			√
	Pine Forest Health and Rehabilitation *(Jackson)*	120	√	√	
	Pleasant Hills Community Living Center *(Jackson)*	100	√	√	
Holmes	Holmes County Long Term Care Center *(Durant)*	80	√	√	
	Lexington Manor Senior Care *(Lexington)*	60	√	√	
Humphreys	Humphreys County Nursing Center *(Belzoni)*	60	√	√	
Itawamba	Courtyards Community Living Center *(Fulton)*	66	√	√	
	The Meadows *(Fulton)*	130	√	√	
Jackson	River Chase Village *(Gautier)*	60	√	√	
	Diversicare of Moss Point *(Moss Point)*	160	√	√	
	Ocean Springs Health & Rehabilitation Center *(Ocean Springs)*	115	√	√	
	Sunplex Subacute Center *(Ocean Springs)*	73	√	√	
	Plaza Community Living Center *(Pascagoula)*	100	√	√	
	Singing River Skilled Nursing Facility *(Pascagoula)*	54		√	
Jasper	Jasper County Nursing Home *(Bay Springs)*	110	√		
Jefferson	Jefferson County Nursing Home *(Fayette)*	55	√	√	
Jefferson Davis	Jefferson Davis Extended Care Facility *(Prentiss)*	60	√	√	
Jones	Jones County Rest Home *(Ellisville)*	122	√	√	
	Care Center of Laurel *(Laurel)*	105	√	√	
	Comfort Care Nursing Center *(Laurel)*	126	√		
	Laurelwood Community Living Center *(Laurel)*	60	√	√	
Kemper	Mississippi Care Center of Dekalb *(DeKalb)*	60	√	√	
Lafayette	MS State Veterans Home-Oxford *(Oxford)*	125			√
	Oxford Health and Rehabilitation Center *(Oxford)*	120	√	√	
Lamar	Lamar Healthcare and Rehabilitation Center *(Lumberton)*	120	√	√	
	Merit Health Wesley *(Hattiesburg)*	25		√	
Lauderdale	Bedford Care Center of Marion *(Marion)*	120	√	√	
	Arabella Health & Wellness of Meridian *(Meridian)*	77	√	√	
	Diversicare of Meridian *(Meridian)*	120	√	√	
	James T. Champion Nursing Facility *(Meridian)*	70	√		
	North Pointe Health & Rehabilitation *(Meridian)*	60	√	√	
	Poplar Springs Nursing Center *(Meridian)*	89	√	√	
	Reginald P. White Nursing Facility *(Meridian)*	70	√		
	The Oaks Rehabilitation and Healthcare Center *(Meridian)*	82	√	√	

County	Nursing Home *(City)*	Total Capacity	Certification Type		
			Medicaid	Medicare	State Licensure Only
Lauderdale	Trend Health and Rehab of Meridian, LLC *(Meridian)*	60	√		
Lawrence	Lawrence County Nursing Center *(Monticello)*	60	√	√	
Leake	Trend Health and Rehab of Carthage, LLC (Carthage)	83	√	√	
	Carthage Senior Care *(Carthage)*	60	√	√	
Lee	North MS Medical Center/ Baldwyn Nursing Facility *(Baldwyn)*	107	√	√	
	Cedars Health Center *(Tupelo)*	140	√	√	
	Diversicare of Tupelo *(Tupelo)*	120	√	√	
	Tupelo Nursing and Rehabilitation Center *(Tupelo)*	120	√	√	
Leflore	Crystal Rehabilitation and Healthcare Center *(Greenwood)*	100	√	√	
	Golden Age Nursing Home *(Greenwood)*	95	√	√	
	Riverview Nursing & Rehabilitation Center *(Greenwood)*	91	√	√	
Lincoln	Trend Health & Rehabilitation of Brookhaven, LLC *(Brookhaven)*	60	√	√	
	Haven Hall Health Care Center *(Brookhaven)*	81	√	√	
	Silver Cross Health & Rehab *(Brookhaven)*	60	√	√	
	Diversicare of Brookhaven *(Brookhaven)*	58	√	√	
Lowndes	Aurora Health and Rehabilitation *(Columbus)*	120	√	√	
	Windsor Place Nursing & Rehabilitation *(Columbus)*	140	√	√	
	Trinity Healthcare Center *(Columbus)*	60	√	√	
	Vineyard Court Nursing Center *(Columbus)*	55	√	√	
Madison	Madison County Nursing Home *(Canton)*	95	√	√	
	Parkway Health & Rehabilitation *(Canton)*	87	√	√	
	St. Catherine's Village Siena Center *(Madison)*	120			√
	The Madison Health and Rehabilitation Center *(Madison)*	60	√	√	
	The Nichols Center *(Madison)*	60	√	√	
	Highland Home (Madison Community Care Center) *(Ridgeland)*	120	√	√	
	The Arbor *(Ridgeland)*	60			√
Marion	Columbia Rehabilitation and Healthcare Center *(Columbia)*	100	√	√	
	The Myrtles Nursing Center *(Columbia)*	98	√	√	
	The Grove *(Columbia)*	86	√	√	
Marshall	Great Oaks Rehabilitation and Healthcare Center *(Byhalia)*	60	√	√	
	Holly Springs Rehabilitation and Healthcare Center *(Holly Springs)*	120	√	√	
Monroe	Care Center of Aberdeen *(Aberdeen)*	105	√	√	
	Diversicare of Amory *(Amory)*	152	√	√	
	River Place Nursing Center *(Amory)*	60	√	√	

County	Nursing Home *(City)*	Total Capacity	Certification Type		
			Medicaid	Medicare	State Licensure Only
Montgomery	Middleton Oaks Health and Rehabilitation *(Winona)*	120	√	√	
Neshoba	Choctaw Residential Center *(Philadelphia)*	120	√	√	
	Neshoba County Nursing Home *(Philadelphia)*	145	√	√	
	Hilltop Manor Health & Rehabilitation Center *(Union)*	60	√	√	
Newton	Bedford Care Center of Newton *(Newton)*	60	√	√	
	J. G. Alexander Nursing Center *(Union)*	60	√	√	
Noxubee	Noxubee County Nursing Home *(Macon)*	60	√		
Oktibbeha	The Carrington *(Starkville)*	60	√	√	
	Starkville Manor Health Care and Rehabilitation Center *(Starkville)*	119	√	√	
Panola	Diversicare of Batesville *(Batesville)*	130	√	√	
	Sardis Community Nursing Home *(Sardis)*	60	√	√	
Pearl River	Bedford Care Center of Picayune *(Picayune)*	120	√	√	
	Picayune Rehabilitation and Healthcare Center *(Picayune)*	120	√	√	
	Pearl River County Nursing Home *(Poplarville)*	110	√		
Perry	Perry County Nursing Center *(Richton)*	60	√	√	
Pike	Camellia Estates *(McComb)*	30		√	
	Courtyard Rehabilitation and Healthcare *(McComb)*	145	√	√	
	McComb Nursing and Rehabilitation Center *(McComb)*	140	√	√	
Pontotoc	Pontotoc Health & Rehab Center *(Pontotoc)*	60	√	√	
	Pontotoc Nursing Home *(Pontotoc)*	44	√		
	Sunshine Health Care *(Pontotoc)*	60	√	√	
Prentiss	Landmark Nursing & Rehabilitation Center, Inc. *(Booneville)*	80	√	√	
	Longwood Community Living Center *(Booneville)*	64	√	√	
Quitman	Quitman County Health and Rehab *(Marks)*	60	√		
Rankin	Brandon Court *(Brandon)*	100	√	√	
	Brandon Nursing and Rehabilitation Center *(Brandon)*	230	√	√	
	Community Place *(Brandon)*	60	√	√	
	Briar Hill Rest Home *(Florence)*	60	√	√	
	Methodist Specialty Care Center *(Flowood)*	60	√		
	Wisteria Gardens *(Pearl)*	52		√	
	Jaquith Nursing Home-Jaquith Inn *(Whitfield)*	45	√		
	Jaquith Nursing Home-Jefferson Inn *(Whitfield)*	90	√		
	Jaquith Nursing Home-Madison Inn *(Whitfield)*	63	√		
Scott	S.E. Lackey Convalescent Home *(Forest)*	20			√
	Mississippi Care Center of Morton *(Morton)*	120	√	√	

County	Nursing Home *(City)*	Total Capacity	Certification Type		
			Medicaid	Medicare	State Licensure Only
Sharkey	Sharkey-Issaquena Nursing Home *(Rolling Fork)*	54	√	√	
Simpson	Hillcrest Nursing Center *(Magee)*	100	√	√	
	Bedford Care Center of Mendenhall *(Mendenhall)*	60	√	√	
Smith	Mississippi Care Center of Raleigh *(Raleigh)*	110	√	√	
Stone	Azalea Gardens Nursing Center *(Wiggins)*	99	√	√	
	Stone County Nursing and Rehabilitation *(Wiggins)*	59	√	√	
Sunflower	Indianola Rehabilitation and Healthcare Center *(Indianola)*	75	√	√	
	Ruleville Nursing and Rehabilitation Center *(Ruleville)*	111	√	√	
	Walter B. Crook Nursing Facility *(Ruleville)*	60	√	√	
Tallahatchie	Tallahatchie General Hospital Extended Care Facility *(Charleston)*	98	√		
Tate	Senatobia Healthcare and Rehab (Senatobia)	106	√	√	
Tippah	Diversicare of Ripley *(Ripley)*	140	√	√	
	Rest Haven Health and Rehabilitation *(Ripley)*	60	√	√	
	Tippah County Nursing Home *(Ripley)*	40	√	√	
Tishomingo	Tishomingo Community Living Center *(Iuka)*	73	√	√	
	Tishomingo Manor *(Iuka)*	105	√	√	
Tunica	Tunica County Health and Rehab Center *(Tunica)*	60	√		
Union	New Albany Health & Rehab Center *(New Albany)*	114	√	√	
	Union County Health and Rehabilitation Center *(New Albany)*	60	√	√	
Walthall	Billdora Senior Care *(Tylertown)*	60	√	√	
	Diversicare of Tylertown *(Tylertown)*	60	√	√	
Warren	The Bluffs Rehabilitation and Healthcare Center *(Vicksburg)*	107	√	√	
	Heritage House Nursing Center *(Vicksburg)*	60	√	√	
	Shady Lawn Health and Rehabilitation *(Vicksburg)*	100	√	√	
	Vicksburg Convalescent Center *(Vicksburg)*	100	√	√	
Washington	River Heights Healthcare Center *(Greenville)*	60	√	√	
	Arbor Walk Healthcare Center *(Greenville)*	60	√	√	
	Legacy Manor Nursing & Rehab Center *(Greenville)*	60	√	√	
	Mississippi Care Center of Greenville *(Greenville)*	90	√	√	
	Washington Care Center *(Greenville)*	60	√	√	
Wayne	Pine View Health and Rehabilitation Center *(Waynesboro)*	90	√	√	
Webster	Diversicare of Eupora *(Eupora)*	119	√	√	
	Webster Health Services Nursing Facility *(Eupora)*	36	√		
Wilkinson	Wilkinson County Senior Care *(Centreville)*	60	√	√	
Winston	Louisville Healthcare *(Louisville)*	60	√	√	

County	Nursing Home *(City)*	Total Capacity	Certification Type		
			Medicaid	Medicare	State Licensure Only
Winston	Winston County Nursing Home *(Louisville)*	108	√	√	
Yalobusha	Yalobusha County Nursing Home *(Water Valley)*	122	√		
Yazoo	Yazoo City Rehabilitation and Healthcare Center *(Yazoo City)*	165	√	√	
	Martha Coker Greenhouse Homes *(Yazoo City)*	60	√	√	

SOURCE: Mississippi State Department of Health facility directory.

Agency Response: Mississippi State Department of Health

MISSISSIPPI STATE DEPARTMENT OF HEALTH

November 12, 2025

Ted Booth
Executive Director
Joint Committee on Performance Evaluation and Expenditure Review
Woolfolk Building, Suite 301-A
501 North West Street
Jackson, MS 39201

RE: A Review of the Provision of Routine Dental Hygiene Services in Mississippi Nursing Homes and Correctional Facilities

Mr. Booth,

On behalf of the Mississippi State Department of Health, I would like to express our appreciation for the recent report, *"A Review of the Provision of Routine Dental Hygiene Services in Mississippi Nursing Homes and Correctional Facilities."*

We commend the professionalism and thoroughness of the PEER committee staff who conducted this review. Their research, attention to detail, and balanced analysis reflect a strong commitment to improving access to quality services for Mississippians in long-term care and correctional settings.

The Department has reviewed the report's recommendations in detail and will incorporate them into existing efforts to strengthen access to healthcare, the agency's regulatory framework, and system coordination across the state. We look forward to continued collaboration with the Committee and its staff to advance these shared goals.

Thank you again for your leadership, partnership, and the high standard of work demonstrated throughout this review process.

Sincerely,

Daniel Edney, MD
Daniel P. Edney, MD, FACP, FASAM
State Health Officer

570 East Woodrow Wilson • Post Office Box 1700 • Jackson, MS 39215-1700
601-576-8090 • 1-866-HLTHY4U • www.HealthyMS.com

SOURCE: Mississippi State Department of Health.

Agency Response: Mississippi Department of Corrections

The Mississippi Department of Corrections reviewed the report and elected not to provide a formal agency response.

SOURCE: Mississippi Department of Corrections.

Agency Response: Mississippi State Board of Dental Examiners

MISSISSIPPI STATE BOARD OF DENTAL EXAMINERS

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Stephen W. Joe, D.M.D.
Haley Harrison Birmingham, R.D.H.

Telephone: (601) 944-9622
Facsimile: (601) 944-9624

715 S. Pear Orchard Rd., Suite 200
Ridgeland, MS 39157

Internet: www.dentalboard.ms.gov
E-Mail: dental@dentalboard.ms.gov

Date: November 07th, 2025

To: Mr. James F. (Ted) Booth, Executive Director
The Mississippi Legislature Joint Committee on Performance Evaluation and Expenditure Review (PEER Committee)
501 North West Street, Suite 301-A
Jackson, MS 39201

HAND DELIVERED

Re: MSBDE Response to PEER Report, *The Provision of Routine Dental Hygiene Services in Mississippi Nursing Homes and Correctional Facilities*

Dear Honorable Chairman Kevin Felsher and the Honorable Members of the Mississippi Legislature Joint Committee on Performance Evaluation and Expenditure Review,

The Mississippi State Board of Dental Examiners appreciates the PEER Committee's work and dedication to this important issue. Additionally, the Board appreciates the opportunity to provide input on this report and to provide a formal response.

On behalf of the Mississippi State Board of Dental Examiners, please find enclosed the formal response to the PEER Committee's report concerning *The Provision of Routine Dental Hygiene Services in Mississippi Nursing Homes and Correctional Facilities.* Thank you for your time and consideration on this issue. Please do not hesitate to contact me if the Board can be of further assistance.

Sincerely,

Denny Hydrick
Executive Director
Mississippi State Board of Dental Examiners
(601) 944-9625
denny@dentalboard.ms.gov

Enclosure: MSBDE Response to the PEER Committee Report on *The Provision of Routine Dental Hygiene Services in Mississippi Nursing Homes and Correctional Facilities*

MISSISSIPPI STATE BOARD OF DENTAL EXAMINERS

Telephone: (601) 944-9622
Facsimile: (601) 944-9624

715 S. Pear Orchard Rd., Suite 200
Ridgeland, MS 39157

Internet: www.dentalboard.ms.gov
E-Mail: dental@dentalboard.ms.gov

Date: November 07th, 2025

To: Joint Committee on Performance Evaluation and Expenditure Review
PEER Committee

Re: MSBDE Response to PEER Report, *The Provision of Routine Dental Hygiene Services in Mississippi Nursing Homes and Correctional Facilities*

The Mississippi State Board of Dental Examiners is charged with implementing the Mississippi Dental Practice Act (Miss. Code Ann. § 73-9-1, et seq.), which provides for a formalized system of vetting applicants for licensure as dentists and dental hygienists in the state of Mississippi. Further, pursuant to Miss. Code Ann. § 73-9-13(b), the Mississippi State Board of Dental Examiners is charged with the power and duty to regulate the practice of dentistry and dental hygiene and to promulgate reasonable regulations as are necessary or convenient for the protection of the public. Succinctly stated, the Board is charged to protect the Mississippi public from the unauthorized, unqualified, and unsafe practice of dentistry and dental hygiene.

On July 01st, 2025, the Mississippi legislature enacted amendments to Miss. Code Ann. § 73-9-5 that significantly expanded the scope by which dental hygienists may practice under the general supervision of dentists (i.e. without a dentist physically on the premises). For the first time in Mississippi, dental hygienists may now work in dental offices under general supervision, so long as certain prerequisite conditions are met. In response to this change, the Board implemented a regulatory framework providing for such.

The Board recognizes the intent of the report as an objective needs assessment and its value in identifying how those needs may be met. Recommendation 10 of the report states the Mississippi legislature should consider amending Miss. Code Ann. §73-9-5 to further expand the practice of dental hygiene under general supervision to include public health settings, such as nursing homes and correctional facilities. As the foremost regulatory agency charged with ensuring the safe delivery of dental care in Mississippi, the Board is concerned with the timing of Recommendation 10 – or rather, the lack of time since July 01st, 2025. Only four (4) months ago, the Mississippi legislature ushered the dental profession in Mississippi into a new era in which dental hygienists are authorized to work under general supervision. Unfortunately, there can be no reasonable assessment of the impact of this significant change in only four (4) months.

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The opportunity for the gathering of evidence and assemblage of data by the Board is foregone by recommending another enlargement of dental hygiene scope of practice so hastily.

While it is certainly cognizable that persons in the identified public health settings – nursing homes and correctional facilities – may have challenges in having his or her oral healthcare needs met, it is equally important to assess the potential for harm by reducing the level of supervision required in such settings. In assessing the potential for harm, it is important to understand the population to be affected by the recommendation.

According to the National Post-acute and Long-term Care Study[1]:

- The 10 most frequently observed chronic conditions among residential care community residents were high blood pressure (58%), Alzheimer disease or other dementias (44%), heart disease (33%), depression (26%), arthritis (18%), chronic obstructive pulmonary disease (chronic bronchitis or emphysema) (16%), diabetes (16%), osteoporosis (12%), stroke (7%), and cancer (6%).
- The following distribution shows the prevalence of these conditions ever experienced by nursing home residents.
    - 4-10 chronic conditions – 18%
    - 2-3 chronic conditions – 55%
    - 1 chronic condition – 19%
    - No chronic condition – 8%

Additionally, according to the United States Department of Justice[2], approximately 51% of state and 43% of federal prisoners reported ever having a chronic condition, while 40% of state and 33% of federal prisoners reported currently having a chronic condition.

The data supports what we already know – persons in nursing homes and correctional facilities are sicker and have more chronic conditions than the general population. Recommendation 10 in the report is suggesting that the Mississippi legislature consider amending the law to enable dental hygienists to provide treatment for these populations without a dentist physically present on the premises. The Board is concerned that dental hygienists lack

[1] Melekin, A., Sengupta, M., & Caffrey, C. (2024). *Residential care community resident characteristics: United States, 2022*. NCHS Data Brief, no 506. https://doi.org/10.15620/cdc/158327
[2] Maruschak, L. M., Bronson, J., & Alper, M. (2021). *Medical problems reported by prisoners: Survey of prison inmates, 2016* [Report]. U.S. Department of Justice, Bureau of Justice Statistics

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the education and training to properly account for the risks associated with delivering dental hygiene treatment to a population shown to have such a breadth of chronic health conditions. The concern is elevated further when considering that dental hygienists often engage in scaling and root planning, an invasive procedure that can be contraindicated by the presence of certain diseases. Finally, this concern is only amplified by the minimal window afforded to the Board to evaluate the risk of dental hygienists delivering dental hygiene treatment under general supervision to the general population.

Respectfully Submitted,

Marion Lewis Grubbs, D.M.D.
President, MSBDE

SOURCE: Mississippi State Board of Dental Examiners.

James F. (Ted) Booth, Executive Director

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Stephanie Harris
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