OREGON CLINICAL & TRANSLATIONAL RESEARCH INSTITUTE

Evaluation of Oregon Health Plan Dental Provider Enrollment

Conducted by Oregon Clinical & Translational Research Institute at Oregon Health & Science University in collaboration with the Oregon Health Authority Health Policy and Analytics Division

October 2024

BACKGROUND

Historically, Oregon has been at the forefront of recognizing and prioritizing health coverage for all with the development of the Oregon Health Plan (OHP) as the state's Medicaid program in the 1990s to the creation of Coordinated Care Organizations (CCOs) in 2011.[i] Since 2013, there has been a 131 percent increase in the total number of individuals enrolled in Medicaid/Child Health Improvement Plan (CHIP).[ii]

Not only are more people eligible and enrolled in OHP than ever before, but coverage has become increasingly more comprehensive, especially around oral health. For example, in 2014 Oregon used the passage of the Affordable Care Act (ACA) to expand its Medicaid dental program for children. Accompanying this legislation, Oregon expanded adult dental care coverage from offering only traditional emergency services to a comprehensive preventative and routine dental care program.[iii]

Despite policies contributing to more extensive OHP coverage for dental services, a gap between policy and implementation has emerged. For example, Oregon's Medicaid reimbursement is only 28.3 percent as a percentage of dentist charges for adult dental services, compared to neighboring states Washington and California that have higher rates at 42.9 percent and 44.9 percent respectively.[iv] According to the American Dental Association's most recent data from 2017, most dentists in Oregon did not treat Medicaid patients. Most (57 percent) dentists in Oregon are not enrolled Medicaid providers, and 11 percent are enrolled but have not seen a Medicaid patient.[v] This results in relatively few practices serving most Medicaid patients. Moreover, when comparing dental care utilization in 2021 between Medicaid insured children and privately insured children, 27 percent more privately insured children saw a dentist in the last 12 months.[vi] Oregon also falls below the national rate of dental care utilization among children. [v] About one quarter (24 percent) of adults covered by Medicaid have seen a dentist in the last 12 months, compared to 62 percent of privately insured Oregonians.[vii]

Grounded by this landscape of increasing coverage, yet under-utilization, there is a need to understand barriers to implementation. Given that large Federally Qualified Health Centers (FQHCs) and Dental Care Organizations (DCOs) serve the majority of Medicaid patients, this report investigates the implementation of Medicaid reimbursement from the point of view of dentists in Oregon. Special attention was paid to private practices in Douglas, Jackson, Josephine, and Lane counties, which are the focus of a Health Resources and Services Administration (HRSA) Oral Health Workforce Grant.

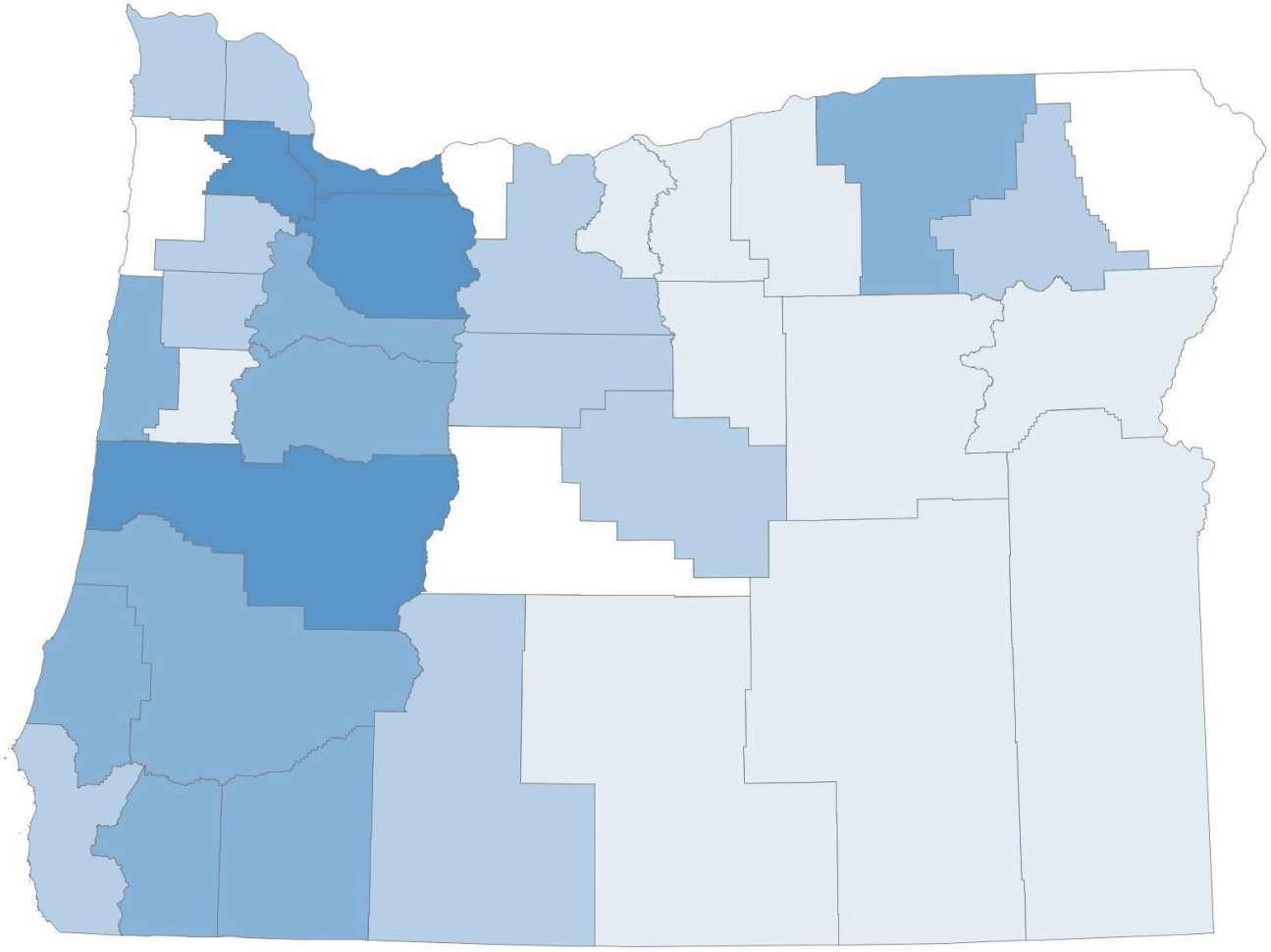
HRSA awarded Oregon Health Authority (OHA) the Grant in 2022 to address dental workforce needs and expand access in dental health professional shortage areas (dental HPSAs) for people experiencing health inequities in these four counties. Appendix 1 includes a map and more information on Oregon's dental HPSAs. OHA selected these counties for the Grant's focus because practices in the area face significant challenges in recruiting and retaining dental providers. OHA contracted with Oregon Clinical & Translational Science Research Institute (OCTRI) to lead the report analysis and drafting using Grant funds.

OREGON DENTAL COVERAGE

Thirty-two of Oregon's 36 counties (89 percent) lack adequate Medicaid dental full-time equivalents (FTE) to meet the needs of enrolled patients. Figure 1 on page 2 shows the Medicaid dental FTE needed to reduce shortage for OHP members in each Oregon county. See Appendix 2 for data sources, breakdown of Medicaid enrolled population, existing Medicaid dental FTE, and need by county, and calculations.

Most counties, noted by shades of blue, need more FTE. Higher need is concentrated in urban/metro areas, while many rural areas are shown to need less than one Medicaid dentist FTE. When considering need in rural counties, the geographic context and associated barriers must also be considered. People using Medicaid living in rural areas such as the HRSA grant's four counties face barriers around the distance to care such as the time and cost associated with transportation. Additionally, where people living in more densely populated areas may have multiple options of dental providers, people living in rural areas have more constrained choices and may be forced to see a provider that is not a good fit for them in terms of language, social identity positions, or treatment approach.

Figure 1. Medicaid dental FTE needed to reduce shortage for OHP members by county



Medicaid FTE dental provider shortage

- < 0
- 0.01 – 0.9
- 1.0 – 2.9
- 3.0 – 6.9
- 7.0 – 22.4

Sources: Medicaid claims and enrollment data, 2023. See Appendix 2 for more information on calculations

KEY INFORMANT INTERVIEWS

Key informant interviews were conducted with two groups: (a) OHA employees engaged in the OHP provider enrollment process and (b) prominent members of oral health systems throughout Oregon. These interviews provided background and context around OHP dental provider enrollment statewide. These interviews were coordinated by and included OHA representatives.

The interviews with OHA employees engaged in OHP dental provider enrollment provided logistical context for program requirements, including the enrollment and reimbursement processes. The processes described by OHA employees were straightforward and clear. However, this narrative ran counter to the experiences described by dental practices. Practices reported conflicting accounts of the enrollment and reimbursement processes, particularly among private practices.

The interviews with prominent members of oral health systems in Oregon focused on broader initiatives to improve oral health access and communication methods around OHP. These interviews highlighted the innovative ways that members of the oral health community are working to expand access to all Oregonians, including the use of teledentistry, expanding the oral health workforce, and integrating oral health into whole body health. They also underscored the complex landscape of oral health in Oregon. They described the need to balance appealing to the altruistic nature of providers with business feasibility and held varied opinions about government involvement with health care when discussing OHP.

DENTAL PRACTICE INTERVIEWS

To better understand the decision-making process around enrolling dental providers in the OHP program among private practices, we conducted interviews with representatives from dental practices in OHA's HRSA Oral Health Grant focus areas: Douglas, Jackson, Josephine and Lane counties that historically have oral health access issues and trouble recruiting and retaining providers. Interviews covered practice background, status of OHP enrollment, and barriers/facilitators to OHP enrollment. See Appendix 3 for the full interview guide.

Eligibility and recruitment

Eligible practices were in Douglas, Jackson, Josephine, and Lane counties. Dental specialists (orthodontic, endodontic, periodontic or surgical) and Veterans Affairs-affiliated clinics were excluded. To ensure clinics serving patients in rural areas were included in the sample, we prioritized those practices in towns with less than 15,000 people.

Recruitment letters explaining the purpose of the project, an incentive for participating, and a QR code to a survey where they could indicate interest and provide contact information were sent to 25 dental practices in each county based on the criteria above. The initial recruitment round yielded seven interviews and met saturation for Josephine and Douglas counties. This process was repeated several months later with additional clinics from Lane and Jackson counties for a total of 12 interviews.

Interview demographics

In total, 12 interviews were conducted with representatives from dental practices in Douglas, Jackson, Josephine, and Lane counties. Sample demographics are detailed in the table on this page.

Interviewee Demographics	
County	
Douglas	4 (33%)
Jackson	3 (25%) *
Josephine	3 (25%) *
Lane	3 (25%)
Practice Type	
Private practice	10 (83%)
CCO/DCO	2 (17%)
OHP Status	
Currently Accept	5 (42%)
Previously Accept	1 (8%)
Never Accepted	6 (50%)
Role	
Dentist	5 (42%)
Practice Manager/Dental Director	7 (58%)
***One practice operated in both Jackson and Josephine counties**	

Altruism among dentists

A salient theme throughout all the interviews was a desire to provide optimal care to patients, which the interview participants felt was difficult with how OHP is currently structured. While charitable motivations led providers to seek out ways to address care gaps, such as providing services at a low or no cost rate for select patients, these values were also cited as a reason for not enrolling in OHP due to long wait times and restrictions to the types of procedures allowed under OHP, such as providing replacement dentures more than once every ten years. This led some provider types to become disillusioned with the program.

General challenges facing dental practices

While the overall purpose of the interviews was to discuss dental provider enrollment in OHP, interviewees also raised several challenges facing dental practices more generally in Oregon.

- **Workforce recruitment and retention are a common challenge for dental practices, particularly in rural areas.** Many providers or practice managers we spoke with shared constraints related to recruitment and retention such as clinics located in undesirable locations, lack of applicants, or competitive pay. This is especially true for dental hygienists, which limit their practice's capacity for expanding their patient panel. Several practices shared that it often could take a year or more to fill open positions.
- **Dental practices face substantial managerial burdens that additionally restrict capacity.** Many dentists described the administrative burden associated with billing and filing insurance claims on behalf of patients, particularly if they work with multiple payer types. This task diverts time and resources away from patient care, and a few dentists described relationships with payers influencing the types of services and quality of care they can provide. Moreover, a few providers shared they either already had transitioned or were planning to transition from accepting insurance to an in-office dental plan.
- **Dental providers shared that existing reimbursement rates are insufficient.** Providers shared that reimbursements for all insurance providers have not kept pace with rapidly rising costs for materials and staffing, and OHP reimbursements are less in comparison to rates offered by private insurance. Providers who accept OHP shared that they were "in the red" – not making money – for any service beyond routine dental exams. For providers who accept OHP, the challenge of low reimbursement was compounded by the variability in fee schedules set by different DCOs/CCOs and among dentists within the same practice. This financial strain makes it difficult for practices to maintain profitability while delivering high-quality care.

OHP dental provider enrollment barriers

In addition to the general challenges outlined above, interviewees cited the following additional barriers to participating (or continued participation) in OHP.

- **The administrative burden required to take OHP is a substantial hurdle, particularly for smaller dental practices.** Providers further emphasized the administrative processes for providing care to OHP patients are complex and confusing. Specific challenges included managing patient assignments, checking OHP eligibility for all patients, and navigating the claims process. Many practices did not have dedicated billing staff to manage these steps, and given challenges related to reimbursement rates and staffing, hiring to fill this gap is not a feasible solution. Variability in the processing time for denials and approvals adds to the complexity of managing OHP patients.
- **Poor communication about changes in covered services**. A few providers who accept OHP expressed frustration that there is limited communication about changes to covered services and that they often hear about updates through word of mouth, rather than from the DCOs/CCOs or OHA itself.
- **Constraints in covered services and equipment prevent dental practices from practicing dentistry at their desired standard.** Several dental providers complained that OHP does not cover the services that they would typically recommend to patients (for example, performing an extraction instead of a root canal). This leads to dentists experiencing moral injury; there is a high stated desire among providers to do well by their patients, but financial and administrative constraints limit their ability to do so. A few providers shared that they thought it was only feasible for private practices to take OHP if they were willing to cut corners or provide substandard care.
- **Enrollment for private practices into OHP is unclear and varies by DCO/CCO, leading to conflicting narratives about the process.** While OHA staff have a clear process for paperwork, the engagement between DCOs/CCOs and private practices remains ambiguous and varies significantly, which creates confusion for dental providers.
- **Some providers shared that the OHP patient population presents additional challenges.** A few providers shared their opinion that OHP patients are less likely to show up for their appointments and are more likely to require complex treatment.
- **Opinions on the capitation model are divided.** Some dental practitioners feel it restricts care to remain financially viable, while others appreciate the guaranteed income it provides.

OHP dental provider enrollment facilitators

Providers accepting OHP had several commonalities, which may speak to enrollment facilitators in the dental setting:

- **Several participating practices that accept OHP are part of an integrated practice offering both medical and dental services.** As one provider shared, integration with medical care made their services financially feasible; while

dental services are "in the red," medical services are "in the black" which offsets costs and facilitate acceptance of OHP patients in the dental setting.

- **Larger practices with multiple locations benefit from an economy of scale that facilitates OHP acceptance.** For example, these types of practices are better positioned to support dedicated billing teams, making the administrative burden of accepting OHP more manageable.

RECOMMENDATIONS

The recommendations included in this section are intended to be a starting point for improving access to oral health care in Oregon and increasing OHP enrollment/retention among private practices.

The following are **lower-effort strategies** that could help to improve OHP enrollment and retention in the short-term:

- **Conduct direct outreach to dentists and improve communication.**
  None of the dental practice representatives we spoke with indicated that they had been directly approached by OHA about accepting OHP, indicating a gap in proactive engagement. Key informant interviews indicated that prior to the COVID-19 pandemic, OHA employed a trainer to aid dentists in OHP enrollment and conduct outreach. However, that role no longer exists. Implementing a communication and outreach plan with dental practices may reduce misconceptions about OHP and provide a point of entry for participation in the program.
- **Clarify and standardize OHP dental provider enrollment process.**
  While OHA staff have a clear process for OHP enrollment, the engagement between DCOs/CCOs and private practices needs to be streamlined and made more transparent. Interviewees reported conflicting narratives about how DCOs/CCOs and private practices coordinate treatment of OHP patients and determine reimbursement. Standardization will reduce administrative burdens and facilitate participation in OHP.

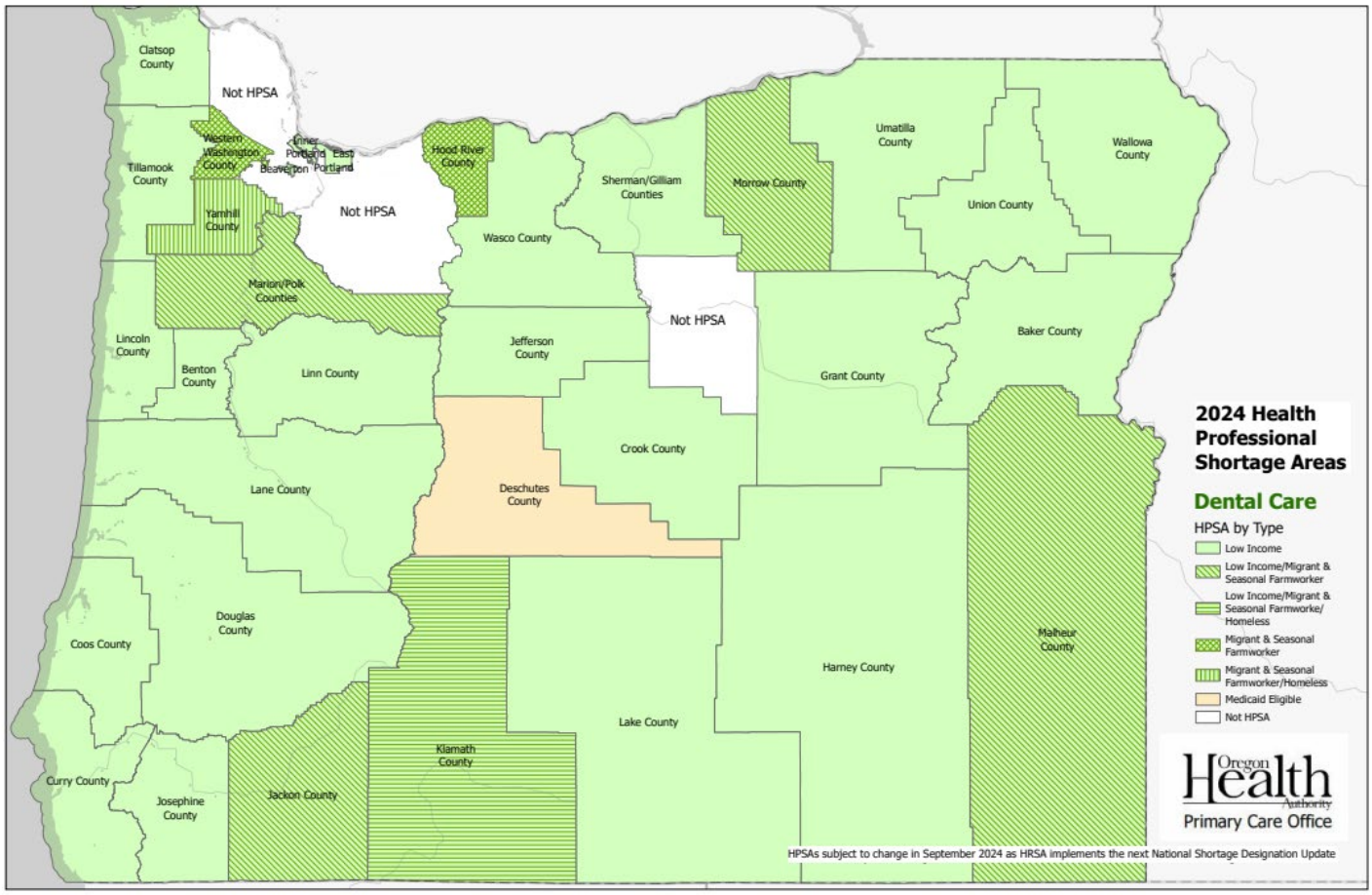
The following recommendations are **higher-effort strategies** that require financial investment and time to accomplish:

- **Increase reimbursement rates.**
  Inadequate reimbursement was the most common barrier to accepting OHP, and improving reimbursement would alleviate financial pressures for providers. Many providers who do not accept OHP shared that they would be interested in providing care for OHP patients, but they could not make it financially worthwhile.
- **Improve loan repayment incentives.**
  Several private practice dentists we spoke with highlighted that they had substantial student debt which influenced their decision to go into private practice and additionally constrains financial flexibility. Improving communication about existing student loan repayment options, as well as expanding eligibility, would likely increase interest among dentists.
- **Address workforce constraints.**
  Improvements to expand the dental workforce could alleviate pressures that all dental providers experience and redress constraints to caring for more patients. Addressing the broader shortage of oral health providers involves increasing training programs and expanding opportunities for dental therapists and dental hygienists. Subsidizing living costs for students in oral health training programs could expand the numbers enrolled. Additionally, educational institutions making a concerted effort to recruit students from rural areas will increase the likelihood of providers working in rural areas once licensed.
- **Add covered services to OHP.**
  Including services that providers deem necessary to meet the standard of care would align financial incentives with professional judgment and mitigate concerns that OHP patients are receiving substandard care.

ACKNOWLEDGEMENTS

Thank you to the dentists from across Oregon, OHA staff, and prominent members of Oregon's dental community who volunteered their time and shared their experiences for the interviews conducted as part of this evaluation. This work was made possible by funding from OHA's HRSA Oral Health Workforce Grant.

Appendix 1. Map of Oregon's Dental HPSAs



Dental HPSA scores are determined by several factors, including the availability of fluoridated water, population-to-provider ratios, distance to the nearest provider, and the prevalence of populations experiencing health inequities (e.g., Migrant Seasonal Farmworkers, homeless, and residents under the federal poverty threshold). Higher scores indicate a larger shortage of dental providers and lower access to care. For more information on the latest dental HPSA scores, please check https://data.hrsa.gov/tools/shortage-area.

Appendix 2. OHP/Medicaid enrolled population, existing OHP/Medicaid dental FTE, and FTE needed by county

	OHP Enrolled Patients (Dec 2023)	Existing OHP Dental FTE (2023)*	FTE Needed to reduce OHP Dental FTE Shortage**
Oregon	**1,465,893*** **	**196.96**	**96.21**
Baker	6,350	1.05	0.23
Benton	22,557	4.09	0.42
Clackamas	108,930	13.95	7.84
Clatsop	14,846	1.36	1.60
Columbia	16,078	1.76	1.46
Coos	27,215	2.24	3.21
Crook	10,577	0.36	1.76
Curry	9,085	0.56	1.26
Deschutes	61,285	16.99	(4.73)
Douglas	46,933	5.60	3.79
Gilliam	763	0.00	0.15
Grant	2,475	0.02	0.47
Harney	3,073	0.44	0.18
Hood River	8,800	2.04	(0.28)
Jackson	91,848	12.89	5.48
Jefferson	12,461	0.00	2.49
Josephine	42,840	5.20	3.37
Klamath	31,699	3.92	2.42
Lake	3,354	0.42	0.25
Lane	134,945	19.46	7.53
Lincoln	20,290	0.60	3.45
Linn	51,211	3.71	6.53
Malheur	16,491	3.19	0.11
Marion	141,423	25.20	3.09
Morrow	5,589	1.08	0.03
Multnomah	284,558	34.54	22.37
Polk	27,627	3.60	1.92
Sherman	697	0.00	0.14
Tillamook	10,215	2.41	(0.37)
Umatilla	32,801	2.47	4.09
Union	9,782	0.61	1.34
Wallowa	2,657	0.81	(0.28)
Wasco	10,940	1.04	1.14
Washington	159,856	20.69	11.29
Wheeler	442	0.05	0.04
Yamhill	33,834	4.62	2.15

* number of 2023 claims / 4,000
** Dental FTE needed to meet needs of Medicaid population – Existing Dental Medicaid FTE
*** Includes 1,366 individuals whose county is unknown

Calculations

- **Dental FTE needed to meet needs of Medicaid population:** number of Medicaid enrolled patients / 5,000. 5,000 is the population-to-provider ratio used by HRSA.
    - Data source: number of Medicaid enrolled patients pulled from OHA dashboard of December 2023 enrollment data
    - Calculation: HRSA Designated Health Professional Shortage Area Statistics

- **Existing Dental Medicaid FTE:** number of Medicaid claims / 4,000 equals one FTE, as defined by HRSA.
    - Data source: 2023 claims data provided by OHA Medicaid claims team
    - Calculation: HRSA Shortage Designation Management System (SDMS): Manual for Policies and Procedures. Dental Provider FTE Calculations

Appendix 3. OHP Evaluation Interview Script and Guide

Clinic ID:
Interviewee:
Interviewee role:

Interviewer:
Date and Time:

Introduction and Consent

Hello, thank you for participating in this interview. My name is [introduce self and notetaker, if applicable]. The purpose of this discussion is to better understand, from your practice's perspective, barriers and opportunities of Medicaid/Oregon Health Plan insurance coverage and participation. This information will help Oregon Health Authority recommend changes to OHP to try to improve the process and make it easier for dental practices.

Participating in this interview is completely voluntary – meaning you can stop the interview at any time. You may choose to skip any questions you do not want to answer. Please feel free to be honest, there are no right or wrong answers. This is not an audit nor evaluation of your specific practice. When we report findings back to OHA, we will not use your name nor your organization's name.

What questions do you have for me before we begin?
Is it okay with you if we record this discussion?

Interview Questions

1. To start, can you tell me more about your practice?
    a. How long has your practice been in business?
    b. Staffing?
    c. Space/facility?
    d. Catchment area? Community demographics?
    e. Are there any dental specialties your practice focuses on? If so, what are they?

2. What types of payments does your practice currently accept?
    a. How would you describe the breakdown of payments your patients present with?
    b. Have you worked with a DCO/CCO in your area?

3. How would you describe your current capacity to take on more patients?
    a. What does your wait time for a new appointment look like?
    b. What are barriers to taking on more patients? (e.g., limited space, staff capacity, COVID catch-up)

4. Does your practice currently accept Medicaid or Oregon Health Plan (OHP) insurance?

If yes:	**If no:**

• What are specific reasons your practice does accept OHP or Medicaid?
• Do you know how long your practice has accepted OHP or Medicaid?
• What has been your experience like filing OHP claims? Reimbursement process?
  ○ What barriers have you experienced accepting OHP or Medicaid?
  ○ What are the most common procedures billed at your practice? What does the OHP reimbursement rate look like for those?
• What are your future plans for OHP or Medicaid acceptance?
• From your practice's perspective, what would make accepting OHP or Medicaid easier?
• Capitated v fee for service
	• What are specific reasons your practice does not accept OHP or Medicaid? (e.g., reimbursement rates, administrative burden, staff or space capacity, limited-service coverage, population characteristics)
	• Do you know if your practice has accepted OHP or Medicaid in the past? If so, when? What was that experience like?
	• What do you tell OHP patients if they ask to be seen? Do you know where to refer OHP patients in your community?
	• From your practice's perspective, what are the biggest barriers to serving OHP patients?
	• Again, from your practice's perspective, what are some ways that could alleviate those barriers?

	• Is there anything that would make your practice consider accepting OHP or Medicaid? If so, tell me more about that.

5. What else would you like us to know about OHP/Medicaid and your practice?

6. Are there are any other providers in your community that you think we should talk to? We won't share anything about this interview or your name with anyone we reach out to.

Closing

That's all the questions I have, what questions do you have for me?

Thank you for your participation. We greatly appreciate your time and honesty. We will be following up with a gift card ($75) in appreciation for your time, is there an email or way to send it to you that works best?

We will be summarizing and sharing these results with OHA, who may use this information to try to improve the OHP process for dental. If you have any questions, you can email us at evaluation@ohsu.edu.

CITATIONS

[i] DiPrete, Bob, and Darren Coffman. 2007. *A Brief History of Health Services Prioritization in Oregon.* Oregon Health Authority. https://www.oregon.gov/oha/HPA/DSI-HERC/Documents/Brief-History-Health-Services-Prioritization-Oregon.pdf (Accessed September 10, 2024).

[ii] Kaiser Family Foundation (KFF). "Total Monthly Medicaid & CHIP Enrollment and Pre-ACA Enrollment." April 2024. https://www.kff.org/affordable-care-act/state-indicator/total-monthly-medicaid-and-chip-enrollment/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D.

[iii] Oregon Health Authority. "Dental Coverage Awareness Toolkit. KFF. "Total Monthly Medicaid & CHIP Enrollment and Pre-ACA Enrollment." April 2024. https://www.kff.org/affordable-care-act/state-indicator/total-monthly-medicaid-and-chip-enrollment/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D.

[iv] ADA Health Policy Institute. August 2023. "Medicaid Reimbursement for Dental Care Services- 2022 data update" https://www.ada.org/-/media/project/ada-organization/ada/ada-org/files/resources/research/hpi/medicaid_reimbursement_dental_care_2022.pdf?rev=16c2f572ec974b01a787949294187ac6&hash=5869A65C6E259FED5733ECFEB5181E34.

[v] Vujicic M, Nasseh K, Fosse C. Dentist Participation in Medicaid: How Should It be Measured? Does It Matter? American Dental Association. Health Policy Institute Research Brief. October 2021. Available from: https://www.ada.org/-/media/project/ada-organization/ada/ada-org/files/resources/research/hpi/hpibrief_1021_1.pdf.

[vi] ADA Health Policy Institute. "Dental Care Utilization Rate for Children." https://www.ada.org/resources/research/health-policy-institute/child-dental-care-utilization-dashboard.

[vii] Vujicic M, Nasseh K, Fosse C. Dentist Participation in Medicaid: How Should It be Measured? Does It Matter? American Dental Association. Health Policy Institute Research Brief. October 2021. Available from: https://www.ada.org/-/media/project/ada-organization/ada/ada-org/files/resources/research/hpi/hpibrief_1021_1.pdf.