

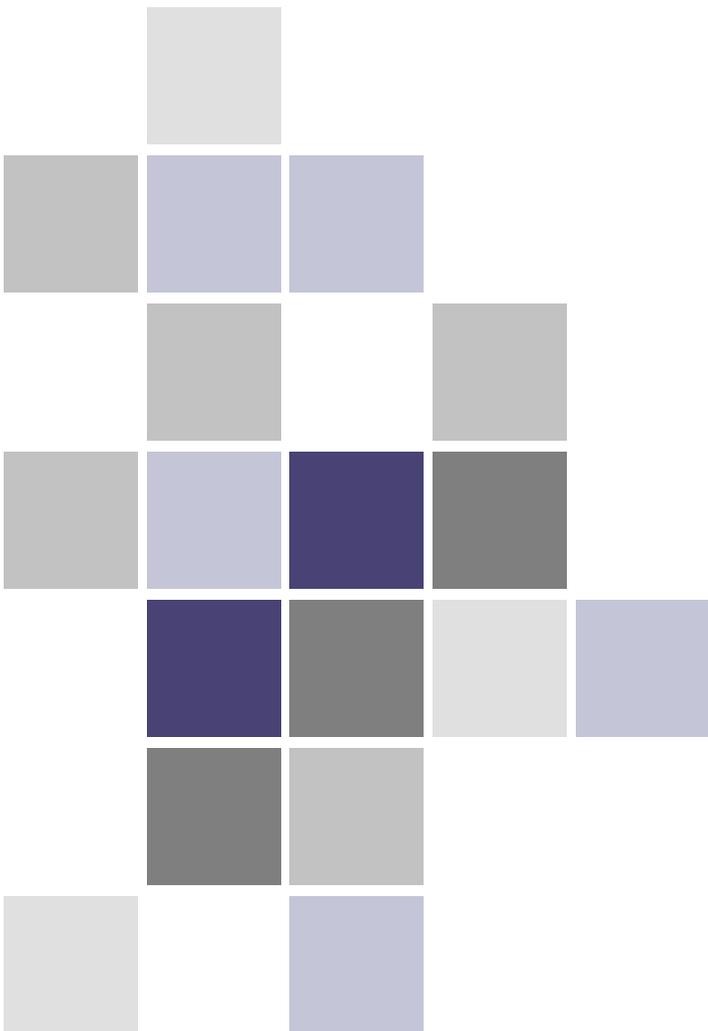


OREGON DEMOGRAPHIC DENTAL CARE STUDY

DEPARTMENT OF CONSUMER AND
BUSINESS SERVICES

Final Report

January 31, 2020



DEPARTMENT OF CONSUMER AND BUSINESS SERVICES

Oregon Demographic Dental Report
January 31, 2020

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EXECUTIVE SUMMARY

The purpose of this report is to provide information on a study of the dental needs and geographic distribution of low-income Compact of Free Association (COFA) citizens in Oregon. Those who are considered low-income are above the age of 18 with income eligible for Medicaid in the state of Oregon. COFA is an international agreement between the United States (U.S.), the Republic of the Marshall Islands (RMI), the Federated States of Micronesia (FSM), and the Republic of Palau (Palau). The compact allows citizens from these Pacific Islands to come to the U.S. to live, work, go to school, and serve in the U.S. Military without being U.S. citizens.

COFA members reside in the North Western part of the state with a few residing in the East. Most are in Multnomah and Marion counties.

Dental Care Organizations (DCOs) contract with dental practices to provide critical business management and support, including non-clinical operations. These organizations allow dentists to focus solely on providing the best care possible for their patients.

Based on the oral health assessment data, taking on this population would cost between an average of \$63 and \$163 per member per month depending on preventative and restorative dental needs. About half of the COFA members need preventive services such as cleaning and the other half need restorative services including extractions, dentures, and crowns.

With an estimated 695 to 890 enrollees for the first year, the state would need a maximum of \$6,154,724 to support this program for the first year and following years vary based on enrollment estimates. The report includes three scenarios that consider general population growth, likelihood of usage if Oregon offers dental care coverage for COFA residents, and exclusion of those with current coverage through dental insurance through their employers.

Dental coverage for adults under the federal Medicaid program is not mandated, and the federal Medicare program for older and disabled adults does not include routine oral health services.¹

¹ Medicaid and CHIP of Lawfully Residing Children and Pregnant Women. Retrieved from <https://www.medicaid.gov/medicaid/outreach-and-enrollment/lawfully-residing/index.html>

CHAPTER I. INTRODUCTION

The purpose of this report is to provide information on a study of the dental needs and geographic distribution of low-income Compact of Free Association (COFA) citizens in Oregon. Those who are considered low-income are above the age of 18 with income eligible for Medicaid in the state of Oregon.

COMPACT OF FREE ASSOCIATION

COFA is an international agreement between the United States (U.S.), the Republic of the Marshall Islands (RMI), the Federated States of Micronesia (FSM), and the Republic of Palau (Palau). The compact allows citizens from these Pacific Islands to come to the U.S. to live, work, go to school, and serve in the U.S. Military without being U.S. citizens.

COFA PREMIUM ASSISTANCE HEALTH CARE PROGRAM

For the COFA Premium Assistance Program, the state supplements health insurance premiums and all out-of-pocket expenses for COFA residents living in Oregon. Although the program does not include dental services coverage, a study in the U.S. National Library of Medicine National Institutes of Health Journal, concluded that Oregon has the most progressive policies for providing health insurance to COFA migrants.²

Since the inception of the program as of October 2019, 1,138 unique people from COFA island nations enrolled in the COFA Premium Assistance Program to receive assistance with premiums and in-network out-of-pocket expenses for medical coverage. **Exhibit 1** displays the number of those from COFA nations who applied for COFA Premium Assistance, were approved, renewed and had continuous enrollment. The COFA Premium Assistance bill did not include dental care. These numbers provide a context for understanding the health needs of those from COFA island nations and provide a potential basis for forecasting dental needs.

EXHIBIT 1 COFA PREMIUM ASSISTANCE HEALTHCARE PROGRAM ENROLLEES

Plan Year	Applicants	Approved	Prior Year Renewals	Yearly Renewals	New***
2017	644	419	-	-	-
2018	766	639	167	-	471
2019	874	789	269	129	520
2020*	765	688	439	81**	328

*2020 Open Enrollment is in progress. The current approval is 688 and the goal is 800 for the full plan year.

**As of Dec. 30, 2019. This number may continue to grow through enrollments through special enrollment periods.

***Calculation in process.

² McElfish, P., Purvis, R, Riklon, S. & Yamada, S. (2019). Compact of Free Association Migrants and Health Insurance Policies: Barriers and Solutions to Improve Health Equity. Retrieved from <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6906344/>

COFA DENTAL CARE OPTION

The COFA Dental Care Option establishes a dental program in the Oregon Health Authority (OHA) to provide oral health coverage. The bill authorizes OHA to contract with dental care organizations (DCOs) to provide oral health services to individuals enrolled in the program. The legislation specifies covered services are based on services provided to medical assistance recipients without any out-of-pocket costs for enrollees. It also allows OHA to establish the program application and eligibility verification process through rulemaking. The legislation directs OHA to contract with DCOs and with individual oral health care providers to provide oral health care to COFA citizens enrolled in the COFA Dental Program. The Oregon Dental Association supported this bill and stated, “every Oregonian deserves access to quality affordable oral health care. Extending dental coverage to this population is fair, equitable, and necessary.”³

A representative from the Oregon Commissions on Asian and Pacific Islander Affairs (OCAPIA) testified that many islanders do not go to the dentist because they do not have dental insurance and cannot afford regular cleanings or preventive services. Additionally, he shared that referral programs are not available and often dental problems escalate, requiring an expensive visit to an emergency room where they hope for a waiver which is an expensive process for Oregon.⁴ Other testimonies expressed the need for parity with other low-income populations.⁵

Coordinated Care Organization (CCO) is a network of all types of health care providers (including dental care) who work with local communities to serve people on Medicaid. According to findings in the “Oral Health in Oregon’s CCOs: A Metrics Report”:

- Certain counties have fewer dentists compared with the number of residents they serve
- Members didn’t receive preventive dental services
- Hawaiian/Pacific Islanders consistently receive services at lower rates than other members

These findings highlight the need for preventive dental care in Oregon.

THE IMPORTANCE OF DENTAL CARE

The Mayo Clinic calls oral health the window to overall health and highlighting the connection between the two. Without proper oral hygiene, bacteria may lead to oral infections, such as tooth decay and gum disease. Further, side effects of medications may reduce saliva flow that washes away food and neutralizes acids to protect from disease. Certain diseases such as diabetes and HIV/AIDS, can lower the body’s resistance to infection, making oral health problems more severe. Oral health has the potential to contribute to various diseases and conditions including endocarditis, cardiovascular disease, pregnancy and birth complications, and pneumonia.⁶ Cultural factors may impact the perceptions of dental care and

³ Support of HB 2706: Dental Coverage for COFA. Retrieved from <https://olis.leg.state.or.us/liz/2019R1/Downloads/CommitteeMeetingDocument/203684>

⁴ Testimony in Support of HB 2706. Retrieved from <https://olis.leg.state.or.us/liz/2019R1/Downloads/CommitteeMeetingDocument/203825>

⁵ Alishia Perman Testimony Retrieved from <https://olis.leg.state.or.us/liz/2019R1/Downloads/CommitteeMeetingDocument/172299>

⁶ Mayo Clinic. Oral Health: A window to your overall health. Retrieved from <https://www.mayoclinic.org/healthy-lifestyle/adult-health/in-depth/dental/art-20047475>

needs. In some of the Pacific island cultures, gold crowns are valued as an indicator of prestige and status. At least nine of 105 interviews had gold crowns, mostly the older population. Some possible, but rare side effects of gold crowns include redness, swelling, lip and mouth pain, gum swelling and irritation, lesions in the mouth, and allergic reactions.⁷

THE COST OF DENTAL CARE

According to the Health Policy Institute of the American Dental Association, in 2013 the average per patient spending on dental care was \$685 per year with no insurance and average expenditures for patients in the 90th percentile was \$1,624. Adjusted for current inflation, the per patient cost annually is \$765 and \$1,814 as of November 2019 based on the U.S. Bureau of Labor Statistics Inflation Calculator.⁸ These higher average costs represented restorative procedures such as crowns and implants, which are not typically required annually. The same study also indicated a median expenditure of \$254. Dental expenditures accounted for almost 5% of total health care spending in 2013, which was down from 8.5% in 1960.⁹ To further understand dental care expenditures, the report disaggregated costs by type of dentists to understand differences. Visits to general practice dentists average \$514 and visits to dental specialists average \$1,755. Nationally, the study noted that dental care is often not covered by employers and when it is, the cap is typically \$1,000 to \$1,500. The study also concluded that the median of \$254 reflects improvements in the oral health of the U.S. population and the shift in dental services from relatively high cost restorative services to lower cost diagnostic and preventative services. Further, this report notes that even a cost of zero leaves costs to the patients when personal considerations—transportation, childcare, and time lost from work—are factored into the cost burden.

A study of average out-of-pocket spending on services and premiums for traditional Medicare beneficiaries in 2016 was \$449 for dental services, which is \$487 in 2019 dollars when calculated for inflation. Out-of-pocket spending increased with income, purportedly due to those with lower incomes forgoing dental services.¹⁰

FUTURE TRENDS: MOBILE DELIVERY OF DENTAL CARE

New trends in dental care focus on access and meeting people in convenient locations. For example, The American Dental Association Council on Advocacy for Access and Prevention is offering a webinar entitled On the Move; Multiple Mobile Models of Care. The webinar includes an overview of the Mobile Healthcare Association; a hospital-funded mobile emergency department diversion model; and a mobile dental/pediatric primary care model with a focus on human papillomavirus (HPV) vaccination. Such a system of mobile delivery may be useful service for the COFA population considering transportation issues.

⁷ How Does a Gold Crown Stack Up to Porcelain? Healthline. Retrieved from <https://www.healthline.com/health/gold-crown-tooth>

⁸ CPI Inflation Calculator. Retrieved from <https://data.bls.gov/cgi-bin/cpicalc.pl?cost1=540&year1=201701&year2=201911>

⁹ The Per-Patient Cost of Dental Care, A Look Under the Hood. Retrieved from https://www.ada.org/~media/ADA/Science%20and%20Research/HPI/Files/HPIBrief_0316_4.pdf

¹⁰ How Much do Medicare Beneficiaries Spend Out of Pocket on Healthcare? Retrieved from <https://www.kff.org/medicare/issue-brief/how-much-do-medicare-beneficiaries-spend-out-of-pocket-on-health-care/>

CHAPTER 2. METHODOLOGY

MGT gathered and analyzed currently available data sources to highlight a context for the study and, particularly, the target populations. In addition to secondary data, MGT collected primary data through multiple sources.

PROJECT INITIATION

To begin the project, MGT met with the Agency Project Managers to finalize the proposed work plan and schedule as well as established working relationships critical to the success of the project. We developed a communications plan to work through email and hold meetings as needed and requested.

DATA GATHERING AND REVIEW

MGT requested information from the Agency to gain insight into prior work and studies. The Agency provided a prior survey conducted over two years and this information was used to better understand the needs of the population.

QUANTITATIVE DATA ANALYSIS

MGT reviewed population data such as historic population, racial and ethnic information, socio-economic data, household information, population age structure, and immigration data beginning with Pacific Islanders. Although this population was broader than the desired population for the study, the context was helpful for framing the work. MGT also reviewed prior dental reports for similar populations based on socioeconomic status. MGT compiled the quantitative data into charts, tables, and graphs along with geocoded and mapped data to enhance the analysis and create visual tools for communicating the analysis to the community. With GIS, MGT analyzed the existing boundary conditions to create scenarios to help the Agency achieve its goals. This data formed the underlying foundation for a robust demographic study. MGT looked at the data from different perspectives to draw out themes and conclusions for implications on future enrollment.

QUALITATIVE DATA ANALYSIS

Qualitative analysis provided context for the collected facts and figures. MGT engaged agency officials, local facility representatives, and other local stakeholders who are familiar with trends and community dynamics. These conversations helped understand why the numbers say what they say. MGT interviewed over 100 people from the target audience in person and via phone. The enrollment event at the Rosewood Initiative in Portland, Oregon was the first location for collecting data directly from the population. The interviews took place sometimes through interpreters at a medical enrollment event, a church, in homes, and via phone which allowed the team to learn the community and specific needs as well as the culture and the customs which may impact dental needs for the identified population.

GEOGRAPHICAL ANALYSIS

The geographical analysis of the COFA populations in Oregon focused on understanding the quantitative and qualitative data to determine where COFA citizens are located, how many are in each area, ages, gender, COFA country, and dental health insurance status at the time of the study.

DEMAND ANALYSIS

To determine the range of demand for COFA Dental Coverage, actual application and approved enrollment statuses were used as benchmarks for estimates. For 2020, the anticipated enrollment 800. The population forecast from the U.S. Census predicts a growth of approximately 1.5% for Hawaiian and Pacific Islander population per year, which was rounded to 2% to ensure room for growth in the program. To determine costs, MGT used a 2013 study from the American Dental Association, as described in Chapter 1, and used the U.S. Labor Statistics Bureau Consumer Price Index calculator to determine 2019 equivalents which were an annual average of \$765 for preventative care and \$1,960 for restorative services at specialists offices. The survey indicated 47% of the COFA respondents needed restorative services and 53% need preventative care. Further, the model used the percent of those who responded that they were “very likely” or “somewhat likely” to use the dental coverage, which was 97% and the model also accounted for those with dental insurance which was 22%. The demand analysis resulted in three scenarios. One scenario is based on estimated population growth, another scenario excluded those not likely to use the dental coverage, and the third scenario excluded those with dental insurance.

PROJECT REPORTING AND PRESENTATION

Once the quantitative and qualitative data was collected, MGT analyzed the results and used the information to provide findings and make recommendations to the Agency in order to address the dental care needs of those from FSM, Palau, and the RMI who are in Oregon under COFA. MGT will present the information to the Agency.

CHAPTER 3. DEMOGRAPHIC AND ECONOMIC FACTORS

The study focuses on the populations of those living in Oregon who are from the FSM, Palau, and the RMI which are part of the Caroline Islands and the Micronesian Groups. The native languages for those living in Oregon from the islands include primarily Marshallese and Chuukese. Additional languages include Yapese, Palauan, and Pohnpeian.

DEMOGRAPHICS

Accurately capturing the demographics of the target population is challenging for a couple of reasons. First, the United States does not currently capture the three island populations that fall under COFA separately from the aggregate Pacific Islanders data in the Census or other surveys. To further complicate the situation, the populations are migrant and move throughout the U.S. residing primarily in Oregon, Washington, and Arkansas. Oregon has the largest concentration of COFA islanders on the U.S. mainland with estimates of more than 10,000 in Oregon.¹¹

The population of pacific islanders in Oregon is expected to grow by 15% from 2019 to 2029, approximately 1.5% per year, as noted in **Exhibit 2**. These numbers provide context and a potential benchmark for understanding potential growth of the targeted population.

EXHIBIT 2 2019 TO 2029 NATIVE HAWAIIAN AND PACIFIC ISLANDER POPULATION

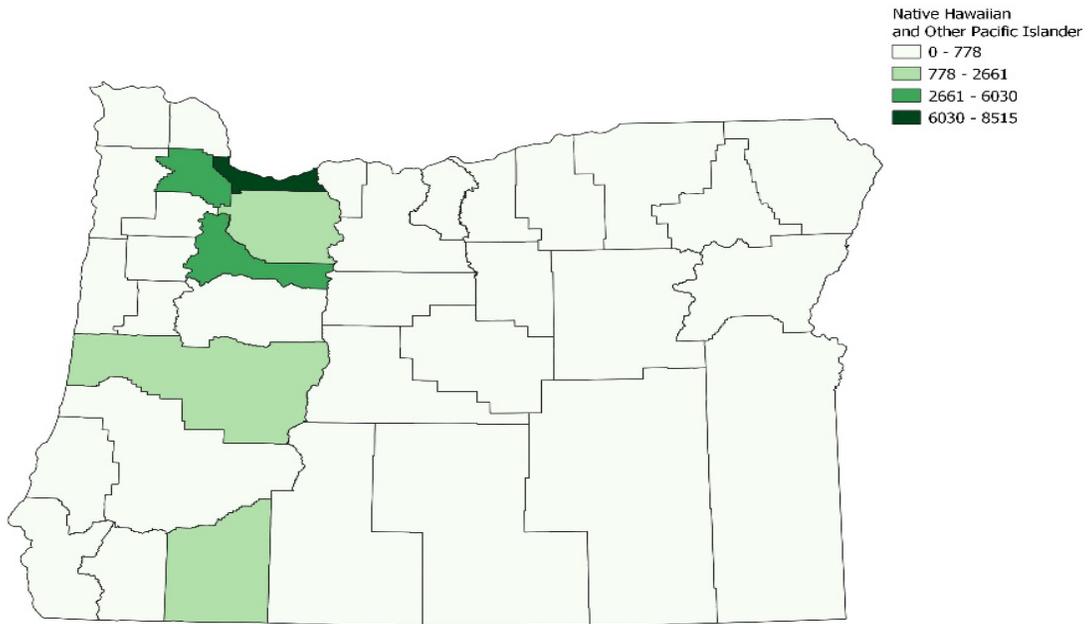
Race/Ethnicity	2019 Population	2029 Population	Change	% Change
Native Hawaiian or Pacific Islander, Non-Hispanic	17,339	19,961	2,622	15%
Native Hawaiian or Pacific Islander, Hispanic	2,207	2,566	359	16%
Total	19,546	22,527	2,981	15%

Source: Emsi Q4 2019 Data Set.

¹¹ Islanders of Micronesia: Understanding the History and Context of Micronesian Islander Health in Oregon. Retrieved from <https://www.oregon.gov/oha/PH/DISEASES/CONDITIONS/COMMUNICABLE/DISEASE/TUBERCULOSIS/Documents/statewidetbforum/MicronesianIslandersinOregonTBconference.pdf>

To provide context using available data, the American Community Survey data indicates that Pacific Islanders in Oregon reside mostly in the western part of the state, concentrated in the north west as noted in **Exhibit 3**.

EXHIBIT 3 PACIFIC ISLANDERS RESIDING IN OREGON



Source: 2013-2017 American Community Survey data for Native Hawaiians and Other Pacific Islanders.

CHAPTER 4. OTHER STATE PLANS AND INITIATIVES

This chapter reviews dental plans from other states with larger populations of COFA islanders. The purpose of this chapter is to provide a context for understanding dental coverage states provide to COFA islanders and other low-income populations. Further, this information may be used to compare with Oregon’s current efforts to provide dental coverage for COFA islanders as noted in the first chapter.

CALIFORNIA DENTAL COVERAGE

SUMMARY OF CURRENT COVERAGE

In California, there are no specific laws providing dental care for members of the COFA population. Most Californians shop for dental insurance on *Covered California* which is California’s official health insurance marketplace. Covered California offers two types of dental plans: health maintenance organization (HMO) plans and preferred provider organization (PPO) plans. For the HMO plan, there is no deductible or annual limit on what the plan will pay for a member’s care. However, care provided by dental providers outside the network aren’t covered. For the PPO plan, there’s a \$50 co-pay for each enrolled adult. Some out-of-network dental costs are covered. For this plan, there can be a six-month waiting period for major services and the plan has an annual limit of \$1,500. **Exhibit 4** summarizes the cost of different services for members in the PPO and HMO plans.

EXHIBIT 4 CALIFORNIA'S DENTAL SERVICES BY PLAN

Service	HMO	PPO In-Network, Out-of-Network
Diagnostic and Preventive (X-Rays, exams, cleaning, sealants)	\$0	0%, 10%
Amalgam filling – one surface	\$25	20%, 30%
Root canal – molar	\$300	50%, 50%
Gingivectomy per tooth *per quad for PPO plan	\$50	50%, 50%
Extraction – single tooth, exposed root or erupted	\$65	50%, 50%
Extraction – complete bony	\$160	50%, 50%
Crown – porcelain with metal	\$300	50%, 50%
Medically-necessary orthodontia	Not Covered	Not Covered
Deductible (waived for diagnostic and preventive)	\$0	\$50

Source: Covered California.

California’s form of Medicaid, known as Medi-Cal, provides free or low-cost health coverage for children, pregnant women, and adults with limited incomes and resources. When you complete a Covered California application, your eligibility for Medi-Cal will be determined automatically. Dental services are currently provided as some of the benefits under the Medi-Cal program. Medi-Cal’s dental coverage is known as Denti-Cal. The following services are provided under Denti-Cal for free or a lowered cost:

- ◆ Diagnostic and preventive dental hygiene (e.g. examinations, x-rays, and teeth cleanings);
- ◆ Emergency services for pain control;
- ◆ Tooth extractions;
- ◆ Fillings;
- ◆ Root canal treatments (anterior/posterior);
- ◆ Crowns (prefabricated/laboratory);
- ◆ Scaling and root planning;
- ◆ Periodontal maintenance;
- ◆ Complete and partial dentures; and
- ◆ Orthodontics for children who qualify.

The Department of Health Care Services (DHCS) is responsible for providing dental services to eligible Medi-Cal beneficiaries, and offers services through two delivery systems, Dental Fee-For-Service (FFS) and Dental Managed Care (DMC). Dental FFS is the delivery system in all but two counties in California. In 2019, approximately 13.5 million people were using Medi-Cal.

Member Outreach Objectives:

- Increase the Annual Dental Visit for California’s Medicaid population enrolled in Medicaid for at least ninety (90) continuous days by 3.3 percentage points.
- Increase preventive dental services for children ages one through twenty (20) enrolled in Medicaid for at least ninety (90) continuous days by 3.3 percentage points.
- Increase sealants on permanent molars for children ages six through nine enrolled in Medicaid for at least ninety (90) continuous days by 3.3 percentage points.

Provider Outreach Objective:

- Increase the number of actively participating Medi-Cal dentists who have provided at least one service in the calendar year by 2.5 percentage points.
- Increase the number of service offices accepting new patients and referrals by 2.5 percentage points.
- Overall, Delta Dental sees the following indicators as positive signs that Medi-Cal is moving in the right direction for members – more members having annual dental visits, preventive services and dental sealants. As of 2016, the utilization percentages for these three metrics were 31.4% (annual visits for all ages), 43.3% (preventative care for children age 1-20), and 17.4% (sealants on permanent molars for children age 6-9). For providers, the primary goal is to increase the number of actively participating Medi-Cal Dental providers who have provided at least one service in the calendar year (7,821 in 2016) and increase the number of service offices accepting new members and referrals (4,719 as of 2016).

HAWAII DENTAL COVERAGE

SUMMARY OF CURRENT COVERAGE

The Hawaii State Department of Health, Family Health Services Division, Oral Health Program is responsible for statewide surveillance, planning, and prevention. The Department operates five dental clinics to serve individuals with chronic and severe developmental and intellectual disabilities, medically indigent, frail elderly, and clients under the Developmental Disabilities Division. Hawaii does not have a routine system for assessing the oral health of residents and does not have a dental public health program within the State Department of Health.¹²

Realizing the critical connection between oral health and general health and well-being, Hawaii conducted a study to understand the need for oral health for residents. One of the key findings was the impact of lacking oral health on hospital emergency visits. Over six years, a 58% increase in visits to emergency rooms demonstrated the costs associated with a lack of access to preventative and scheduled dental care services.¹² A recent Briefing Report from the Hawaii Advisory Committee to the U.S. Commission on Civil Rights captures some of the discrepancies and costs to equal opportunity for Micronesians in Hawaii.¹³

Bright Smiles Hawaii notes that the state has the worst oral health for children and adults in the nation. Hawaii's low-income residents are also more likely to experience dental problems and less likely to see a dentist than other U.S. residents. To address this issue, the Hawaii Public Health Association has been funded by the DentaQuest Foundation under its 2020 Oral Health Initiative to lead a project that focuses on incorporating more collaboration and consultation with at-risk populations and stakeholders that lead to innovative, out-of-the-box, and culturally-sensitive strategies specifically to improve oral health status and reduce disparities for Hawaii's residents.¹⁴

PROGRAM COSTS

As a U.S. port of entry in the Pacific, Hawaii has paid the cost of public services for COFA islanders who migrate to the islands.¹³ As of 2011, Hawaii estimates the cost to provide public services to COFA islanders living in Hawaii at over \$100 million annually. Most of the costs are for education and health services, but do not specifically include dental services. With the COFA funding set to expire in 2023, the Advisory Committee expressed concerns regarding the strain on limited resources and the cost to the state.

FUTURE EFFORTS

The Oral Health 2020 Network is working to build relationships, connecting members to learn from one another, advancing oral health as a social justice framework, and promoting the national network to strengthen the collective impact.¹⁵

¹² Family Health Services Division, Hawaii Department of Health, State of Hawaii (2015). Oral Health Data Report.

¹³ Hawaii Advisory Committee (2019). Micronesians in Hawaii: Migrant Group Faces Barriers to Equal Opportunity.

¹⁴ Bright Smiles Hawaii. About Bright Smiles Hawaii. Retrieved from <http://brightsmileshawaii.org/about-bright-smiles-hawaii/>

¹⁵ Bright Smiles Hawaii. Oral Health for All 2020. Retrieved from <http://brightsmileshawaii.org/oh-2020-dgf/>

WASHINGTON DENTAL COVERAGE

SUMMARY OF CURRENT COVERAGE

The State of Washington, unlike California, has passed a bill specifically addressing the needs of the COFA Population. Legislature worked COFA community representation to create a COFA Islander Advisory Committee (through 2021), which advises the Washington Health Care Authority on COFA Islander Health Care needs. On April 29th, 2019, the Washington State Legislature pass Senate Bill 5274, establishing a COFA Islander Dental Program. This bill creates no cost dental coverage available to all adults from COFA nations residing in Washington, who are income-eligible to receive Medicaid. All associated costs such as premiums, co-insurance, and other out-of-pocket costs will be paid for by the Washington State Health Care Authority. Here are additional points of information about this program.

- ♦ COFA community members who are eligible for COFA Islander Health Care AND COFA community members who receive some or all of Medicare coverage and are income-eligible for Medicaid can enroll in the program.
- ♦ There is no annual maximum benefit. This means people enrolled in the program can receive as many covered services that they need, regardless of cost.
- ♦ Covered dental services are limited to services covered by the qualified dental plan (QDP) and performed by an in-network provider, as well as services that are not covered by the QDP but are covered under Apple Health Dental.
- ♦ Coverage through COFA Islander Dental Care begins no later than January 1, 2021.
- ♦ Program enrollment will happen at the same time as Open Enrollment for Qualified Health Plans, which generally takes place November 1 through December 15th but can be changed from year to year. Enrollment will begin no later than November 2020.
- ♦ HCA will work with the Commission on Asian Pacific American Affairs (CAPAA) to establish an ongoing, annual comprehensive community education and outreach program to support both COFA Islander Health Care and Dental Care.
- ♦ The state budget includes funds to support culturally and linguistically appropriate outreach for the dental program and COFA Islander Health Care as well as an ongoing annual contract with a COFA organization.

PROGRAM COSTS

Washington's program provides dental services to income-eligible citizens of the COFA nations who reside in the state by providing no premium or cost-sharing payment requirement. The budget for the program includes funding for a Full-Time Equivalent Medical Program Specialist to manage program implementation, including the development of rules, an outreach plan, materials, and the formation and coordination of meetings for an advisor committee. The position also oversees eligibility, develops and manages reporting, supports community partners in their outreach to eligible, but not yet enrolled households, and plans for future program improvement. The benefits are implemented in the same way as the medical program. The projected operational expenditures for the program are outlined in **Exhibit 5** and total \$4,935,000. Additionally, a one-time IT impact was estimated at \$1,173,000. With additional

professional services contracts Washington's total estimate using the General Fund from the State is \$8,531,000.

EXHIBIT 5 WASHINGTON COFA PROJECTED EXPENDITURES

	FY 2020	FY 2021	FY 2022	FY 2023	FY 2024	FY 2025
Salaries and Wages	80,000	80,000	80,000	80,000	80,000	80,000
Employee Benefits	29,000	29,000	29,000	29,000	29,000	29,000
Services Contract	55,000					
Goods and Services	12,000	12,000	12,000	12,000	12,000	12,000
Travel	1,000	1,000	1,000	1,000	1,000	1,000
Capital Outlay	10,000					
Grants, Benefits Services	362,000	579,000	695,000	834,000	834,000	834,000
Total	549,000	701,000	817,000	956,000	956,000	956,000

Source: Washington Office of Financial Management. Retrieved from <https://fortress.wa.gov/ofm/fnspublic/FNSPublicSearch/Search/bill/5274/66>.

FUTURE EFFORTS

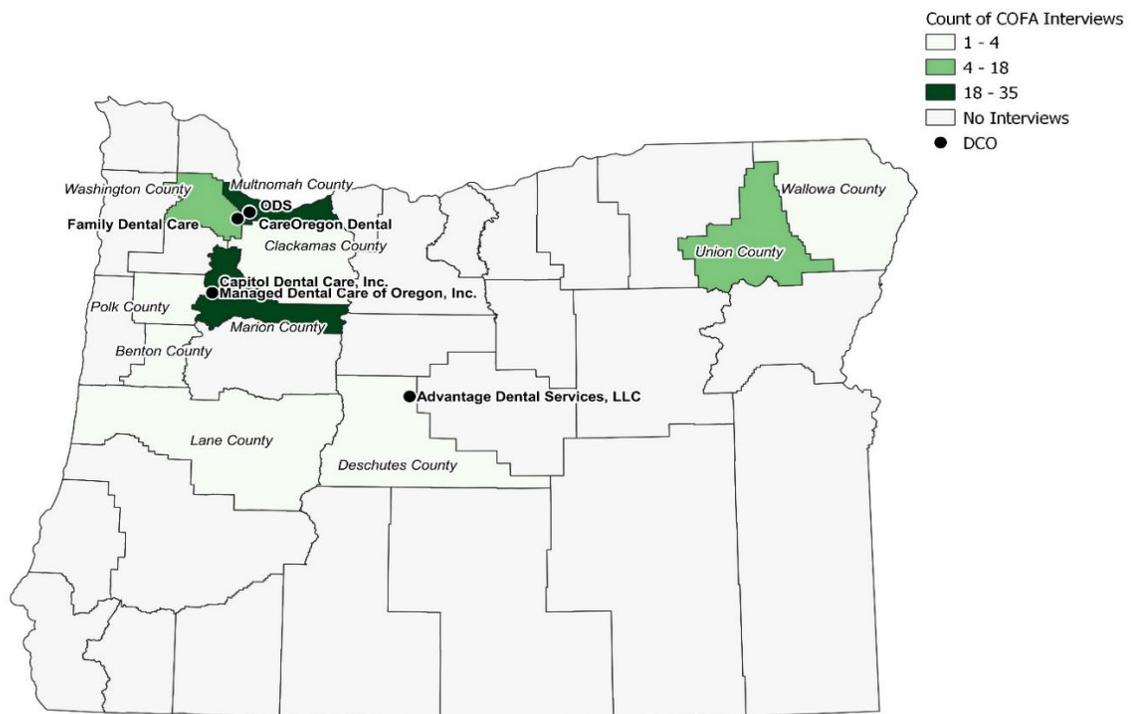
The next steps for the Washington HCA, Washington State Health Benefits Exchange, and advocates is to create an implementation plan for COFA Islander Dental Care.

CHAPTER 5. DENTAL CARE PROVIDERS

DENTAL CARE ORGANIZATIONS

Dental Care Organizations contract with dental practices to provide critical business management and support including non-clinical operations. These organizations allow dentists to focus solely on providing the best care possible for their patients. DCOs support dental businesses by providing professional services that are outside of the scope of patient care. This business model has been increasingly popular with the passage of the Affordable Care Act and the expansion of Medicaid. It's allowed some dental practices to provide more affordable care to a larger patient population. Some examples of the services provided by DCOs include: Human Resources, Recruiting, Capital & Financing, Marketing, Budgeting, IT Services, Payroll, Risk Management, Accounting, and Tax Services. In Oregon specifically, there are six Dental Care Organizations and **Appendix A** includes contact information. **Exhibit 6** indicates the location of the DCO's in relation to the counties in which the COFA populations reside.

EXHIBIT 6 DCOS AND COFA INTERVIEW POPULATION

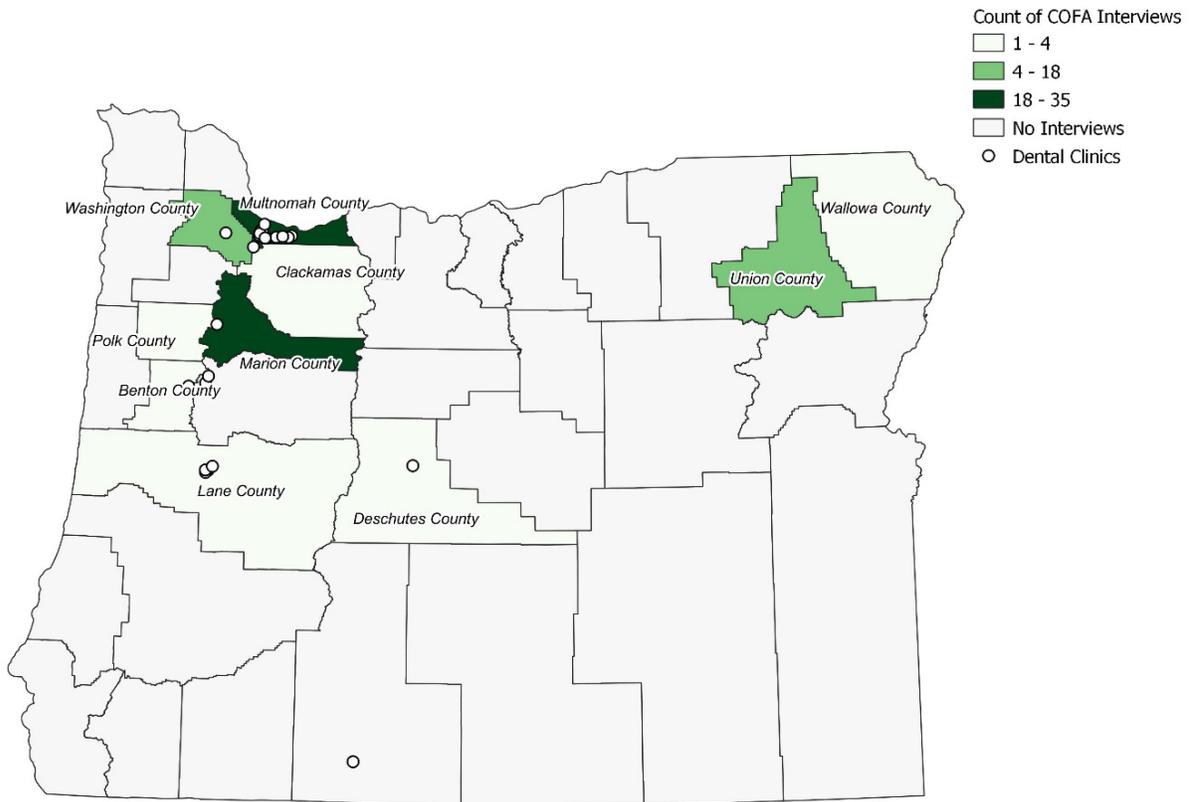


Source: MGT Consulting Group and the Oregon Health Authority.

DENTAL CLINICS

Oregon has an estimated 1,567 dental practices in the state, which equates to an average of 2,688 residents per general dental practice. There are 855 “specialty” practices. Specialty practices include oral surgeons, endodontists, orthodontists, and periodontists. **Appendix B** lists 19 dental clinics that provide free or low-cost dental care to Oregon’s residents and **Exhibit 7** shows the location of the Dental Clinics in relation to the COFA population.

EXHIBIT 7 DENTAL CLINICS AND COFA INTERVIEW POPULATION



Source: MGT Consulting Group.

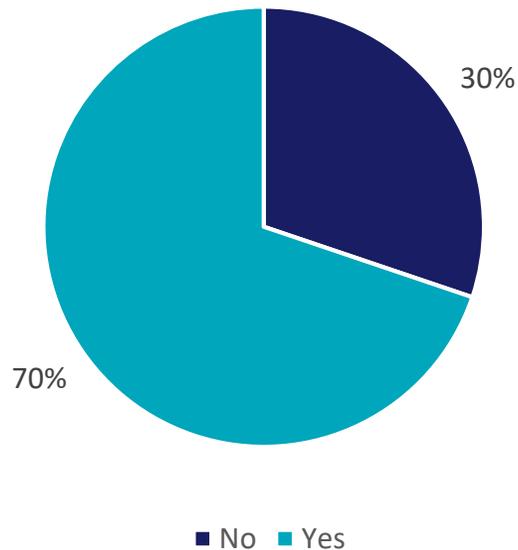
CHAPTER 6. SURVEY RESULTS

The purpose of the survey was to understand the current needs, prior services, and interest in dental care of the COFA population in Oregon. Demographic information provides context for understanding where the respondents live and who they are.

PRIOR DENTAL PROCEDURES AND ISSUES

Most lost teeth were due to decay or disease as noted in **Exhibit 8**. One respondent lost all his teeth as a side effect of medication.

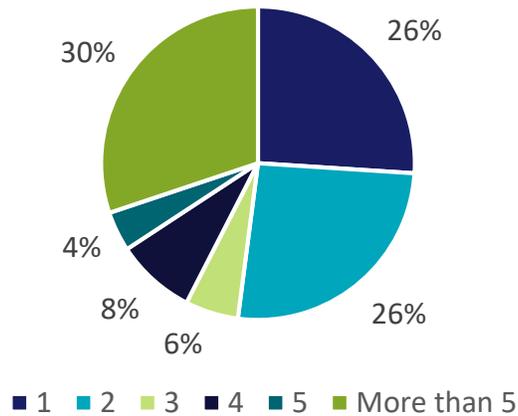
EXHIBIT 8 LOST TEETH DUE TO DECAY OR DISEASE



Source: MGT Consulting Group.

Of those who lost teeth due to decay or disease, most lost more than 5 teeth, followed by one or two lost teeth as displayed in **Exhibit 9**.

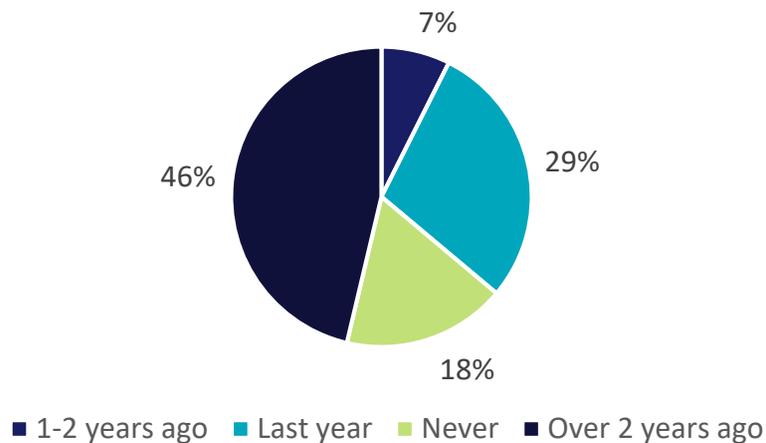
EXHIBIT 9 NUMBER OF TEETH LOST DUE TO DECAY OR DISEASE



Source: MGT Consulting Group.

Most participants visited a dentist over two years ago, almost 30% had visited a dentist in the last year and 18% had never been to a dentist as noted in **Exhibit 10**.

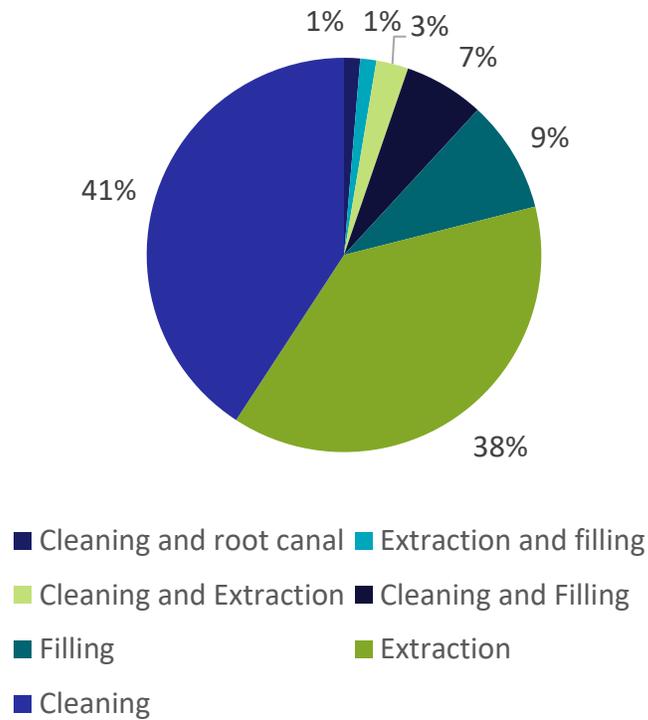
EXHIBIT 10 LAST DENTAL VISIT



Source: MGT Consulting Group.

The respondents had teeth extracted from common occurrences such as wisdom teeth removal to extraction of teeth that were cracked or pulled. **Exhibit 11.**

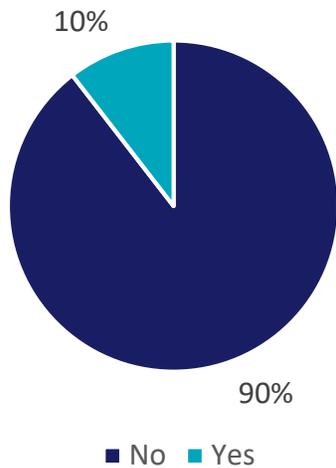
EXHIBIT 11 MOST RECENT DENTAL TREATMENT



Source: MGT Consulting Group.

A few of the residents did return to the island for free dental care ad displayed in **Exhibit 12**. Some of the participants mentioned barriers including flight costs of \$2,000 and upwards, as well as the time to travel and be away from work and family.

EXHIBIT 12 RETURNED TO THE ISLAND FOR CARE

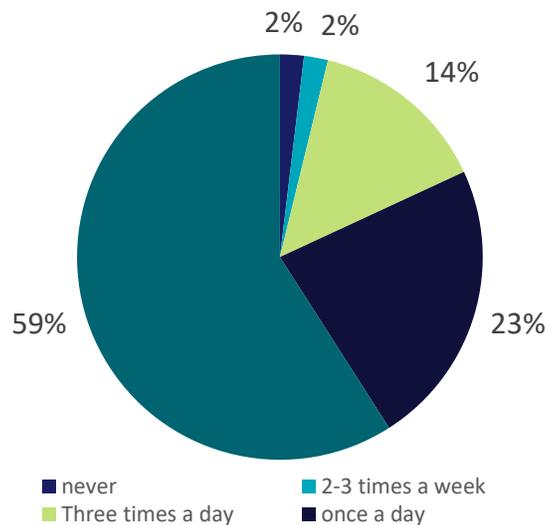


Source: MGT Consulting Group.

CURRENT DENTAL CARE AND NEEDS

The interviewer asked about current dental care and needs. When asked about preventative care, most respondents stated that they brush their teeth at least twice a day as displayed in **Exhibit 13**. Preventative care is important to maintaining good oral health as well as overall health.

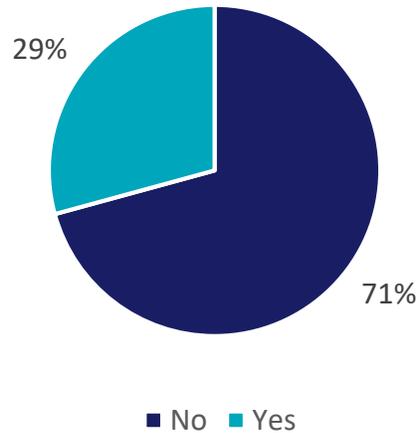
EXHIBIT 13 NUMBER OF TIMES THAT TEETH ARE BRUSHED



Source: MGT Consulting Group.

When asked about mouth pain, most shared that they currently have pain and the majority of those with pain described teeth as the location, as show in **Exhibit 14**.

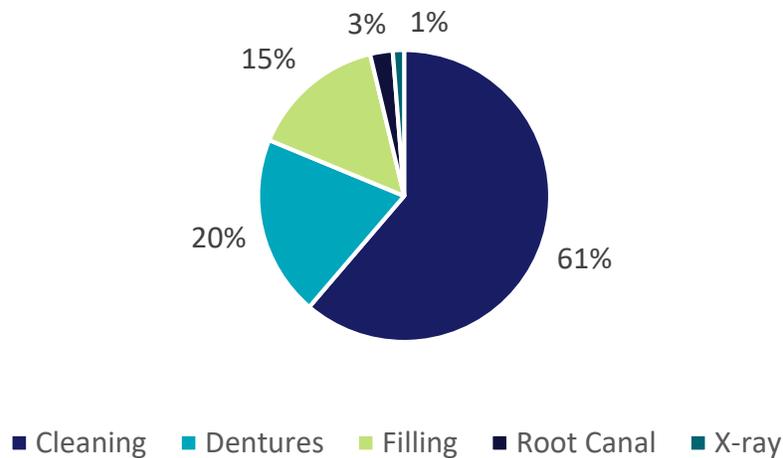
EXHIBIT 14 MOUTH PAIN



Source: MGT Consulting Group.

Respondents reported a need for dental services, and most shared the need for a cleaning, indicating a desire for preventative care. Dentures were the next most commonly mentioned needed services, highlighting needs for restorative care. **Exhibit 15** displays current dental needs.

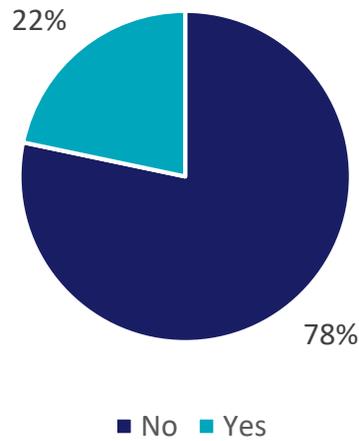
EXHIBIT 15 DENTAL NEEDS



Source: MGT Consulting Group.

Most of the interview participants did not have dental insurance **Exhibit 16**. For those that do have dental insurance, most have it through their employer or their spouse’s employers.

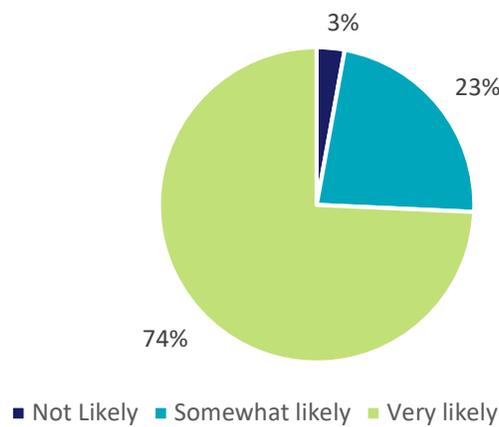
EXHIBIT 16 DENTAL INSURANCE



Source: MGT Consulting Group.

Of those responding regarding their likelihood of using dental care if offered by Oregon, **Exhibit 17** indicates that 97 percent shared that they would be “very likely” or “somewhat likely” to use offered dental care.

EXHIBIT 17 LIKELIHOOD OF USING DENTAL CARE IF OFFERED

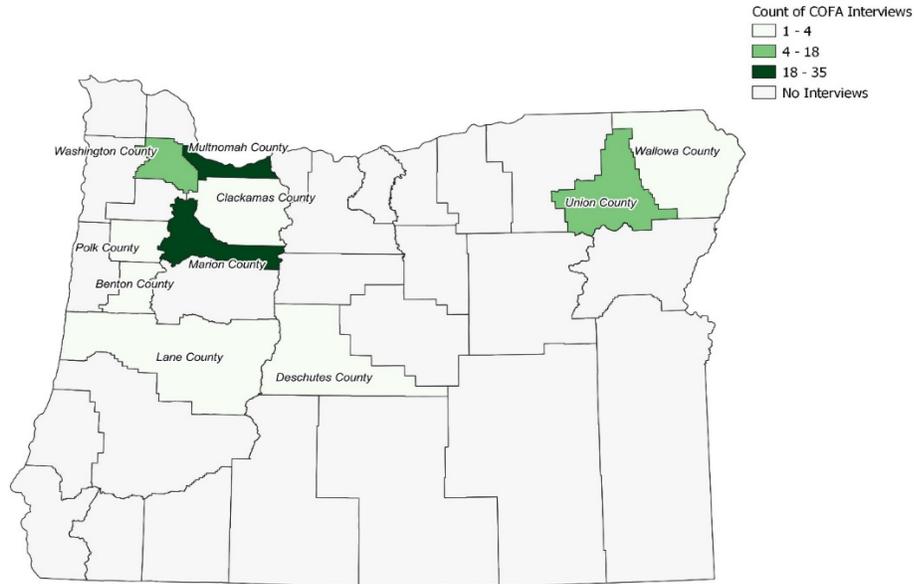


Source: MGT Consulting Group.

DEMOGRAPHICS OF SURVEY RESPONDENTS

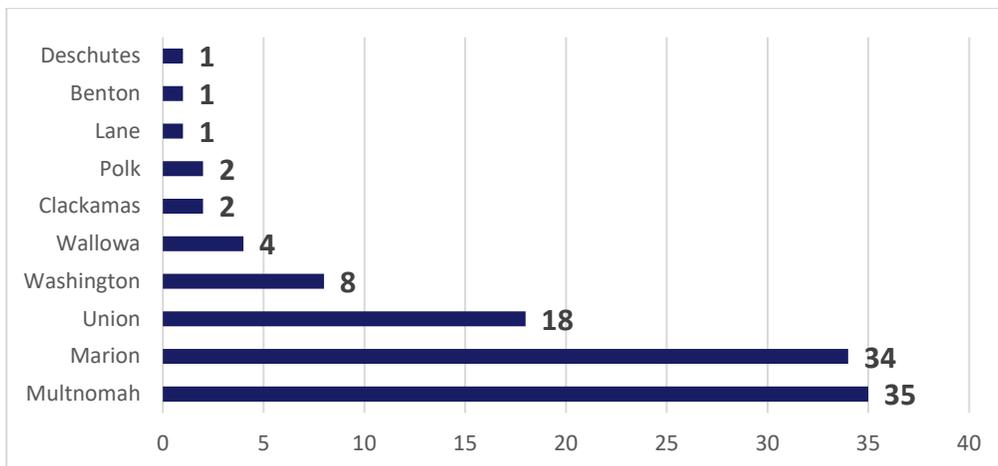
Most of the respondents live in Western Oregon in Multnomah County, which is where Portland is located and Marion County, where Salem is located. A few live in Eastern Oregon. **Exhibit 18** illustrates where respondents live and **Exhibit 19** displays numbers of respondents living in the counties.

EXHIBIT 18 LOCATION OF COFA RESIDENCES



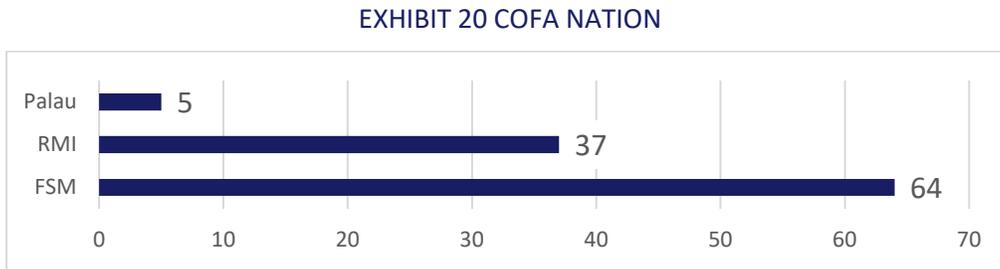
Source: MGT Consulting Group.

EXHIBIT 19 COUNTY OF RESIDENCE



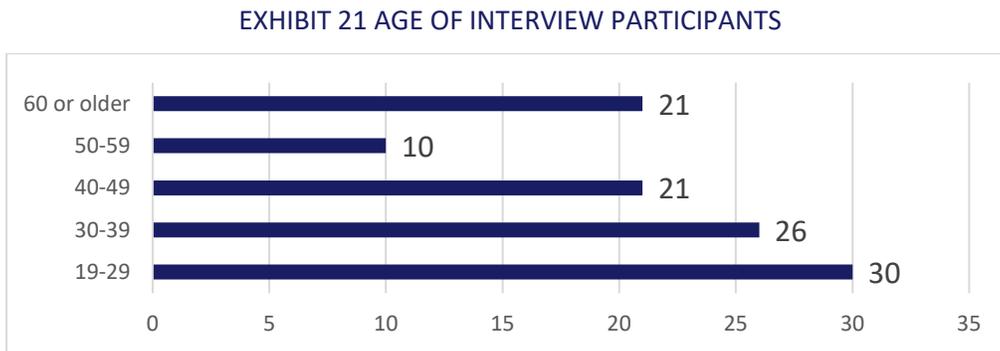
Source: MGT Consulting Group.

Most respondents were from the FSM, followed by RMI, and Palau as shown in **Exhibit 20**.



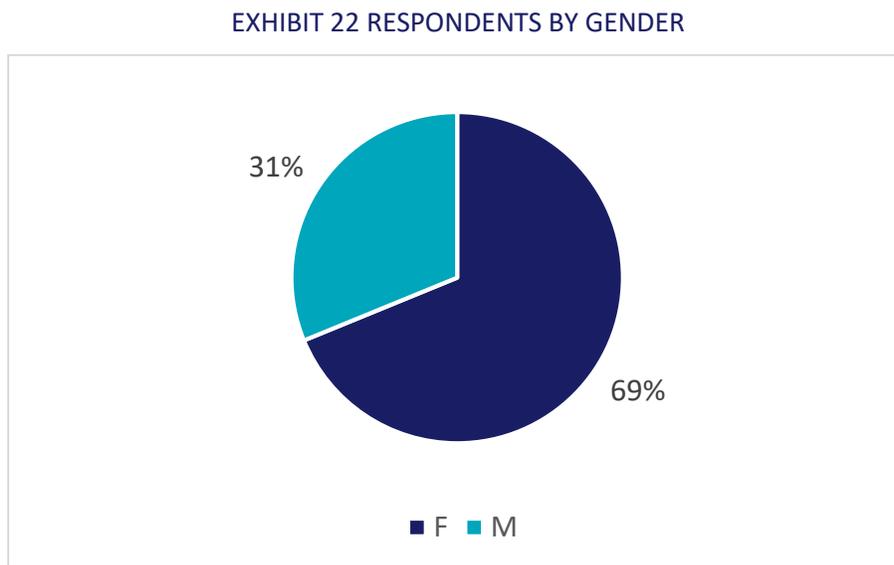
Source: MGT Consulting Group.

Many of the participants were between the ages of 19 and 29 as noted in **Exhibit 21**.



Source: MGT Consulting Group.

The respondents were primarily female as shown in **Exhibit 22**.



Source: MGT Consulting Group.

CHAPTER 7: DEMAND ANALYSIS

The demand analysis uses the calculations noted in the methodology and accounts for estimated population growth, interest in dental coverage, and those with dental insurance. This also assumes outreach to the population will occur in tandem with renewal of the COFA Premium Assistance Program. Three Scenarios are detailed in **Exhibit 23** based on the assumptions of no current dental coverage, those who indicated they were very likely or somewhat likely to use coverage if available, and with population growth based on U.S. Census data projections for Native Hawaiians and Pacific Islanders.

EXHIBIT 23 DEMAND ANALYSIS SCENARIOS

Year	Scenario 1 No Dental Coverage		Scenario 2 Likelihood of Use		Scenario 3 Population Growth	
	Projected Enrollment	Cost	Projected Enrollment	Cost	Projected Enrollment	Cost
2021	636	\$844,386	792	\$1,050,070	816	\$1,082,546
2022	649	\$861,274	807	\$1,071,071	832	\$1,104,197
2023	662	\$878,499	823	\$1,092,493	849	\$1,126,281
2024	675	\$896,069	840	\$1,114,343	866	\$1,148,807
2025	689	\$913,991	857	\$1,136,630	883	\$1,171,783
		\$4,394,219		\$5,464,606		\$5,633,615

Note: Figures are rounded to the nearest whole dollar.
Source: MGT Consulting Group.

APPENDIX A: DENTAL CARE ORGANIZATION CONTACT INFORMATION

Plan Name	Address	Phone Number	Fax Number	Website
Advantage Dental Services	442 SW Umatilla Ave, STE 200, Redmond, OR 97756	(866)268-9631	(541)504-3907 (866)268-9618	www.advantagedental.com
Capitol Dental Care, Inc.	3000 Market St NE, STE 228, Salem, OR 97301	(503)585-5205 (800)525-6800	(503)581-0043	www.capitoldentalcare.com
Family Dental Care	6700 SW 105 th Ave, STE 210, Beaverton, OR 97008	(503)644-2663 (888)350-0996		www.familydentalcareinc.com
CareOregon Dental	315 SW 5 th Ave, Portland, OR 97204	(503)416-1444 (888)440-9912		www.careoregondental.org
Managed Dental Care of Oregon, Inc.	3000 Market St NE, STE 222, Salem, OR 97301	(800)538-9604	(503)581-0043	www.mdcodental.com
ODS	601 SW 2 nd Ave, Portland, OR 97204	(503)243-2987 (800)342-0526	(503)952-5259	www.modahealth.com/ohp

APPENDIX B: DENTAL CLINIC CONTACT INFORMATION

Name	Phone Number	Notes
Oregon Health & Science University Dental Clinics	503-494-8830	
COI (Linn-Benton Community College)	541-758-3000 ext 115	
Portland Community College Dental Hygiene Clinic - Sylvania Campus	971-722-4909	
Pacific Dental Hygiene Clinic (Pacific University)	503-352-7373	No emergencies, extractions or crowns. Preventative, basic and restorative only.
Mount Hood Community College	503-491-7176	
University of Oregon University Health Center	541-346-2770	Must be a registered student to use the facilities
Lane Community College Dental Clinic	541-463-5206	Adults and children, emphasis on adults who have not had regular preventative care.
OIT Dental Hygiene Clinic	541-885-1330	Adults only. Call for details, no insurance accepted at this time
Portland State University Student Clinic	503-725-2611	Portland State University students enrolled in 5 credits or more per term only people allowed to use
Carrington College Dental Hygiene Clinic	503-419-4971	General Public
Multnomah County Health Dept. - Dental Services		Routine and Urgent dental care in 5 county clinics. OHP Plus and Standard-No fee, Uninsured, Discounted fees based on family size & income-Bring proof of income.
FRIENDS OF CRESTON DENTAL CHILDREN'S CLINIC	503-916-5808	Creston Children's Dental Clinic is a nonprofit committed to children's dental health. The mission is to provide prevention, education and dental care of the highest quality at no cost to low-income children of Multnomah County. Dental Services:
Boys & Girls Club of Albany	541-926-6666	Dental services provided to uninsured children 6-18 at no cost to their families.
Donated Dental	503-594-0837	Services provided to approved applicants by volunteer dentists. Free
Salem Free Medical and Dental Clinic	503-990-8772	Adults under 65 and teens, without insurance only (extractions only). Free
Kemple Memorial Children's Dental Clinic	541-617-1653	Children and young adults, ages 3-25. No fees for uninsured
Medical Teams International (Traveling Dental Vans)	503-624-1026	FREE. Limited to extractions and fillings as needed to treat severe pain or infection
A.L.E. Dental Center – Eugene	541-485-3721	Children ages 5 to 18 yrs. Must be low-income
Caring Hand to Mouth	541-393-7000	Preventative and restorative treatment. Required to be under 100% of federal poverty level no insurance and not qualified for Care Credit, no fee with approved treatment plan.

APPENDIX C: DISCLAIMER

MGT's analysis and recommendations rely on the accuracy of information the client provided, information provided by COFA citizens to MGT, and information available online. This report also relies on near-term and long-term assumptions influenced by factors outside of MGT's control that may adversely impact the client's future plans based on this report.

Changes such as those to the client's financial health and costs, as well as state, local, and global economic conditions, may impact both the demand and outcomes for the project, costs, and/or the project's financial feasibility. Additional risks to the client's project include but are not limited to changes to demand, competitive programs, regulatory changes, population changes, and general acts of disaster.