



# Without a Net

Understanding the Impact  
of Medicaid Expansion on  
Colorado's Oral Health Safety Net



**AUGUST 2015**

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# Working Without a Net

## Understanding the Impact of Medicaid Expansion on Colorado's Oral Health Safety Net

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*Colorado expanded Medicaid to more lower-income residents and began providing dental benefits to adult enrollees in 2014. Together, these policy changes were an important step in helping vulnerable Coloradans improve their health.*

*The dental benefit sparked more demand for services among both children and adults, while the need for geriatric dental services also grew. Today, about one of five Coloradans – more than 1.2 million people – has a Medicaid dental benefit.*

Still, dental insurance – especially Medicaid – does not ensure access to a dentist. An analysis by the Colorado Health Institute (CHI) found that Medicaid enrollees in 15 of Colorado's 64 counties have no available dental care. Either no dentists existed in these areas or practicing dentists did not accept Medicaid.

Colorado's oral health safety net plays a crucial role in meeting the oral health needs of Medicaid enrollees, as well as patients who are uninsured or underinsured.

For this report, CHI surveyed oral health safety net leaders to understand the impact of Colorado's policy changes and what they mean for the future.

Safety nets clinics report full schedules and lengthy waiting lists, and they expect demand to keep growing. Most organizations are planning to expand capacity, programs and services. But that will require additional funding, and few organizations have enough resources.

While Medicaid reimbursement is important, it is not sufficient to sustain organizations, let alone support expansion.

Safety net clinics need capital funding for infrastructure and equipment, additional staff and operational support. Many are interested in innovative models of care delivery, such as medical-dental integrated care and the Virtual Dental Home (VDH). These new models offer promising strategies to meet the needs of underserved patients.

CHI's analysis takes a look behind Colorado's safety net clinic doors to examine how organizations are working in the post-expansion era. The analysis also examines how Colorado can strengthen the oral health safety net.

Findings suggest the oral health safety net is under-

## Understanding the Data: 2015 Oral Health Safety Net Survey

CHI sent an online survey to 30 safety net organizations in March 2015 to determine their capacity and scope of services, their needs and their plans. These organizations provide free or low-cost dental care to uninsured and insured Coloradans.

Twenty organizations responded to the survey, a 69 percent response rate. The respondents operate a total of 65 clinics. Thirty percent serve rural communities, and half are Community Health Centers (CHCs). This report summarizes responses for these 20 organizations (see page 14).

The Caring for Colorado Foundation, Delta Dental of Colorado Foundation and the Colorado Health Foundation commissioned the survey and assisted in its development. These philanthropies provide grant support to many of the organizations surveyed.

resourced and will need additional government and private sector funding and support to continue improving patient access.

These findings have implications for policymakers, state agencies and funders. Insights on the safety net are also valuable for private practice dentists and hygienists, other safety net clinics and advocates working to improve access to care for Colorado's most vulnerable populations.

## Organizations are being impacted by higher patient demand, and they expect the demand to continue growing.

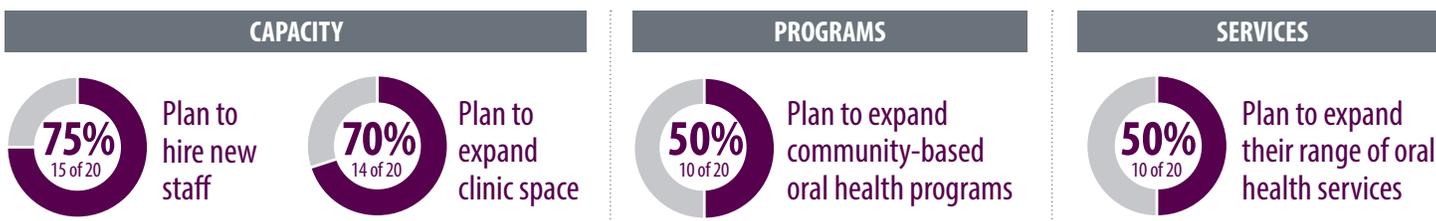
Number of Organizations Reporting Impacts From Increased Demand, by Patient Type



**19 of 20**  
respondents (95%) expect to serve more patients over the next 5 years

## But organizations are already reaching capacity.

*“The need for more dentists and dental chairs is crucial to get ahead of this oral health need.”*



## Organizations need additional funding and support to improve patient access ...

**75%**  
15 of 20

of respondents say **Facility Expansion and Renovation** is their greatest need.

## ... And are thinking outside the box on care delivery models.

<b>80%</b> 16 of 20	<b>55%</b> 11 of 20
Are highly interested in establishing medical-dental integrated care	Are highly interested in establishing tele-dentistry (aka VDH)

## 1 Medicaid Expansion Sparked Growth in Demand for Dental Services.

*The most significant increase in demand was among adults enrolled in Medicaid, followed by seniors over age 65 and children enrolled in Medicaid. Organizations anticipate demand will continue to grow. Meanwhile, the uninsured will still need the safety net for dental care.*

### Analyzing the Data

#### Safety net providers reported an increase in patient demand among children and adults enrolled in Medicaid.

Most of the increases occurred following the implementation of the Medicaid adult dental benefit in April 2014. Nearly all organizations (94 percent) saw more adults as well as children with Medicaid – a possible indication that parents enrolled in the program may be seeking oral health care for themselves and their children. Additional time and information are needed to understand whether the adult dental benefit has a “two-generation” impact.

#### The trend in patient demand is likely to continue, especially among Medicaid adults and seniors 65 and older.

All but one safety net provider expect to serve more patients over the next five years. Organizations pointed to a movement toward integrated care and growing awareness of the importance of oral health as two factors that will drive demand. Data on utilization show that only one of three Medicaid adults used their dental benefit by the end of March 2015 – suggesting that many adults may still be seeking out care in the future.<sup>1</sup> And as Colorado's population ages, the already-high demand for geriatric services will also increase.

#### Colorado's uninsured population still needs oral health services.

Despite the rising number of adults with a dental benefit, the safety net saw fewer Medicaid adults than uninsured individuals in 2014. Almost one of three individuals served by the safety net was uninsured, compared with one of five individuals with Medicaid. The safety net remains a vital source of dental care for uninsured Coloradans.

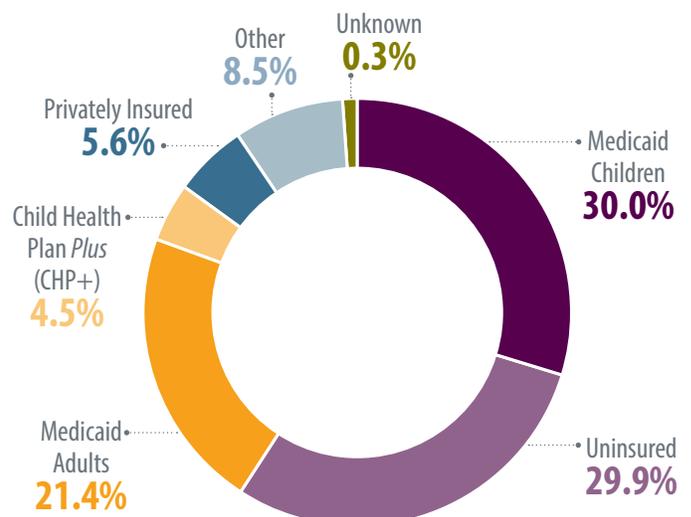
### Hearing from the Safety Net

- “The Medicaid adult expansion in April of 2014 has significantly increased our adult patient pool. There is competition in the schedule for appointments due to this increase in the adult need.”
- “We are recruiting every day to try to get a (patient to provider) ratio that will aid us in treating all of the oral health needs.”
- “As the only safety net dental clinic in the area, we continually accept new patients to expand access to oral care.”
- “The demand for oral health services is extremely high.”

#### Who Does The Oral Health Safety Net Serve?

The 20 responding organizations together served almost 119,500 Coloradans in 2014. The chart below shows insurance coverage for these patients.

**Figure 1: Safety Net Oral Health Patients, by Insurance Types, 2014**



## 2 Safety Net Organizations Are Reaching Capacity With the Increased Demand.

*Many are trying to meet patient needs efficiently and effectively by changing their scheduling practices and staffing models. These efforts are often coupled with expansion plans to increase capacity, programs and services.*

### Analyzing the Data

#### Safety net providers are reaching capacity.

As summarized by one respondent, “The need is much greater than what we can keep up with at this time.” Organizations are seeing more new patients each month and are barely able to stay ahead of the demand. Some clinics are fully booked, even up to two months. Rural providers are more likely to have waiting lists for preventive, restorative and specialty dental services.

#### Organizations are trying to serve more patients by maximizing what they have, such as their current staff and clinic space.

Twelve respondents are adding more dental chairs to their existing clinics. Other strategies to see more patients include expanding the age range of patients accepted, improving clinic efficiencies, reducing patient no-show rates, expanding clinic hours and maximizing provider schedules to open additional appointments for patients.

#### Clinics are looking to the future, making plans to hire additional staff, expand clinic space and locations, and offer additional oral health programs and services.

Fifteen of 20 organizations are hiring providers or support staff, especially registered dental hygienists; 11 are adding square footage to their oral health space; 10 are expanding community-based oral health programs such as school-based sealant programs; and another 10 are expanding the oral health services they offer.

### Hearing from the Safety Net

- “The need for more dentists and dental chairs is crucial to get ahead of this oral health need.”
- “We are adding four chairs this summer and are considering expanding hours to improve access to our existing facilities. We hope to hire additional dental hygienists in community settings in 2015.”
- “New patient demand could decrease our ability to provide quality care to existing patients. The more new patients we take extends the period of time between appointments and decreases treatment plan completion.”

#### By the Numbers, Oral Health Safety Net Providers.

The oral health workforce among the 20 respondents consists mostly of paid dentists and dental assistants, though many organizations report recent plans to hire dental hygienists. Volunteer dentists and dental assistants make up a combined two full time equivalent staff.

Figure 2: Full Time Equivalent (FTE) Staff



### 3 Medicaid Reimbursement is Good, But Not Enough to Sustain Safety Net Organizations.

The new Medicaid adult benefit is an important new funding resource for many Community Health Centers (CHCs). Conversely, other safety net clinics (non-CHCs) are financially hurting from this change in dental care payments. Organizations are recalibrating their ratios of patient served to balance low Medicaid reimbursement with direct pay patients. Medicaid doesn't fully cover clinic costs, let alone expensive dental equipment and expansion efforts. Most organizations are planning and budgeting for the future, but need additional resources to support operations and more equipment, space and staff.

#### Analyzing the Data

##### Non-CHCs face particular challenges maintaining financial sustainability.

Medicaid reimburses non-CHCs differently. While CHCs receive a fixed, cost-based payment from Medicaid each time they care for a client, non-CHCs receive fee-for-service reimbursements based on the same rates as private practice dentists billing Medicaid. Non-CHCs may actually receive lower payments from Medicaid than from their direct pay patients (anyone who doesn't have a third party payer).

So as clinics serve a higher proportion of Medicaid patients and fewer uninsured patients who pay based on a sliding fee scale, non-CHCs have seen their revenues decrease. To offset the low Medicaid rates, some organizations are trying to balance their patient mix by seeing more direct pay patients.

##### Organizations are combining funding, including grants, foundation support, capital campaigns, Medicaid reimbursement and patient fees.

Still, they need additional funds for facility expansion and renovation, staff, and operational support. Rural CHCs are most in need of additional staff. Urban and non-CHCs most need clinic expansion and renovation support, but they report great difficulty finding philanthropic and federal funds for this. An additional need is for operational support to help with new Medicaid administrative burdens such as billing, efficiently managing electronic records and building sustainable business models.

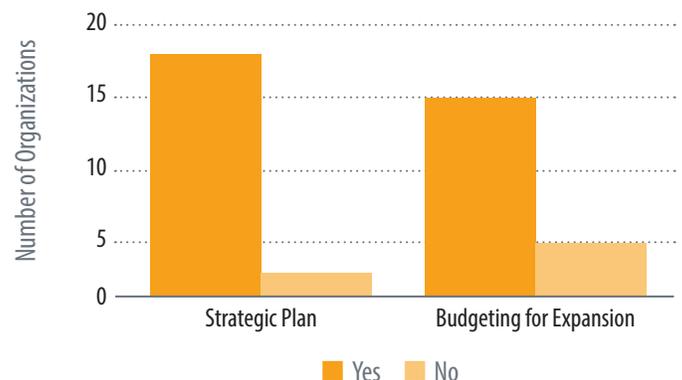
#### Hearing from the Safety Net

- "More franchised dentistry coupled with increased Medicaid demand and poor Medicaid reimbursement is changing the fee for service business model. Financial sustainability may depend on a higher percent of the patient mix having insurance or other means of payment."
- "The equipment expense (of an integrated medical/dental office) is dramatically higher than providing physical health services... Medicaid billing is extremely frustrating and complicated and the reimbursements for non-federally funded clinics is inadequate. Even if done efficiently, it cannot cover the cost of the staff."
- "Physical infrastructure expansion relies on philanthropic support."

#### Oral Health Safety Net Organizations Prepare for the Future.

Most respondents plan to grow their services and programs.

Figure 3: Planning and Budgeting



## 4 Innovative Models of Oral Health Care Offer Promise for Meeting Patient Demand in an Environment of Increased Coverage and Financial Limitations.

*Safety net providers are interested in establishing medical-dental integrated care, tele-dentistry (Virtual Dental Home) and programs for specific populations. These models could help organizations meet their patient-centered goals more efficiently than expanding clinic space or building new facilities. By incorporating dental care into community settings and medical offices, patients with otherwise limited access can conveniently receive services.*

### Analyzing the Data

**The short-term (one to two years) and long-term (three+ years) goals of the organizations generally center on expansion plans such as increasing staff numbers, clinic space and services.**

Some organizations even prioritize the integration of dental care with primary care in their strategic plans. Others mention goals of improving clinic operations and efficiencies and implementing electronic records. Ultimately, the message is clear: organizations want to serve more patients without sacrificing quality of care or financial longevity.

**Safety net providers are interested in pioneering new models, and many are taking steps towards implementation.**

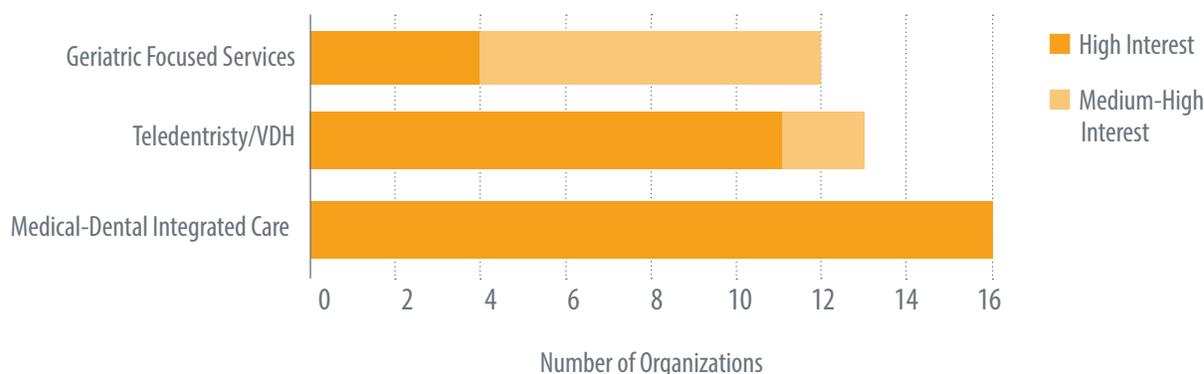
Organizations hope medical-dental integrated care and tele-dentistry/Virtual Dental Homes will improve access, reach more adolescents and children with prevention, divert emergency room visits and increase patient follow-up with dental care. Several clinics recently hired (or are planning to hire) additional registered

dental hygienists, who play a key role in medical-dental integrated care and Virtual Dental Homes (see Figure 4). Additionally, more than half already offer co-located services, which can make the process of fully integrating medical and dental services more viable. A few are receiving foundation support to pilot these new models.

### Hearing from the Safety Net

- “[Our long-term goals are to] open a new dental access point, serve more patients, and increase integration with primary care.”
- “[Our long-term goals are to] develop a fully integrated medical, dental, and behavioral health model of care that moves beyond co-location or limited scope of oral health services in the medical setting.”
- “Virtual Dental Home [is] mobile ... a mechanism to medical-dental integration ... an easy way to integrate Cavity Free at Three ... a component of a school based sealant program ... [and the] geriatric population can be served through a virtual dental home model.”

**Figure 4: Interest in Establishing Different Care Models**





# Meeting Needs in New Ways

## Virtual Dental Homes and Medical Dental Integration

### What are Virtual Dental Homes?

The Virtual Dental Home (VDH) model places dental hygienists in underserved community-settings, where they provide preventive dental services, such as cleanings, oral cancer screenings and fluoride treatments. Hygienists also provide interim therapeutic restorations (ITR) dental services, such as temporary fillings. Through telehealth technology, the hygienists work closely with a dentist for assessment, treatment planning and referrals. The model was developed in California and Colorado is currently the second state implementing it.

### What is the potential?

- **Access:** VDH extends dental care directly to patients who would otherwise have no access. Hygienists can see patients in schools and community organizations. VDH may be especially useful in rural communities and areas with few dental providers or limited transportation to providers.
- **Care:** Evaluation of California's VDH pilot project suggests that patients are receiving safe, effective and low-cost dental care. All VDH procedures, including ITR, were safely and effectively delivered. Satisfaction surveys from 2012 and 2013 show parents of children served were highly satisfied by the VDH system, as were administrators of organizations and facilities (e.g., schools) affiliated with VDH. Four of five patient respondents found VDH much more convenient than the traditional system, and almost half said the wait time was less, quality was better, and costs were lower.<sup>2</sup>
- **Cost:** Per-visit costs tend to be lower in VDHs. In California, total expenses on VDH oral health personnel, supplies and equipment averaged \$42 per visit in elementary schools and \$31 per visit in Head Start preschools, well below the average Medicaid cost of \$83 per visit for similar services in the traditional model of care.<sup>3</sup> VDH allows clinics to serve more

patients without incurring the costs of expanding facilities.

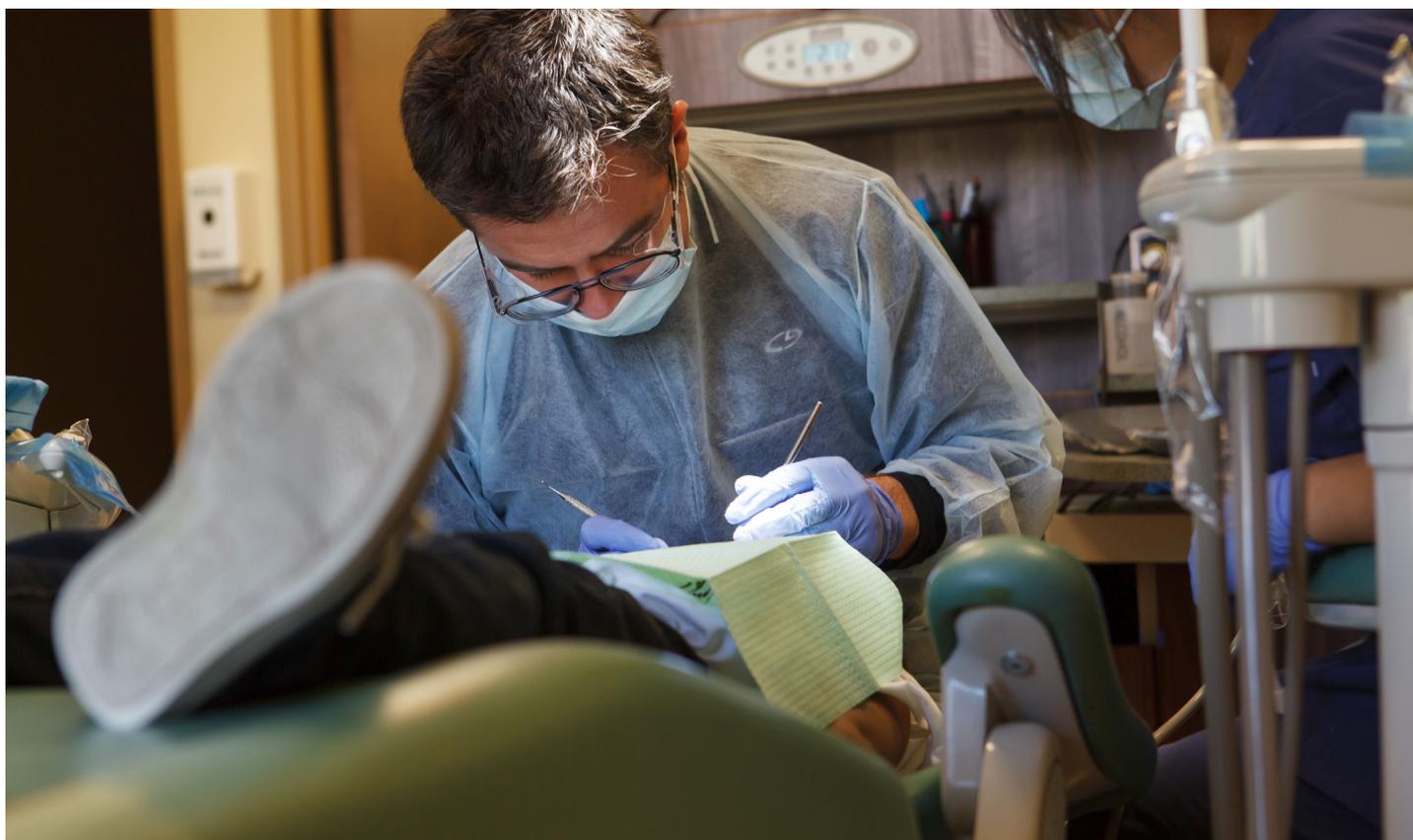
### What is happening in Colorado?

- The Colorado General Assembly passed House Bill 1309 in 2015, allowing dental hygienists to provide ITR after completing a training course and receiving a permit from the Colorado Dental Board. A multi-stakeholder advisory committee will be convened this fall to develop an ITR curriculum, which must be submitted to the Dental Board by the end of 2015. Providers will receive CHP+ and Medicaid reimbursement for ITR-related services provided via telehealth beginning in 2016.
- Caring for Colorado Foundation launched a VDH initiative, the SMILES (Spanning Miles in Linking Everyone to Services) Dental Home project, in 2015 to provide Colorado's most vulnerable populations with community-based oral health care. Caring for Colorado will award grants to four to six communities to plan and implement VDHs that expand access for pregnant women, children, seniors and people with disabilities, by combining workforce innovations and advances in teledentistry. SMILES awardees will begin a year-long planning process in October 2015 and begin implementing three year pilots in 2016.

### What is Medical Dental Integration?

Medical dental integration is care that results from primary care and oral health professionals working together to coordinate care. The level of integration can vary widely. In co-located facilities, medical and dental providers work in the same location and are supported by staff members such as nurses or care coordinators who keep track of patients' medical and dental needs.

In fully integrated models, dental and medical providers work together in teams, share a single administrative



system for patient follow-up, tracking, referrals and electronic health records. This model also encourages medical and dental staff to offer services outside of their disciplines, such as medical staff providing fluoride varnish, or dental staff providing diabetes screenings.<sup>4,5</sup>

### What is the potential?

- **Access:** Medical dental integration can improve access to oral health care by making it available in medical settings.<sup>6,7</sup>
- **Care:** Integration can help providers make early diagnoses of some diseases and complications. For example, periodontitis among diabetic patients might be a signal that their blood sugar levels are not under control. Adults without their natural teeth can have a harder time consuming fresh fruits and vegetables – which can pose challenges to managing high blood pressure or obesity.<sup>8</sup> And by sharing information and consulting one another, medical and dental professionals are more likely to offer comprehensive patient-centered care, chronic health management and prevention, and seamless medical-dental referrals.
- **Cost:** The increased efficiency of disease prevention and treatment has demonstrated cost savings when risk factors of dental disease, such as diabetes, are controlled and reduced.<sup>9</sup>

### What is happening in Colorado?

- Colorado workforce and Medicaid policies provide important support for medical dental integration. Colorado's dental hygienists can practice independently and bill Medicaid for their services. Primary care providers can also receive Medicaid payment for providing certain preventive dental measures such as oral screenings and fluoride varnish.
- Delta Dental of Colorado Foundation launched a five-year initiative in 2014, the Colorado Medical Dental Integration Project (CO MDI), to expand medical dental integration to 17 pediatric and family practice medical clinics across the state. Dental hygienists are members of health care teams, providing preventive dental services, coordinating care within the medical clinic, and collaborating with community dentists to link patients to comprehensive dental care.

## Next Steps for Oral Health

Colorado has made important progress in opening access to oral health. It expanded Medicaid to low-income adults and added an adult dental benefit to the public insurance program. Legislators this year passed a bill to advance virtual dental homes. And private foundations and oral health providers are partnering to test new models of delivering care.

Safety net clinics are rising up to meet the challenge of serving more Coloradans. Critical momentum is there to make this reality.

These insights, based on CHI's research, will be useful to decision makers as they consider ways to support these essential providers serving vulnerable patients.

- **Safety net providers need to easily and efficiently submit claims for their Medicaid patients.**

Instead, they report rules and definitions for billing Medicaid changed four times in one year until being finalized in March 2015. Providers point to other administrative challenges associated with the dental benefit that go beyond appropriate accountability and oversight. For example, providers cannot get Medicaid payment for dentures until the service is delivered. This puts clinics at a financial disadvantage, as it takes about five visits with costly lab services until dentures can be delivered. Some of these inefficiencies have been resolved, yet continued efforts to streamline processes for submitting claims and treatment plans are needed.

- **Colorado's Medicaid Accountable Care Collaborative (ACC) program emphasizes patient-centered care coordination and prevention, but does not explicitly include oral health.**

Safety net providers, especially those that provide only oral health services, may have limited connection to the ACC and patients' primary care medical providers. The oral health safety net and its advocates may be untapped resources for addressing issues such as emergency department visits and preventive oral health screenings.

- **Medicaid is an increasingly large payment source that helps safety net providers keep their doors open.**

But many clinics are struggling to keep up with demand. Most have limited room to grow due to the constraints of their current staff, clinic space and finances. Medicaid reimbursement, though helpful, cannot sustain clinics on its own, let alone fund expensive dental equipment: building a five to six chair dental practice in an existing space currently costs around \$400,000. Private philanthropy plays a significant role in supporting the safety net, especially as organizations report a significant need for capital funds for infrastructure, equipment and expanding new models of care.

- **Additional state funds to support loan repayments for safety net providers could help organizations recruit and retain needed workers.**

Safety net organizations report difficulty in recruiting, hiring and retaining staff. Some organizations struggle to find providers willing to take Medicaid, while others also have difficulty retaining providers given the limited availability of loan repayment funds. Federal funding through the National Health Service Corps Loan Repayment Program is increasingly limited. However, state funds, such as Colorado Department of Public Health and Environment's Colorado Health Service Corps, offer opportunities to continue supporting safety net providers.

- **Colorado oral health providers and stakeholders need better information on the Medicaid dental benefit for future planning.**

Safety net organizations anticipate continued growth in future patient demand. But to strategically plan for this, organizations need more accurate data to predict the patient need and provider supply of care. Questions related to the utilization and provision of Medicaid dental remain unanswered. For example, who is receiving care, where are they receiving it and which dentists are treating the greatest number of enrollees?



## Conclusion

Oral care is now within reach for many more adult Coloradans with Medicaid, thanks to recent policy changes extending dental coverage. Safety net organizations are focused on meeting these new demands while still serving children and seniors as well as uninsured Coloradans and planning for the future.

These efforts are costly, and require a dental workforce willing to serve in the safety net and work differently. Colorado leaders in the public and private sectors are already taking steps to address some of these issues.

But more is needed to ensure that Colorado's bold coverage expansions result in care for all who need it.



## End Notes

<sup>1</sup> Colorado Department of Health Care Policy and Financing

<sup>2</sup> [http://dental.pacific.edu/Documents/community/special\\_care/acrobat/VirtualDentalHome\\_OvierviewResults\\_PolicyBrief\\_May\\_2013.pdf](http://dental.pacific.edu/Documents/community/special_care/acrobat/VirtualDentalHome_OvierviewResults_PolicyBrief_May_2013.pdf)

<sup>3</sup> [http://dental.pacific.edu/Documents/community/special\\_care/acrobat/VirtualDentalHome\\_OvierviewResults\\_PolicyBrief\\_May\\_2013.pdf](http://dental.pacific.edu/Documents/community/special_care/acrobat/VirtualDentalHome_OvierviewResults_PolicyBrief_May_2013.pdf)

<sup>4</sup> <https://nosorh.org/wp-content/uploads/2014/02/Medical-Dental-Integration-What-It-Looks-Like-How-to-Achieve-It-M.-Smith.pdf>

<sup>5</sup> [http://www.gih.org/files/FileDownloads/Returning\\_the\\_Mouth\\_to\\_the\\_Body\\_no40\\_September\\_2012.pdf](http://www.gih.org/files/FileDownloads/Returning_the_Mouth_to_the_Body_no40_September_2012.pdf)

<sup>6</sup> Institute of Medicine (IOM), *Advancing Oral Health in America* (Washington, DC: 2011).

<sup>7</sup> Institute of Medicine (IOM) and National Research Council (NRC), *Improving Access to Oral Health Care for Vulnerable and Underserved Populations* (Washington, DC: 2011)

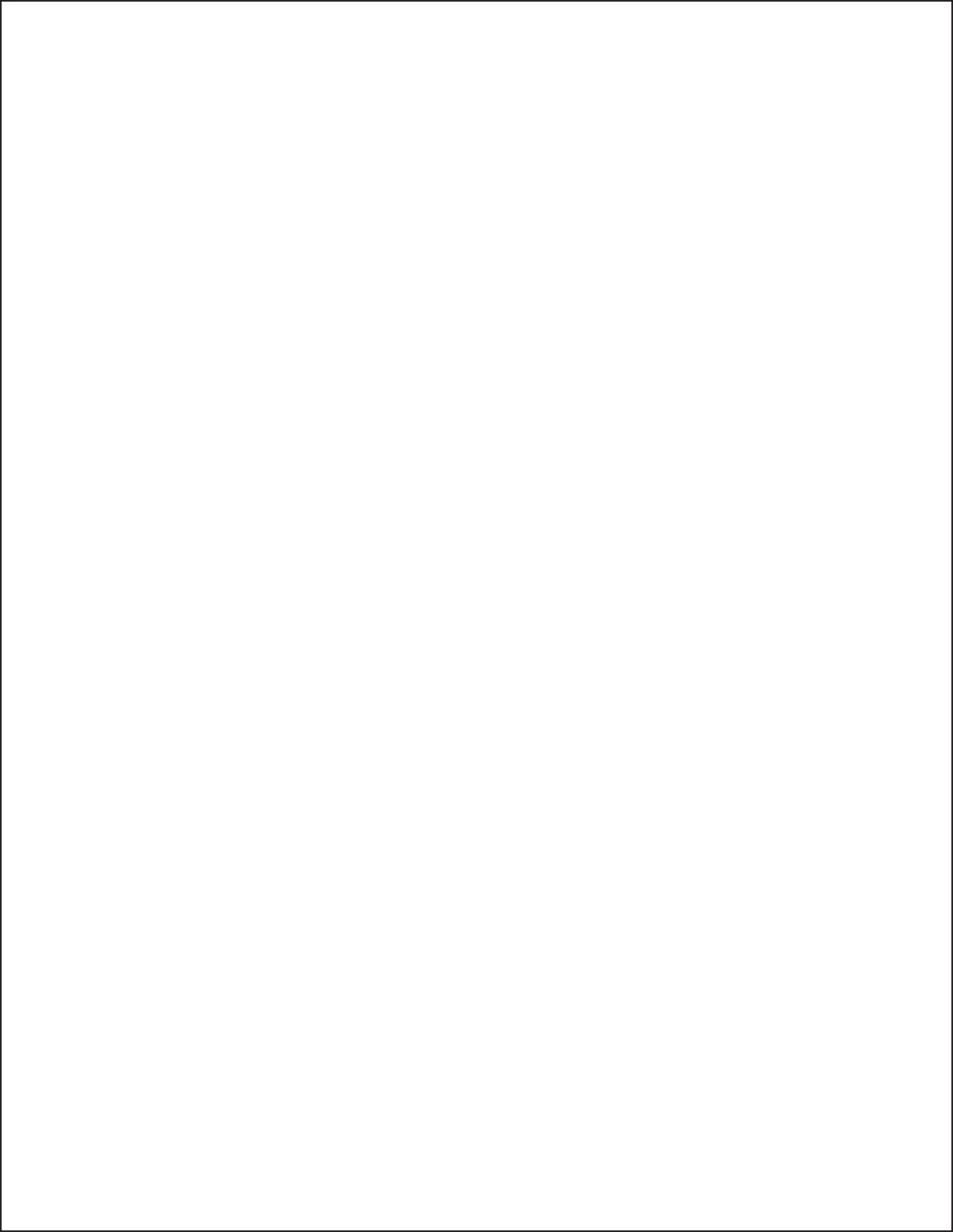
<sup>8</sup> Mealey, Brian L., and L.F. Rose, "Diabetes Mellitus and Inflammatory Periodontal Diseases: Current Opinion in Endocrinology," *Diabetes and Obesity* 15:135-141, April 2008.

<sup>9</sup> Cigna, Medscape Publishes Cigna Study Supporting Association between Treated Gum Disease and Reduced Medical Costs in Individuals with Diabetes, <http://www.medscape.com/viewarticle/751609>, November 1, 2011.



## Appendix: Survey Respondents

- Carin' Clinic
- Clinica Family Health
- Dental Aid Inc.
- Doctors Care
- High Plains Community Health Center
- Inner City Health Center
- Kids In Need of Dentistry
- Metro Community Provider Network
- Mission Medical Clinic
- Mountain Family Health Centers
- Northwest Colorado Dental Coalition
- Peak Vista Community Health Centers
- Pueblo Community Health Center, Inc.
- Salud Family Health Centers
- San Juan Basin Health Dental Clinic
- Senior Mobile Dental
- Summit Community Care Clinic
- Sunrise Community Health
- University of Colorado School of Dental Medicine
- Valley Wide Health Systems, Inc.





The Colorado Health Institute is a trusted source of independent and objective health information, data and analysis for the state's health care leaders. The Colorado Health Institute is funded by the Caring for Colorado Foundation, Rose Community Foundation, The Colorado Trust and the Colorado Health Foundation.

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