A Mixed Methods Analysis of Oregon Orthodontists' Participation in and Perception of Oregon Health Plan Medicaid Program

Cherry Choy, DMD

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Introduction

Authorized by Title XIX of the Social Security Act, Medicaid was first signed into law in 1965 to provide health insurance coverage to serve millions of low-income individuals. [1] However, at the time, orthodontic treatment was not specified as part of dental care coverage under Title XIX. It wasn't until the introduction of the Medicaid Early and Periodic Screening, Diagnosis, and Treatment Program (EPSDT) in 1967 that coverage of handicapping malocclusions became part of the expansion for comprehensive health coverage required from each state to include physical, dental, developmental and mental health covered services for individuals under the age of 21 enrolled in the Medicaid program. [2]

While the federal government establishes general guidelines for all states to follow, implementing these guidelines depends on each state's Medicaid program and its administration.[1] Even with the introduction of the EPSDT program, for decades, Oregon Health Authority (OHA) received permission from the US Department of Health and Human Services (HHS) to limit EPSDT benefits to Oregon Health Plan (OHP)'s beneficiaries. [3] Prior to 2023, instead of providing coverage for handicapping malocclusions for all Medicaid beneficiaries under twenty-one years of age, OHP limited coverage for orthodontic services to only publicly insured children diagnosed with cleft lip and palate under this age. It wasn't until January 1st, 2023 that OHP instated EPSDT benefits, including expanding orthodontic coverage to handicapping malocclusions for all Medicaid beneficiaries under twenty-one years of age . [4]

The recent expansion of OHP coverage for handicapping malocclusions to all Medicaid beneficiaries under twenty-one years of age utilizes the California model of the Handicapping Labiolingual Deviation index, abbreviated as HLD (CalMod), which is a tool utilized to quantify the severity of malocclusion. [4,5] To qualify, a severe handicapping malocclusion must include at

least one of six automatic qualifying conditions or an HLD index of 26 or higher. Utilizing Washington state as a model, approximately 0.81% of children between the ages of zero and twenty-one enrolled in the Washington Medicaid program in 2012 initiated orthodontic treatment. [5] OHA had also developed an initial model estimating the expected prevalence of Medicaid beneficiaries under twenty-one years of age that would qualify for orthodontic care to be approximately 0.8-2.5%. [6] With around 465,000 children in Oregon on OHP, it is anticipated that around 3,720-11,625 children and adolescents might be approved annually statewide. With this increase in the number of publicly insured children and adolescents eligible for orthodontic coverage under OHP, it is important to consider whether there will be enough orthodontists to provide care to this population. Historically there has been low participation in Medicaid by providers nationwide. In the neighboring state of Washington, it was reported that approximately one-quarter of practicing orthodontists participated in Medicaid in 1999 with the majority of participating orthodontists only treating a few cases a year. [7] Furthermore, it was reported ten orthodontists treated approximately 81% of Medicaid orthodontic cases statewide in Washington. Previous studies have concluded that the low Medicaid participation rate by orthodontists has been attributed to a myriad of factors, including low reimbursement rates, prior authorization processes, delays or denials in reimbursement, and patient compliance concerns during treatment. [7-15]

The goal of this study was to utilize a mixed methods design to examine and explore Oregon orthodontists' familiarity, perception, and attitude towards the OHP program and its beneficiaries. With the recent expansion of the OHP program and the anticipated increase in the number of publicly insured children and adolescents eligible for coverage, it was important to understand the challenges and barriers affecting Oregon orthodontists' decisions to participate in

OHP. There may be a need to address changes in program policy and/or in orthodontists' perspectives in order to improve utilization of the program and increase access to care for eligible OHP beneficiaries.

Study Aims:

(1) To assess Oregon orthodontists' perceptions and attitudes towards the OHP Medicaid program and its beneficiaries;

(2) To determine whether there are differences between Oregon orthodontists who are interested in accepting and those who are not interested in accepting OHP patients; and

(3) To evaluate the impact of orthodontists' demographics (type of practice, location, years in practice, training in residency) on their level of interest in participation in the OHP program.

Null hypothesis: There are no reported differences in perceptions and attitudes among Oregon orthodontists who are currently accepting and those who are not currently accepting OHP patients.

Materials and Methods

The protocol for this study was approved by the Oregon Health & Science University Institutional Review Board (Appendix A). This study utilized a mixed quantitative and qualitative study design method. Participants consented to take part in this study after reading the information sheet. The following inclusion criteria was used: practicing orthodontists in the state of Oregon over the age of 18 years. All research activities were conducted at Oregon Health & Science University School of Dentistry.

Quantitative Study Design:

A survey questionnaire was developed, tested and then used to ask participants about their perception and attitude towards the Medicaid OHP program and its beneficiaries. An invitation to participate in the web-based survey was emailed to Oregon orthodontists who were members of the Oregon State Society of Orthodontists (Appendix B). The email informed participants that the survey would collect data for a MS thesis research project, and that survey responses would be anonymous. The consent form was provided as an attachment via email to the members of the Oregon State Society of Orthodontists (Appendix C). It included an information sheet as well as a waiver of documentation of consent. Consent for the survey was assumed by the completion of the survey. Consent for the semi-structured interview was obtained verbally during the interview prior to starting the questions.

The web-based survey was conducted using a cloud-based platform that was approved for use at OHSU (Qualtrics, Provo UT). The survey included provider self-reported demographic information, including gender, age, ethnicity, and race, as well as questions about the practice; zip code, practice type, years in practice, Medicaid participation, percentage of patients treated with Medicaid and if they care for patients from underserved communities (Appendix D). At the

end of the survey, participants were invited to share additional relevant comments as well as their email if they were interested in participating in a semi-structured interview. Those who had not completed the survey after 2 weeks were sent one reminder message via email. Those who had not completed the survey after 4 weeks were sent a final reminder message via email. After 6 weeks, the survey was closed and all completed survey data gathered for analysis. After completing the survey, the survey-respondent's participation was over unless they volunteered to take part in the interview process. For the survey-respondents that volunteered to participate in the interview process, they were contacted via email to schedule a date and time for the interview via Webex. After the interview, the survey-respondent's participation was complete. Respondents were not compensated for responding to the survey.

Qualitative Study Design:

Respondents who expressed interest in participating in the interviews were contacted via email to schedule the interview which was conducted via Webex at a time suitable to the interviewee. Following the interviews, each participant was provided a ClinCard of $50 as compensation for their time and participation. A flexible evolving interview guide was used to conduct the interview. The interview guide consisted of open-ended questions that allow for elaboration from participants and exploration of unanticipated lines of inquiry concerning factors that contribute to the provider's familiarity, perception, and attitude regarding the OHP program and its beneficiaries (Appendix E). Preliminary data analysis occurred simultaneously throughout the process as interviews were being conducted. After each completed interview, the data was compared with those of previous interviews and utilized to update the interview guide. The interview guide became more sophisticated as it was continuously revised based on previous

data. The entire interview was conducted in English. The interviews lasted approximately 20-60 minutes and were recorded, transcribed verbatim, and anonymized.

Data Analysis:

Quantitative data was analyzed using descriptive statistics and frequency of distribution to survey questions. The Fisher's Exact Test was used to test for associations between the two groups, currently accepting OHP orthodontists compared to formerly accepting OHP or never accepting OHP orthodontists. Logistic Regression was used to test for the probability of OHP participation based on practice location and setting. Significance was defined if $P<0.05$.

Qualitative data was analyzed using Dedoose software which identified sections of text containing important and reoccurring ideas. These were extracted, categorized, and labeled to form a set of descriptive categories that were refined into a codebook with a hierarchy of analytical themes and sub-themes (Appendix F). The transcripts were coded by treating each theme and subtheme as an individual node. The coded data were independently checked and verified by two additional members of the research team. The two independent researchers were invited to recode any data in which they did not agree with the coding as well as review and refine the themes and subthemes. All three researchers discussed any variances in the coded data and made subsequent amendments for agreement.

Results

Quantitative Findings

Quantitative data from the survey is presented in Table 1-13. The demographics of Oregon orthodontists is shown in Table 1.

Table 1. Orthodontists Characteristics from Survey

	Overall (N=41)
Gender	
Female	13 (31.7%)
Male	28 (68.3%)
Age Group	
25 - 34 years	4 (9.8%)
35 - 44 years	7 (17.1%)
45 - 54 years	17 (41.5%)
55 - 64 years	9 (22.0%)
65 years or over	3 (7.3%)
Under 25 years	1 (2.4%)
Race	
Asian	9 (22.0%)
Other	1 (2.4%)
White	31 (75.6%)
Practice	
Corporate	8 (19.5%)
Partner or Group	9 (22.0%)
Solo Private	19 (46.3%)
University	5 (12.2%)
Location	
Rural	5 (12.2%)
Suburban	22 (53.7%)
Urban	14 (34.1%)
Years of Practice	
0-5 years	9 (22.0%)
11-15 years	11 (26.8%)
15+ years	20 (48.8%)
6-10 years	1 (2.4%)

Forty-one orthodontists out of 131 Oregon State Society of Orthodontists active members (31.3%) responded to the survey, of which 31.7% were Female and 68.3% were Male (Table 1). Nearly half of participants (46.3%) practiced in a solo private practice setting, with 19.5% of participants in a corporate setting, 22% in a partner/group setting, and 12.2% in an academic setting. Over half of the participants (53.7%) described their main practice to be in the suburban area with 34.2% situated in the urban area and only 12.2% practiced in the rural area.

Oregon orthodontists' experience with OHP and treating underserved communities is shown in Table 2.

Table 2. Experience with OHP and Treating Underserved Populations

	Overall (N=41)
For patients with Oregon Health Plan's coverage, your participation is best described as:	
Currently accept	14 (34.1%)
Formerly accepted	2 (4.9%)
Never accepted	25 (61.0%)
What is the maximum number of OHP patients you will treat annually?	
1-10	6 (31.6%)
11-20	3 (15.8%)
21-30	4 (21.1%)
41-50	2 (10.5%)
71-80	1 (5.3%)
91-100	3 (15.8%)
How did you learn about OHP's expansion of orthodontic coverage?	
Received information directly from Oregon Health Plan	10 (24.4%)
Received information from other sources (peers, OSSO, conferences, newsletter)	27 (65.9%)
Have not received any information	4 (9.8%)
Did your orthodontic residency treat Medicaid patients?	
No	7 (17.1%)
Unsure	8 (19.5%)
Yes	25 (61.0%)
Missing	1 (2.4%)
Do you currently treat patients from underserved communities with or without support from nonprofit	

	Overall (N=41)
organizations (A Smile for Kids, Smile Changes Lives, AAOF Donated Orthodontic Services)?	
No	12 (29.3%)
Yes	28 (68.3%)
Missing	1 (2.4%)

Most orthodontists (61%) reported never accepting OHP, while 4.9% reported formerly accepting OHP and approximately one-third (34.1%) reported currently accepting OHP (Table 2). Moreover, 68.4% of respondents reported limiting the number of OHP cases they treat annually to under 30 patients. Only one-quarter (24.4%) reported receiving information directly from OHP regarding its recent expansion of orthodontic coverage, while 65.9% reported receiving the information from other sources (peers, OSSO, conferences, newsletter) and 9.8% reported never having received any information from OHP or other sources. Majority of respondents did report having experience treating Medicaid patients in their residency (61%) and currently treating patients from underserved populations either with or without support from other nonprofit organizations (68.3%).

Perception of fair OHP reimbursement rates for Phase 1 and 2 is shown in Table 3.

Table 3. Perception of fair OHP reimbursement rates

	Overall (N=41)
What would you consider a fair Medicaid reimbursement rate for Phase 1 orthodontic treatment?	
$2000-2499	8 (19.5%)
$2500-2999	11 (26.8%)
$3000-3499	15 (36.6%)
$3500-3999	1 (2.4%)
$4000-4499	1 (2.4%)
Less than $2000	2 (4.9%)
Missing	3 (7.3%)
What would you consider a fair Medicaid reimbursement rate for Phase 2 orthodontic treatment?	
$2500-2999	3 (7.3%)

	Overall (N=41)
$3000-3499	4 (9.8%)
$3500-3999	2 (4.9%)
$4000-4499	1 (2.4%)
$4500-4999	2 (4.9%)
$5000-5499	13 (31.7%)
$5500-5999	7 (17.1%)
More than $6000	6 (14.6%)
Missing	3 (7.3%)

Majority of orthodontists perceived a fair reimbursement rate to be higher than $5000 for Phase 2 orthodontic treatment and lower than $3499 for Phase 1 orthodontic treatment (Table 3).

OHP participation based on practice setting and location is shown in Table 4 and 5 respectively.

Table 4. OHP Participation based on Practice Setting

	Corporate Practice (N=8)	Partner or Group Practice (N=9)	Solo Private Practice (N=19)	University (N=5)	Overall (N=41)
For patients with Oregon Health Plan's coverage, your participation is best described as:					
Currently accept	7 (87.5%)	1 (11.1%)	3 (15.8%)	3 (60.0%)	14 (34.1%)
Former/never	1 (12.5%)	8 (88.9%)	16 (84.2%)	2 (40.0%)	27 (65.9%)

p-value = 0.0005556*, *Fisher's Exact Test*

Table 5. OHP Participation based on Practice Location

	Rural (N=5)	Suburban (N=22)	Urban (N=14)	Overall (N=41)
For patients with Oregon Health Plan's coverage, your participation is best described as:				
Currently accept	2 (40.0%)	4 (18.2%)	8 (57.1%)	14 (34.1%)
Former/never	3 (60.0%)	18 (81.8%)	6 (42.9%)	27 (65.9%)

p-value = 0.03349*, *Fisher's Exact Test*

Practice setting and location differed significantly between the two practitioner groups of currently accepting OHP and formerly/never accepting OHP (P-value < 0.001 and < 0.03 respectively).

The odds ratio for OHP participation based on practice and setting location is shown in Table 6.

Table 6. Odds ratio for OHP Participation based on Practice Location and Setting

Practice Location	Currently Accept	Currently Not Accept	OR	95% CI	p-value
Suburban (Reference)	4	18			
Urban	**8**	**6**	**6**	**1.3942-30.1997**	**0.02***
Rural	2	3	3	0.3176-25.1549	0.303
Practice Setting					
Corporate (Reference)	**7**	1			
Solo Private Practice	**3**	**16**	**0.0179**	**0.0011 ~0.2207**	**0.004***
Group Practice	**1**	**8**	**0.0268**	**0.0004 ~0.2245**	**0.008***
University	**3**	2	0.2142	0.0078 ~3.0886	0.273

Odds ratio from Logistic Regression

Practitioners in urban locations were more likely to be currently accepting OHP than those in suburban or rural settings. Practitioners in corporate and university settings were more likely to be currently accepting OHP than those in solo private practice or group practice settings.

OHP Participation based on practice years is shown below in Table 7.

Table 7. OHP Participation based on Practice Years

	0-10 years (N=10)	11-15 years (N=11)	15+ years (N=20)	Overall (N=41)
For patients with Oregon Health Plan's coverage, your participation is best described as:				
Currently accept	3 (30.0%)	4 (36.4%)	7 (35.0%)	14 (34.1%)
Former/never	7 (70.0%)	7 (63.6%)	13 (65.0%)	27 (65.9%)

p-value = 1.0, *Fisher's Exact Test*

There was no difference in years of practice between the two practitioner groups of currently accepting OHP and formerly/never accepting OHP.

OHP Participation based on experience of treating Medicaid patients during residency is shown below in Table 8.

Table 8. OHP Participation based on experience of treating Medicaid patients during residency

	No/Unsure (N=15)	Yes (N=25)	Overall (N=40)
Did your orthodontic residency treat Medicaid patients?			
Currently accept	5 (33.3%)	9 (36.0%)	14 (35.0%)
Former/never	10 (66.7%)	16 (64.0%)	26 (65.0%)

p-value = 1.0, *Fisher's Exact Test*

There was no difference in experience of treating Medicaid patients during residency between the two practitioner groups of currently accepting OHP and formerly/never accepting OHP.

Perception of fair reimbursement rate for Phase 1 and Phase 2 treatment based on participation is shown below in Table 9 and 10 respectively.

Table 9. Perception of Fair Reimbursement rate for Phase 1 based on OHP Provider Participation

	$2499 or less (N=10)	$2500-2999 (N=11)	$3000 or more (N=17)	Overall (N=38)
What would you consider a fair Medicaid reimbursement rate for Phase 1 orthodontic treatment?				
Currently accept	6 (60.0%)	4 (36.4%)	3 (17.6%)	13 (34.2%)
Former/never	4 (40.0%)	7 (63.6%)	14 (82.4%)	25 (65.8%)

p-value = 0.076, *Fisher's Exact Test*

Table 10. Perception of Fair Reimbursement rate for Phase 2 based on OHP Provider Participation

	$4499 or less (N=10)	$4500 or $5499 (N=15)	$5500 or more (N=13)	Overall (N=38)
What would you consider a fair Medicaid reimbursement rate for Phase 2 orthodontic treatment?				
Currently accept	6 (60.0%)	5 (33.3%)	2 (15.4%)	13 (34.2%)
Former/never	4 (40.0%)	10 (66.7%)	11 (84.6%)	25 (65.8%)

p-value = 0.089, *Fisher's Exact Test*

There was no difference in perceived fair reimbursement rates for phase 1 or phase 2 treatment between the two practitioner groups of currently accepting OHP and formerly/never accepting OHP.

The following Tables 11 to 13 describe orthodontists' perceived concerns with OHP, perceived concerns with OHP patients' behavior, and perceived motivators with OHP respectively characterized by orthodontists' participation with OHP.

Table 11. Perceived Concerns with OHP

C, current OHP provider; F/N, formerly accept/never accepted OHP provider	Overall	Minor factor/Not a factor (%)	Major factor (%)	P-value
Unclear Medicaid provider enrollment process				
C	13	7 (53.85%)	6 (46.15%)	0.508
F/N	26	17 (65.68%)	9 (34.61)	
Need for prior authorization				
C	13	8 (61.54%)	5 (38.46%)	0.734
F/N	26	13 (50%)	13 (50%)	
Low reimbursement rate				
C	13	9 (69.23%)	4 (30.77%)	0.013*
F/N	26	6 (23.08%)	20 (76.92%)	
Delays or denials in receiving payment				
C	13	9 (69.23%)	4 (30.77%)	0.318
F/N	26	13 (50%)	13 (50%)	
Potential loss of coverage during treatment				
C	13	7 (53.85%)	6 (46.15%)	1.0
F/N	26	15 (57.69%)	11 (42.31%)	
Difficulty assessing customer support				
C	13	9 (69.23%)	4 (30.77%)	0.307
F/N	26	12 (46.15%)	14 (53.85%)	
Frequent changes in Medicaid regulations				
C	13	9 (69.23%)	4 (30.77%)	0.087
F/N	26	9 (34.62%)	17 (65.38%)	

Fisher's Exact Test

Table 12. Perceived Concerns with OHP Patients' Behavior

C, current OHP provider; F/N, formerly accept/never accepted OHP provider	Overall	Minor factor/Not a factor (%)	Major factor (%)	P-value
Failure to show up for appointments				
C	13	9 (69.23%)	4 (30.77%)	0.087
F/N	25	9 (36%)	16 (64%)	
Tardiness to appointments				
C	13	10 (76.9%)	3 (23.08%)	0.294
F/N	25	14 (56%)	11 (44%)	
Last minute cancellations				
C	13	10 (76.9%)	3 (23.08%)	0.043*
F/N	25	10 (40%)	15 (60%)	
Uncooperative behavior				
C	13	9 (69.23%)	4 (30.77%)	0.728
F/N	25	15 (60%)	10 (40%)	
Poor oral hygiene & more active disease				
C	13	8 (61.54%)	5 (38.46%)	0.734
F/N	25	13 (52%)	12 (48%)	
More emergency appointments (ie. appliance breakage)				
C	13	9 (69.23%)	4 (30.77%)	1.0
F/N	25	16 (64%)	9 (36%)	
Increased treatment complexity for handicapping malocclusion				
C	13	12 (92.31%)	1 (7.69%)	0.643
F/N	25	21 (84%)	4 (16%)	
Longer treatment time for handicapping malocclusion				
C	13	11 (84.62%)	2 (15.38%)	0.689
F/N	25	19 (76%)	6 (24%)	
Difficulty with coordination with other dental specialist (ie. orthognathic surgery)				

C	13	9 (69.23%)	4 (30.77%)	0.307
F/N	25	12 (48%)	13 (52%)	

Fisher's Exact Test

Table 13. Perceived Motivators with OHP

C, current OHP provider; F/N, formerly accept/never accepted OHP provider	Overall	Minor factor/Not a factor (%)	Major factor (%)	P-value
Reimbursement schedule of one time payment at start of treatment (vs quarterly payments)				
C	13	6 (46.15%)	7 (53.85%)	0.742
F/N	25	10 (40%)	15 (60%)	
Extension of reimbursement past 24 months for complex cases				
C	13	7 (53.85%)	6 (46.15%)	0.502
F/N	25	10 (40%)	15 (60%)	
Standardized qualifiers to reduce ambiguity for patient approval				
C	13	7 (53.85%)	6 (46.15%)	0.163
F/N	25	7 (28%)	18 (72%)	
Streamlined submission process for case approval				
C	13	3 (23.08%)	10 (76.92%)	0.672
F/N	25	4 (16%)	21 (84%)	
Easily accessible Oregon Health Plan Customer Support for training and assistance				
C	13	5 (38.46%)	8 (61.53%)	0.714
F/N	25	7 (28%)	18 (72%)	

Fisher's Exact Test

When considering current OHP providers with those who formerly accepted or never accepted OHP, low reimbursement rate was the only perceived concern with OHP that differed significantly between the groups. More current OHP providers perceived the reimbursement rate to be no problem or a minor factor, whilst non-OHP providers reported it to be a major factor (P-value <0.02). For OHP patients' behavior concerns, last minute cancellation was the only perceived concern that differed between the groups with more current OHP providers perceiving the last-minute cancellations to be no problem or a minor factor, compared to more non-OHP providers reporting it to be a major factor (P-value < 0.05). None of the perceived motivators with OHP differed between the two groups significantly.

Qualitative Findings

Quantitative demographic data from the interviews is presented in Table 14 and representative quotes are shown in Appendix G (Table 15-17).

Major themes identified from the interviews as barriers for orthodontists to OHP participation were mostly administrative concerns rather than patient related concerns (Appendix G, Table 15). There was also an overarching sense within the orthodontic community of a lack of

communication and distribution of information from OHA regarding the recent coverage expansion. This was thought to contribute to the common misconception among the non-OHP participating orthodontists that if they were to accept OHP, they would be overwhelmed with OHP patients and lose autonomy of their practice. Of the major themes identified from the interviews as facilitators for orthodontists to OHP participation, orthodontists commended some current OHP policies including the current reimbursement for both screenings and comprehensive treatment and commented on their positive personal experiences treating the Medicaid population and underserved communities. These serve as the most common motivators for them to accepting OHP (Appendix G, Table 16). Finally, based on their experiences, orthodontists provided recommendations to OHA for strategies to improve and streamline the current program to encourage more orthodontists' participation as well as possible strategies to reduce cost and government funding needed for the program (Appendix G, Table 17). Current OHP accepting orthodontists also shared recommendations for their peers interested in participating in OHP on how to successfully transition their office to accept OHP (Appendix G, Table 17).

The characteristics of the orthodontists who took part in the interviews are shown in Table 14.

Table 14. Orthodontists Characteristics from Interview

	Overall (N=10)
Gender	
Female	3 (30%)
Male	7 (70%)
Race	
Asian	3 (22.0%)
White	7 (70%)
Practice	
Corporate	4 (40%)
Solo Private	5 (50%)
University	1 (10%)

	Overall (N=10)
Location	
Rural	2 (20%)
Urban	8 (80%)

Ten orthodontists participated in the interview with more males (70%) than females (30%) respectively. Half of the participants (50%) practiced in a solo private practice setting, with 40% of participants in a corporate setting, and 10% in an academic setting. Majority of participants (80%) described their main practice to be located in the urban area with 20% situated in the rural area.

Administrative Concerns with OHP

Of the providers who currently accept OHP, the biggest concern they had was the current HLD index used in screening with 100% of providers mentioning that it can be improved.

> Orthodontist A: “No, it does not capture severe handicapping malocclusion. No, I'm uncomfortable with the way that this form is identifying patients.”

Majority of current OHP providers thought the HLD index can be burdensome and can miss some conditions they would consider severe handicapping malocclusions, such as ectopic canines resorbing laterals. Though some did say it gets easier with practice and familiarity with the index.

> Orthodontist B: “The HLD Index works okay, but I think there's a better way. The automatic qualifiers I feel like it is a better scale or criteria to judge who deserves this benefit and who doesn't so. The point system is bias towards, for instance, crowding, but it leaves out patients who have bilateral posterior crossbites. It definitely leaves room for improvement.”

Nearly three-quarters (71%) of providers currently accepting OHP expressed concerns about difficulty with coordinating with specialists for referrals since there are limited in-network providers and the waitlist for appointments is often extensive, which can delay treatment.

> Orthodontist C: “It took a while for me to figure out whether extractions or expose and bonds associated with orthodontics would be covered by OHP. Same for surgical cases. It seems like it should all be covered, but I'm still uncertain about the necessary steps to go through and who will be accepting those cases on the surgeon’s end.”

With the current setup, a few of the current OHP providers also mentioned that it can be confusing working with the different Coordinated Care Organizations (CCOs) when submitting for preauthorization as there are different requirements and documentations required for each CCO.

> Orthodontist A: “There has been some slight variations and requirements from each CCO, whether it's ODS, Capital, Cascade Health Alliance, Advantage…exactly what they require to submit prior to authorization. So I think for offices that are dealing with multiple insurance companies all managing OHP, that can be confusing, particularly at the beginning to dial it all out.”

More than half of the current OHP providers brought up that the reimbursement rate is low, but those who work in DSO or academic settings were less concerned as their salary compensation is less likely to be directly affected.

> Orthodontist D: That's not a fair compensation for some of the cases. But here [in the DSO setting], you know, it doesn't make a difference to me cause I'm not compensated based on that.”

Among the providers who are not accepting OHP, the majority expressed concerns with how time consuming and complex the HLD index currently is. One provider stated that it would be difficult to train their staff to utilize the form and didn't think it would be feasible to incorporate it into their practice.

> Orthodontist E: "I found out that the paperwork was extremely complicated. I took the paperwork that I had, I guess they modeled after the California model. I printed off that. I ran it through on a couple of patients, just to see what it was all about and it was so time consuming to figure out all the numbers and get everything just right. And then you found out that, you know, you've got something that's 1 point off and yet you look at it and go, ok, everything on this kid, for example, they already have gingival recession. Well, you know, this kid's only maybe 11 years old, and they may not have gingival recession, but if they're biting in an under bite, they're going to have gingival recession by the time they're 18 and then it's too late or 21, whenever you can't do it anymore. So any of those kinds of things is just sort of really annoying that you can't, you know, see a debilitating malocclusion and with the knowledge that you have having done this for many years, you know, this is not just an aesthetic tune up for this kid to be able to smile better. And so that's frustrating."

This concern was further amplified among non-OHP providers due to the perceived low reimbursement rate, which they stated does not compensate well for the additional time and resources needed in order to incorporate OHP into their practice.

> Orthodontist F: "You know, because not only are they asking the providers to take less money for a case, but they're also saying spend more of your resources trying to navigate our difficult situation."

Lastly, two non-OHP providers also mentioned concerns with finding specialists that are in network with OHP, especially within a reasonable travel distance for their patients who live in the rural areas of Oregon.

> Orthodontist E: “I think that's a really big deal because again, these are the difficult cases that often require you communicating really well with the dentist. There might be an impacted canine. Where are they going to go for that? Is that going to be readily available? Are they going to have to go from [rural Oregon] to Portland to have a canine exposure with a doctor I've never worked with and then the doctor puts on the gold chain and the first time I touch on, it falls off and then I get blamed for that obviously. So, those kinds of things are really hard to imagine how that's going to work.”

Patient-Related Concerns with OHP

Of the providers who currently accept OHP, there was only 1 mention of a patient-related concern being that OHP approved severe-handicapping malocclusion cases are often more complex than the average case. The concern mainly had to deal with coordinating care with specialty providers for referrals and less with the patient’s behavior.

> Orthodontist G: “In general, the average difficulty for cases that I'm seeing is a little higher than before we've accepted OHP. It takes longer to treat those cases as well because a lot of them need extractions or have impacted canines that take longer to treat and the coordination with specialists is a little tricky because I have to submit a separate referral that will be processed through OHP, instead of just a generic referral letter. It takes longer for the OHP referral to be sent to the dentist or specialist who is doing the

> procedure. As far as I know, it doesn't always go to the one oral surgeon you commonly work with. It could go to anybody else who takes OHP in the area."

Other than that, all the current OHP providers stated they didn't find much of a difference between OHP and non-OHP patients.

For the providers who are not accepting OHP, similarly they mentioned concerns with increased treatment complexity for OHP approved cases, which could increase chair time and affect patient flow.

> Orthodontist E: "If I choose to take care of a severe cleft palate kid, I know that I'm not going to make money on this. And this is not going to be a one-and-a-half-year treatment case. I'm just going to do my best to do it, but if I had an entire practice of that, I probably couldn't keep the practice open...Some of the new doctors coming out might love to have a patient load that comes in like this, but it could be overwhelming to them if you're not careful having these really severe malocclusions that are really hard. And you're going to spend a lot more time with these kids than you would with other patients."

Another patient-related concern mentioned by non-OHP providers was a high frequency of cancelled and failed appointments for OHP patients with the reasoning being that parents might care less about keeping appointments when there aren't any financial obligations.

> Orthodontist E: "I find that probably 90% of the time, the missed appointment is not the kid's fault. It's the parent's fault. So I think if you just set some parameters at the beginning with these patients, and again, if they know that they're getting a freebie, sometimes they don't care."

Finally, one non-OHP provider mentioned noticing on average more broken brackets and poorer oral hygiene among OHP patients compared to non-OHP patients.

> Orthodontist H: "It's not across the board on everybody, but yes, on average, those factors were way higher in the OHP population…missed appointments, broken brackets, poor oral hygiene."

Other Concerns Related with OHP

Both groups of providers who are currently accepting and those not accepting OHP expressed that there is overall a lack of communication and distribution of information regarding OHP's expansion of orthodontic coverage among the orthodontic community.

> Orthodontist I: "No, I heard nothing. I got nothing from OHP or OHA or any of the bodies that were responsible for this rollout. So I don't really know how other orthodontists may have gotten this information cause I'm sure that my information came through ASK (A Smile for Kids which is a nonprofit organization working with local orthodontists to provide free and affordable braces for underserved kids in Oregon)."

More than half of providers expressed they heard nothing from OHA or any government bodies responsible for the rollout and some providers who are currently not accepting OHP said they would not know who to get in contact with even if they were interested in participating.

> Orthodontist F: "I never tried, but you shouldn't be my OHP resource, but I would ask you [interviewer]. Who else would I ask? How do they communicate with us? How do we communicate with them? There's no lines of communication."

Two-thirds of non-OHP providers also expressed concerns of overcommitment and loss of control and autonomy if they were to accept OHP. Those concerns revolved around being designated as the main OHP provider in their area if none of the other orthodontists are accepting

OHP and being overwhelmed by the number of OHP patients, which they fear would affect their practice.

> Orthodontist E: “If I have to become the so called OHP orthodontist in my area, I don't know if I want that headache because now I'm going to be getting phone calls from everybody, and I can't take everybody. So I would love to see the orthodontists in Oregon come together and realize that, hey, if we all just share the load and we all look at this as a way to be helpful, instead of just a way to make money, then we would be able to take care of these kids, but that's not going to happen. So, because, you know, our economy is not doing great and fees are having to go up and overhead going up. So it's going to be a challenge. It really is. But, you know what, what you don't want to see happen is that model where just one orthodontist or one DSO or one company takes all this on and then these kids still get put in line and they never get to care.”

OHP Related Facilitators

Of the providers who currently accept OHP, all providers expressed that they appreciate the one-time payment reimbursement schedule and even though the current reimbursement rate is lower than market value, it might be reasonable for a public health program especially since the screening exam is also compensated separately regardless of if the patient is or isn’t approved for treatment.

> Orthodontist A: “It's enough for me to run my office and feel I'm being compensated. I don't have a collection problem. So I'm not worried about somebody paying their bill, and I think the fact that they pay upfront is great and really aids in cash flow. And, again, I

> think it can become problematic when we begin to have more transfer cases but I think it's reasonable compensation coming from a public health program."

For private practice orthodontists, some mentioned it depends on if they have the choice to limit the number of OHP cases they treat, as well as the financial status of their practice. Some did express concerns about the financial feasibility for newer orthodontic graduates who might have more student loans and financial obligations. On the other hand, a few private practice orthodontists did mention accepting OHP might be profitable for newer practices with open exam slots as they build their patient pool. All of the DSO orthodontists who currently accept OHP patients stated that the reimbursement rate is lower than market value but is not a big concern for them. Some explained that their compensation structure is salaried and the reimbursement rate for OHP patients do not affect their salary.

> Orthodontist B: "I don't really have an opinion on the reimbursement rate. One thing at [DSO] is that doesn't affect us and our compensation. So I can say that is fair, but then I don't know if that would be accurately reflecting the rest of the community."

The experiences with the preauthorization submission process differed among providers accepting OHP. Most in private practice expressed overall positive experiences stating that the process is similar to working with other private insurances.

> Orthodontist A: "At the OHP Workforce meeting, I found it fascinating where people were talking about this administrative burden to submit cases. It's like taking all the records. They're not doing that much more. They're doing an HLD index which they're doing wrong. I mean most orthodontists take pictures, they take an xray, and they do an exam. The only thing they have to do extra is somehow scan and send that to the CCO,

> which is nothing more than what they do for any other insurance company, so I don't understand the administrative burden, and the only other thing maybe again is the HLD, which you can do in a minute and a half at most."

For some DSO orthodontists, depending on the company's protocol, some expressed they don't have any frustrations as the general dentists do the screenings instead of the orthodontists, while others state that the process is burdensome on their workflow, especially if they are working with different CCOs that have different requirements for submission.

> Orthodontist C: "Yeah, so I've seen some of the general dentists, they sit down, they have the models in their hands, and they score the HLD. There're people in the company who are working closely with OHP, they're the ones who do the preauthorization approval or denial. I don't think they've had any problems with all that."

Of the providers who are not accepting OHP, one mentioned that the reimbursement rate is "better than nothing" and he would consider accepting OHP if he had the capacity in his practice.

> Orthodontist H: "It's on the low side, but it's better than nothing. Obviously…it is nice that you get it up front…I think it's doable. It's something that I would consider doing if I had more time."

The same provider who had experience with the Washington Medicaid program also mentioned that OHP appears more streamlined compared to its Washington counterpart from what he has heard.

> Orthodontist H: "I think it appears that Oregon is a little bit more streamlined. So I think it is a lot easier. However, there is a learning curve that we would have to go through,

right? For any new type of process, we'd have to get systems in place. I think Oregon is much better just from talking to the CCO representative and learning about it."

Provider Related Facilitators

A majority of orthodontists currently accepting OHP expressed that part of their motivation for participating is their sense of professional responsibility as a healthcare provider to serve the state population.

> Orthodontist J: "I think it really does come down to a bit of a professional duty, a professional obligation. You know, orthodontists, generally speaking, are fairly well compensated for the work they do, so if they take a hit on some of these patients in order to serve the state, I think that's okay. Or I would encourage them to do those best they could. I understand if people choose not to do that. But I do think that's kind of the best motivation there is. This idea of sort of the duty to the patient population of our state. Having said that again, I would go back to I think it's imperative that OHA makes it as easy as possible."

Some mentioned the experiences serving the OHP community have been personally fulfilling and a way for them to give back to the community.

> Orthodontist B: "I never really had a plan to go into that [treating Medicaid patients]. But I feel like that was just a rewarding part of my career so far. I really enjoyed it. I think I just like it. You know, I'm not 1 of those who want to shun it or to try to avoid it as much as possible. I don't know how many out there are like me. But, yeah, I think I've always liked it."

Providers in private practice stated they feel like they have autonomy over the number of OHP patients they accept where they don't feel like it is overwhelming their practice negatively.

> Orthodontist A: "You could also limit the number of OHP patients in any given month and allow it to trickle in until you got comfortable and until you can really see what your experience is with that. I don't think anyone's practice is going to be overrun or they're going to be forced to take too many OHP patients that is not going to work in their office."

On the other hand, providers employed by DSOs reported that the decision to accept OHP was made early on by the company's administrative staff and they simply followed the plan set by the company.

> Orthodontist C: "Yeah, through [the DSO], once they got a plan going, then they rolled out a policy for our whole ortho program that all the orthodontists at [the DSO] were aware of the policy, and we followed along a plan, a treatment protocol for our OHP patients."

All of the orthodontists who had previously partnered with nonprofit organizations like A Smile for Kids (ASK) to treat underserved communities said these positive experiences encouraged them to serve the OHP population as well.

> Orthodontist I: "I mean, all orthodontists use ASK…I shouldn't say all, but a lot of us who have done this for a while. It's been very good to us. It's a great profession. We feel really good about helping people and making them feel better about themselves. And so, you know, we all want to give back and so I've done the ASK program for years and years. We started doing that 15- 20 years ago and then now, this program came along, so we want to try to help some of these kids if we can."

Similarly, nearly all (85.9%) of providers currently accepting OHP expressed that one of their biggest motivators to participating in OHP is the positive experiences they have had with Medicaid patients either in the past or currently.

> Orthodontist B: “There is no difference between OHP patients and patients with private insurance. There's 0 difference. They're all good patients. There are some that take great care of their teeth and there are some that don't take care of their teeth. But there's no obvious difference between the 2. You know, they are teenagers. And, yeah, I think it's great. I feel like a lot of them, they're appreciative, they're very appreciative of the opportunity to get braces. The kids are great. I just never had an issue myself. “

For the providers who are not accepting OHP, two-thirds (66%) stated they had positive experiences with Medicaid patients in the past as well and would like to help treat the underserved communities, especially if more orthodontists participated in OHP to share the patient load and if they had the ability to choose the number of OHP patients they accept to keep their practice financially viable.

> Orthodontist H: “I'll just say one thing about treating Medicaid patients. In general, it's a privilege to treat them. In the past, when I was treating Medicaid patients on Fridays, it was 1 of the best days of the week to go in there because most of the patients are very thankful and my staff enjoyed it too. You know, that was their favorite day too, because overall, it's just fun to treat them because it's a great thing to do in general. There’re just some challenges so you get some challenging patients that are it's no fun, but the majority of the patients you treat, it's wonderful.”

One orthodontist who had experience working with ASK expressed that he would also be more inclined to accept OHP if the support and process of case approval is comparable to ASK or if OHP partnered with ASK to implement similar protocols.

> Orthodontist E: “I think it would be amazing if I can treat OHP patients the same way I treat ASK patients. I look at [an ASK representative] as almost like one of my employees, but I don't have to pay her payroll taxes. She just takes the bull by the horns and does it and then I have a staff member that obviously communicates with her and I often do too, but they take that load off of my staff. I mean, you haven't probably been in private practice yet, but you've somebody who has to get on the phone. And now a lot of it is done on the websites and stuff, but it used to be that you'd have to get on the phone and wait for the insurance company. And you'd have to pay a staff member to sit there and do that. I mean, if I had to do that for OHP cases, I couldn't have the staff person to do it. If you treated one case, that would be one thing, but if you're going to do this, you're going to probably do 3 or 4 cases and now, you're just eating up a lot of administrative time. So, yes, having [an ASK representative] or a person like her assigned to help coordinate all of that red tape would really help, I think.”

Recommendations to OHP

When asked what they would like OHP to improve to encourage participation from their peers, majority of orthodontists who are currently accepting OHP said they would prefer using a more comprehensive list of automatic qualifiers along with a write-in option instead of the current HLD index.

> Orthodontist B: “I like the idea of using automatic qualifiers which looks at the quality of the malocclusion, as opposed to measurements that are a little bit arbitrary and it doesn't give the holistic picture. So if you're just kind of adding up points that could be misleading, either one way or the other. So it's not great. So automatic qualifiers give a more qualitative and therefore more accurate description of what malocclusion the patient has.”

Some orthodontists recommended increasing coverage to include Phase 1 treatment, which would allow orthodontists to treat patients with time-sensitive conditions at the most optimal time as well as possibly making the program more cost-effective by reducing Phase 2 treatment needs.

> Orthodontist I: “There's nothing with phase 1 early interceptive type treatment and I think that needs to be addressed. We need to have some sort of opportunity for these phase 1 kids to be treated because we can treat them phase 1 orthopedically, we can make phase 2 a lot easier for them and more efficient and more cost effective.”

With the current one-time payment fee schedule, a few orthodontists did mention concerns regarding possible complications if a patient were to relocate or transfer to another provider and recommended OHP designate what the protocol would be to split the payment between the two providers.

> Orthodontist A: “I think the first steps, it'd be great to have providers that would make the care accessible. The second is to have some clarity. I think one of the problems that is going to come up or is beginning to come up is when people leave an area and transfer to another because one thing that's nice about the benefit is they pay you up front in full.

> The only thing they don't pay you for is retainers until you do the debond. But in the case of somebody transferring, you know, who says how do you divide the payment? This I think is gonna be kind of interesting."

One orthodontist specifically mentioned solely having the orthodontists complete the screenings, instead of the general dentists, as a way of reducing cost for OHP as they feel like orthodontists often have to repeat the screenings due to inaccuracies from the general dentists' submissions and OHP ends up paying for double screening exams.

> Orthodontist I: "I think the best thing would probably be to have the general dentist who do OHP just refer patients to the orthodontists. They don't need to try to qualify them beforehand. Hand them over. Let us qualify them. Let us look at them. Not spend extra money on the dentist doing them because most of the ones I've talked to said, 'Why do they want us to do these? We don't even know what we're looking for. We're not orthodontists.' That's what all the dentists are telling me. They're like, we have to do this, but I don't even know what I'm looking for. So, it's kind of a waste of money."

Many orthodontists also felt it would encourage participation among their peers if OHP improves their communication and outreach to the community regarding the new orthodontic coverage and streamline the process for referrals. In particular, there was emphasis on increasing access to specialty referrals, especially addressing the problem of long waitlists for oral surgery procedures and limited in-network providers in rural areas.

> Orthodontist C: "So, in general, the average difficulty for cases that I'm seeing is a little higher with OHP. It takes longer to treat those cases as well because a lot of them need extractions or have impacted canines that take longer to treat and the coordination with

> specialists is a little tricky because I have to submit a separate referral that will be processed through OHP, instead of just a generic referral letter. It takes longer for the OHP referral to be sent to the dentist or specialist who is doing the procedure. As far as I know, it doesn't always go to the one oral surgeon you commonly work with. It could go to anybody else who takes OHP in the area. So I think it would be good if that referral process had some more stability."

Finally, a few orthodontists did mention one way to encourage participation might be to increase the reimbursement rate as well as creating tiers for higher reimbursement for more complex cases.

> Orthodontist G: "One positive change would probably be increasing the reimbursement rate, just increasing the base value and then maybe including a few different tiers, so the more complex the case, the higher the reimbursement."

Orthodontists who are not currently accepting OHP also had recommendations for OHP to increase participation. Some recommendations were similar to those of orthodontists currently accepting OHP, including simplification of the screening process.

> Orthodontist E: "I know my staff are very capable, but they're certainly not capable of filling out the HLD form. That form is harder than doing your board exams…I could train a staff member to fill the form, but I don't know that I would want to do it to that detail. I would rather have it be as simple."

Other recommendations included ability to charge a no-show fee to improve patient attendance as well as simplifying the process for receiving reimbursement from OHP to reduce any administrative burden.

Orthodontist H: “Yeah, it would be nice to be able to charge a no-show fee. I don't usually charge a nominal fee in my office, but I had to do it my low-cost office because we had a ton of no shows and once I implemented that no show fee, I became profitable.”

Orthodontist F: “Not only are they asking the providers to take a less money for a case, but they're also saying spend more of your resources trying to navigate our difficult situation. So, I do think that it's important for their system to try to make it as efficient for the provider as possible to apply and get the money, especially if the money's going to be lower than fair market rates.”

Recommendations for Orthodontic Peers

When asked what advice they would give their peers who are interested in accepting OHP, orthodontists who are currently accepting OHP suggested that it would be helpful for their peers to familiarize themselves and their staff with the HLD index as it would make the screening process much more efficient and reduce burden on their chair time.

Orthodontist A: “Truthfully I don't know how much you've used the index, but once you learn how to do it, it’s a one to 2 min process. It's really pretty straightforward and easy to do. I think so. Specifically for orthodontists.”

A few orthodontists recommended reaching out to other OHP providers and learning from them and their staff as to what has worked well for their practice with managing OHP.

Orthodontist I: “I would speak to an office who's already doing it successfully and request support from their administrative staff, and usually each office has a key person who's managing it. So I think like my office manager would be happy to share her experience with other providers.”

For those just beginning to accept OHP especially in private practice, many orthodontists also recommended starting with only a few patients to learn and implement the system first and designate someone in the office to manage OHP logistically before gradually increasing the patient load if desired.

> Orthodontist J: “My advice would be maybe to try one patient first and work through the process and make sure that questions are being answered. Make sure that you created a system for that. It might be somebody in the office who's going to manage this logistically to make sure that that they're getting the responses that are needed.”

Finally, most orthodontists recommended their peers to make a personal choice to help the underserved community if able and reaffirmed that their experiences with OHP patients have been positive.

> Orthodontist B: “A lot of private practices might be more profit driven or production driven. And so that is basically how much compensation they're going to be getting for this, so that would be the biggest barrier, I would imagine. I think a lot of it is going to be up to the providers and what they feel is their moral obligation to help the community in this way. And that's up to the individual provider. And I don't know if it's something that you can just expect people or even change their viewpoints on. It's kind of a big ask. I think if they are willing to accept the compensation and they are willing to see OHP patients and their variety of severe malocclusion and they're willing to take on the challenge of these case that are considered more challenging, if they're willing to take on that challenge, I think, there is no difference between OHP patients and patients with private insurance.”

Discussion

We evaluated the influence of demographics and administrative, patient, and provider related factors on orthodontists' decision to participate in OHP. Contrary to our null hypothesis, there were reported differences in perceptions and attitudes among Oregon orthodontists who are currently accepting and those who are not currently accepting OHP patients, though the two groups do share some similar views on certain aspects of care to this population group as well.

Level of practitioner participation based on practitioner and practice characteristics

Of the practitioners who replied to our survey, approximately one-third (34.1%) of orthodontists were currently accepting OHP with the majority of them practicing in urban areas and employed in a corporate or academic setting. Around two-thirds (68.4%) of orthodontists reported they would limit the maximum number of OHP patients they treat annually to under 30 patients. This pattern of low provider participation and limitation to number of Medicaid patients treated annually was consistent with a previous study from Washington reporting approximately 25% Medicaid provider participation with majority of participating orthodontists treating only a few cases every year.[7] The low level of participation by orthodontists, especially in suburban and rural areas of Oregon, can be a major impediment to eligible OHP beneficiaries being able to access care. Previous studies of Medicaid program from other states found that the orthodontic utilization differed greatly by state with less than 1% of beneficiaries under the age of 21 years old in Washington in 1999, less than 0.5% in North Carolina from 2002 to 2004, and 3.1% in Iowa from 2008 to 2010.[7,16,17] Under an initial model developed by OHA, the expected prevalence of Medicaid beneficiaries under 21 to qualify for orthodontic care was estimated to be around 0.8%-2.5%. [6] With around 465,000 children in Oregon on OHP, it was anticipated that around 3,720-11,625 kids might be approved annually statewide. 16 months after rollout, as of

April 2024, only 589 OHP patients had started orthodontic treatment (HM Workgroup 2024, unpublished data), which is significantly less than initially projected. By addressing the common barriers to provider participation, more eligible beneficiaries might be able to access care.

Level of provider participation based on reimbursement rate and payment schedule

From our survey responses, the majority of orthodontists perceived a fair reimbursement rate to be higher than $5000 for comprehensive orthodontic treatment. While our quantitative data showed there was no difference between the perceived fair reimbursement by current OHP providers and non-OHP providers, there was a significant difference with non-OHP providers more frequently reporting low reimbursement rate to be a major factor in their decision to not accept OHP compared to current OHP providers. These findings were consistent with those from previous studies that found low reimbursement rates to be one of the most common reasons cited by dentists and orthodontists for not participating in the Medicaid program as many providers perceived treating a child enrolled in Medicaid to be an out-of-pocket loss for their practice. [7,8,16] A study comparing orthodontic Medicaid funding from 2006 to 2015 also found that the Medicaid reimbursement rate for comprehensive orthodontic care had decreased from 65% to 41% compared to private insurance reimbursement over the course of 9 years. [18] We further explored the influence of reimbursement rate in our interviews and found there to be differing opinions between OHP and non-OHP providers. While the majority of interviewees from both groups agreed that the reimbursement rate for comprehensive treatment was low compared to customary fees, all of the orthodontists currently accepting OHP thought that the additional reimbursement for all OHP orthodontic screenings helped compensate for the lower treatment fee. Furthermore, some of them reported that even though the compensation for comprehensive treatment was lower than market value, they felt that the compensation was reasonable for a

public health program and they perceive it as part of their “pro bono” work. Orthodontists who were currently accepting OHP did report they understand how other orthodontists might not be in the same situation to accept OHP’s lower fees, especially those with more financial obligations, such as higher student loans. Some private practice orthodontists also mentioned that newer offices with open exam slots and goals of increasing their patient pool might benefit from screening and treating OHP patients despite the lower reimbursement rate, especially since they would also get compensated for the screening and the one-time payment could help build the office’s cash flow. Other orthodontists who are employed by corporate offices accepting OHP reported that the low reimbursement rate matters less to them as they are salaried and not compensated based off how much is collected for treatment. On the other hand, orthodontists who aren’t currently accepting OHP expressed concerns over the low reimbursement and how OHP participation might negatively impact their practice financially, especially since treating difficult cases covering severe handicapping malocclusion would require more time and resources, which can have financial ramifications. Previous attempts to increase the Medicaid reimbursement rate to the 75th percentile of the usual and customary fees for other areas of dentistry, such as pediatric dentistry, have successfully increased provider participation, but with the state’s limited budget, this solution might not be feasible. [19,20] Another proposed solution included a more favorable income tax rate for providers who increase their treated Medicaid population. [12]

From our interviews, there was also concerns from the majority of non-OHP providers regarding the possibility of being the only OHP provider in their area and their practice being overwhelmed by Medicaid patients if they were to accept OHP. Previous studies did report a pattern of a minority of the state’s orthodontists treating the majority of Medicaid patients including a study

in Washington that reported that 81% of the Medicaid cases were treated by 10 orthodontists in 1999.[7] Similar findings of a small percentage of orthodontists treating the majority of Medicaid patients was reported from a study in Iowa, with only 32 orthodontists submitting claims to Medicaid for more than 10 patients.[17] However, from our interviews, current OHP providers did not report having this issue of being overwhelmed by the number of OHP patients. It is possible that there is this common misconception among non-OHP providers that there is a lack of control and autotomy over the number of OHP patients they are required to treat if they were to accept OHP. A few of these orthodontists said during their interviews they would be more comfortable accepting OHP if they can have more control and autonomy over the number of OHP patients they treat. Furthermore, they expressed they would be more likely to participate in OHP if there was greater participation amongst their peers and even distribution of patients to lessen the demand on each OHP provider.

Interestingly, another recommendation proposed by several orthodontists during our interviews was the extension of the orthodontic benefit to include the coverage of phase 1 treatment. From our survey, most orthodontists perceived a fair reimbursement rate to be lower than $3499, which is significantly lower than the perceived fair reimbursement rate for comprehensive treatment. With coverage of phase 1 treatment, orthodontists would be able to treat patients at an earlier age and decrease the severity of malocclusion later in life, though there is controversy as these patients might not be eligible for subsequent phase 2 treatment due to the improvement of their malocclusion. By extending the coverage to phase 1, it might reduce the cost burden for OHP and more orthodontists might be willing to participate even with a reimbursement rate lower than $3499.

Level of provider participation based on perception of the Medicaid program

From our survey responses, a majority of orthodontists currently not accepting OHP identified these perceived OHP-related concerns as major factors in their decision: Need for prior authorization, low reimbursement rate, difficulty assessing customer support, and frequent changes in Medicaid regulations. However, of those, low reimbursement rate was the only perceived concern that differed between the current OHP providers and non-OHP providers as previously discussed. In further exploring OHP-related concerns during our interviews, 100% of interviewees articulated that the current screening form could use improvement. Most current OHP providers expressed frustration with the HLD index, labeling it as "burdensome" and identifying areas of deficiency, such as failing to capture some conditions that most orthodontists would consider severe handicapping malocclusion necessitating orthodontic treatment, such as an ectopic canine resorbing neighboring roots. Similarly, non-OHP providers who had reviewed the HLD form had similar sentiments and thought it might be difficult for their staff to learn. Current OHP providers who are contracted with multiple CCOs also expressed confusion with the differing requirements required by each organization as part of the pre-authorization submission process, while private practice OHP-providers stated the process felt streamlined and similar to private insurances. Some orthodontists who expressed dissatisfaction with using the HLD index recommended simplifying the screening form by replacing it with the AAO automatic qualifiers identified by the AAO Committee on Medically Necessary Orthodontic Care as well as addition of a write in option for other unique conditions that warrant orthodontic treatment.[21]

Another OHP-related concern that was identified during the interviews by both OHP and non-OHP providers revolved around the concern of specialty referrals. As part of orthodontic treatment, many of these cases of severe handicapping malocclusions require surgical treatment,

including extractions, exposure of an impacted tooth, or orthognathic surgery. However, current OHP providers voiced their concerns regarding the difficulty of locating an in-network oral surgeon to provide these services and even those that do, there is often a long waitlist for appointments, which can cause significant delays in treatment. Non-OHP providers share similar concerns, especially those practicing in rural areas, stating their patients would have to travel far distances to seek care for specialty referrals with in-network providers.

The limited distribution of information and resources by OHA to the dental and orthodontic community prior to rollout of the OHP expansion could also be contributing to the low level of provider participation.. Less than a quarter of survey respondents reported receiving information directly from OHA regarding the expansion to cover handicapping malocclusion. From our interviews, this barrier was reinforced. One of the common frustrations expressed by orthodontists was the lack of communication from OHP and that little to no information was received from the government bodies responsible for the rollout. The majority of the orthodontists who were not currently accepting OHP reported that they wouldn't know who to contact even if they were interested in learning more about the OHP program.

Level of provider participation based on perception of Medicaid patients

From our survey responses, all of the perceived patient behavioral concerns were minor factors or not a factor for the majority of current OHP providers. The only patient behavior concern that differed significantly between OHP and non-OHP providers was last minute cancellation with 60% of non-OHP providers considering it to be a major factor in their decision to not accept OHP. As we explored these topics in the interviews, the findings were similar, with all current OHP providers reporting no patient behavioral concerns. The only patient-related concern from current OHP providers was the increased difficulty of treatment due to the nature of severe

handicapping malocclusion, though the concern mainly centered around the difficulty with coordinating specialty referrals with in-network oral surgeons as previously discussed and not the patients themselves. Contradictory to previous studies' findings where Medicaid patients had a 2-4 times higher rate of failed appointments, all of the current OHP providers perceived little to no difference between the behavior of OHP and non-OHP patients regarding attendance and compliance with treatment instructions based on their experience.[22,23] Furthermore, in our interviews, more than 80% of the providers currently accepting OHP expressed that one of their biggest motivators to accepting OHP are the positive experiences they have had with Medicaid patients, as well as their volunteer work with non-profit organizations to help treat children and adolescents from underserved communities. Many of them also reported that they are motivated to participate in OHP as they feel it is part of their professional responsibility to help serve the state population as healthcare providers.

During our interviews, non-OHP providers shared the same patient-related concern as current OHP providers for increased complexity for cases qualifying for severe handicapping malocclusion. Similar to the results found from the survey, there was also concern expressed by non-OHP providers during the interviews over the high frequency of cancelled appointments with OHP patients, with one provider stating his experience has been that parents and patients with no financial obligation to pay for treatment care less about keeping appointments. Multiple previous studies looking at why dentists' and orthodontists' participation are so low did identify frequent appointment failures to be a commonly cited factor among providers for declining Medicaid participation.[8,9,11,15,24] The only other patient behavioral concern that was reported during our interviews was from one non-OHP provider who stated his previous experience with Washington Medicaid patients was that they did have more emergency appointments with broken

brackets and poor oral hygiene, though current OHP providers did not report sharing the same experience with their OHP patients. Similar to current OHP providers, the majority of non-OHP providers reported positive experiences treating patients from underserved communities, either in residency or with nonprofit organizations such as ASK, and these experiences serve as positive motivators for them to consider accepting OHP. Those who had experience working with ASK complimented the nonprofit's organization's support team and recommended OHP either partner or implement similar case approval and patient follow-up processes to reduce the administrative burden on orthodontists and their staff.

Strengths and Limitations

A strength of this study is that it utilized a mixed methods approach that included a survey and semi-structured individual interviews with orthodontists, which allowed us to have a deeper understanding of the orthodontists' experiences and perspectives. The limitations of this study include that only 41 out of 131 active members of the Oregon State Society of Orthodontists responded to the survey and this could limit the generalizability of our quantitative findings. For our 10 interviews, the qualitative data reached saturation as no new themes emerged from the final interviews. The majority of our interview participants were male and from urban practice locations, hence opinions of female orthodontists or practitioners from rural practice locations might not be as well represented.

Conclusion

In this study, we explored the participation and perception of the OHP program among orthodontists in Oregon. Of our survey participants, only about a third of the orthodontists are currently accepting OHP patients and majority are in urban practice locations and corporate or academic settings. One of the first steps in addressing the problem of limited access to orthodontic care for OHP eligible beneficiaries is to explore the reasons behind the low rate of provider participation, especially in private practice settings and suburban and rural locations. Our interviews highlighted some similarities and differences in the perception of OHP-related factors, patient-related factors, and personal factors among orthodontists. This information might provide a starting point for areas to further explore and deficiencies to address on an administrative and public policy level by OHA to encourage provider participation. As of March 2024, the State of Oregon established The Handicapping Malocclusion Workgroup (HM Workgroup, unpublished data) which brought together representatives from the orthodontic community, administrative leaders from CCOs, and OHA staff in charge of implementation of OHP's orthodontic coverage expansion to identify possible areas of improvement including OHA processes, policy, guidance, and communication. Recommendations from the HM Workgroup, including improvements and clarifications to the current processes, were made in July 2024 to the Health Evidence Review Commission (HERC) and serve as a good first step towards improving quality and access to care for eligible OHP beneficiaries.

Future research areas might include:

(1) A review of current OHP approved cases to assess any barriers to treatment progress and completion including difficulty assessing specialty referrals due to long waitlists and limited in-network providers, which were identified in this study.

(2) Exploration of the patient's experience including factors that enable them to start treatment or barriers that they face in starting treatment and/or continuing treatment.

Comprehensive Literature Review

1. Orthodontic Indices and its use for Medicaid coverage

Orthodontic coverage became eligible for Medicaid starting in 1967 when The Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program was first established. The EPSDT program directed states to expand coverage to include orthodontic treatment for patients with medically necessary handicapping malocclusion. [2] However, the definition of malocclusion is highly subjective since it is not defined as a diseased state, but a deviation from normal anatomy.

In order to minimize this subjectivity, orthodontic indices were developed as a way to quantify malocclusion severity. A series of indices were developed, including Salzmann's Handicapping Malocclusion Assessment Record (HMAR)[25], Draker's Handicapping Labiolingual Deviation (HLD) index[26], Summer's Occlusal Index[27], Grainger's Treatment Priority Index[28], Dental Aesthetic Index (DAI)[29], the Index of Orthodontic Treatment Need (IOTN)[30], and the Index of Complexity, Outcome, and Need (ICON)[31], as tools to help dental providers and state Medicaid officials with categorizing and quantifying malocclusions. Furthermore, due to state public health programs having a limited budget, these indices were also used to determine the allocation of funding to treat the most severe malocclusions.

Originally, the Salzmann index was chosen by the American Association of Orthodontists (AAO) in 1969 as an objective criterion for determining malocclusion. [18] However, in 1985, the AAO rescinded its decision and opposed the use of any index of classification to measure and determine the need for orthodontic treatment. [32] Without one standardized index established, states were left to their own accord to select an index to define "handicapping malocclusion." As

a result, the criteria for coverage today differs from state to state depending on which malocclusion index they utilize. [33] This lack of standardization in determining qualifying cases has led to disparity and differences in Medicaid preauthorization and case coverage between various states.

2. Development of the Handicapping Labio-Lingual Deviation (HLD) Index California Modification

The HLD Index was originally developed by Dr. Harry Draker in 1958. Since the expansion of Medicaid coverage to include handicapping malocclusion, it's one of the most popular indexes utilized by states to quantify orthodontic malocclusion, including California. [26] In 1989 and 1994, California was sued twice in the court cases, Brown v. Kizer and Duran v. Belshe, for failing to comply with the orthodontic provisions of the Medicaid statutes and as an expert witness, Dr. William S. Parker assisted in modifying the HLD Index to refine medically necessary handicapping malocclusion for Medicaid coverage. [32] The modified index, HLD (CalMod), went into effect in 1991 and added the inclusion of the following factors as part of the assessment: overjet in excess of 9mm, deep impinging bite with soft tissue destruction of the palate, anterior crossbite with soft tissue destruction, unilateral posterior crossbite, and reverse overjet greater than 3.5mm. [32] Since its creation, HLD (CalMod) has been validated in multiple studies, though with its current cutoff point of 26 for severe handicapping malocclusion for OHP coverage, it may fail to identify a considerable percentage of handicapping malocclusions. [34-36]

3. History of Oregon Health Plan Coverage of Orthodontic Services

Despite the establishment of the EPSDT program in 1967 to expand orthodontic coverage to Medicaid beneficiaries under 21 with severe handicapping malocclusion, the OHA applied and

received permission from the US Department of Health and Human Service to limit EPSDT coverage and exclude orthodontic benefits even for severe handicapping malocclusions for Oregonians under the OHP. Instead, orthodontic coverage under OHP was limited to services for children diagnosed with cleft lip and palate [3]. It wasn't until January 1st, 2023 that OHP instated EPSDT benefits, including expanding orthodontic coverage to handicapping malocclusions for all Medicaid beneficiaries under the age of 21 [4]. The recent expansion of OHP coverage for handicapping malocclusions to all Medicaid beneficiaries under the age of 21 utilizes the California model of the HLD index, qualifying a handicapping malocclusion to include at least one of six automatic qualifying conditions or an HLD index of 26 or higher [4,37]. Under an initial model developed by OHA, the expected prevalence of Medicaid beneficiaries under 21 to qualify for orthodontic care is estimated to be around 0.8%-2.5%. [6] With around 465,000 children in Oregon on OHP, it is anticipated that around 3,720-11,625 kids might be approved annually statewide. With this increase in the number of publicly insured children eligible for orthodontic coverage under OHP, it is important to consider whether there will be enough orthodontists to treat this population since historically there has been low participation in Medicaid by orthodontic providers nationwide.

4. Utilization of Orthodontic Services by Medicaid Patients

Minority children and low-income children have a higher prevalence of malocclusion but are consistently found to have lower rates of utilization of orthodontic services compared to their more affluent, white counterparts with private health insurance despite the federally required coverage from the EPSDT Program [38,39]. With estimates of 17% of children having orthodontic needs, the reported rates of orthodontic utilization by Medicaid-eligible children are consistently lower with one study reporting less than 6% of Medicaid-covered children and adolescents

receiving care in 2004 compared to 17% of their privately insured counterparts [39,40]. Another study looking at utilization of orthodontic services under public and private dental benefits plans in 2018 reported that only 1.3% of children with Medicaid/Children Health Insurance Program received orthodontic treatment compared to 6.4% of children under a private dental benefit program [41]. The orthodontic utilization of Medicaid programs also differed greatly by state with less than 1% of beneficiaries under 21 year old receiving orthodontic treatment in Washington state in 1999, less than 0.5% receiving orthodontic treatment in North Carolina from 2002-2003, and 3.1% in Iowa from 2008 to 2010 [7,16,17].

5. Barriers Medicaid Patients Face when Seeking Access to Care

Common factors cited that influence the utilization of orthodontic services among Medicaid children include barriers to transportation, access to orthodontic providers, and low participation rate by orthodontists in the Medicaid program. [7,16,17,42]

Geography and barriers to transportation have been proposed to influence the utilization of orthodontic services among Medicaid children. One common assumption is that urban areas with more orthodontists would lead to increase accessibility to care, hence higher utilization rates. However, there have been conflicting results from various studies regarding whether geographic accessibility is an important factor. While one study in 1994 showed a greater demand in urban schools compared to rural schools for third and fourth graders with the urban area having a significantly greater number of orthodontists within a 5-mile radius of the school, two other studies showed conflicting results in Iowa and Oklahoma with children living in rural areas more likely to receive services than those living in metropolitan or micropolitan areas [17,42,43].

Another factor that presents as a barrier to Medicaid patients seeking orthodontic treatment is the low participation rate by orthodontists in the Medicaid program. In Washington in 1999, it was reported that approximately one-quarter of practicing orthodontists participated in Medicaid with the majority of participating orthodontists treating only a few cases a year. Ten orthodontists treated approximately 81% of Medicaid orthodontic cases statewide. In North Carolina in 2005, it was reported only 8% of the practicing orthodontists were significant Medicaid providers, which was defined as practitioners who filed for at least 10 new Medicaid recipients that quarter [7,16]. In 2010, 42 of the 85 licensed orthodontists (49.4%) in Iowa submitted a claim to Medicaid, but only 32 (37.6%) of those submitted claims to Medicaid for 10 or more individuals [17].

6. Deterrents for Medicaid Participation from Providers and Possible Solutions

Multiple studies have looked into why dentists' and orthodontic providers' participation in Medicaid is so low. The factors identified include low fees, denial of payment by Medicaid, high rate of broken or cancelled appointments by Medicaid patients compared to self-pay or private insurance patients, a need for prior authorization of treatment plans, excessive or complex paperwork, patient noncompliance, and slow payment. The two most common deterrents for Medicaid participation cited by providers by far are low reimbursement and broken appointments [8,9,11,15,24].

The low reimbursement rate is one of the most common reasons cited by dentists and orthodontists for not participating in the Medicaid program with many providers who perceived treating a child enrolled in Medicaid as an out-of-pocket loss for their practice [7,8,16]. From 2004 to 2015, the Medicaid reimbursement rate for comprehensive orthodontic care decreased from 65% to 41% compared to private insurance reimbursement [18]. A study done in North Carolina in 2005 found that the Medicaid reimbursement rate of $2521 was $1379 below the minimum and

$3659 below the maximum average full-treatment fee. As Medicaid covers only "severe handicapping malocclusion," many providers feel that the treatment of these patients would require more time and resources, hence increasing the variable costs compared to the average treatment. Previous attempts to increase the reimbursement fee to the 75th percentile of the usual and customary fees have significantly increased the participation rate of providers in other areas of dentistry, such as pediatric dentistry, and could be one possible solution for public health officials to explore to increase orthodontic provider participation in the Medicaid program. [19,20]. While increasing the reimbursement fee might encourage provider participation, given that states have a limited budget, this solution might not be a feasible or popular option with public health officials. On the other hand, even without an increase in reimbursement fee, treatment of Medicaid patients might not have the negative financial impact on a practice as many providers assume. A study using a break-even analysis to examine the simulated effect of profitability of treating patients covered under Medicaid in orthodontic practices in North Carolina found that even an inclusion of 5% of Medicaid patients into the practice's existing patient pool would have minimal effect in the practice's break-even point and assuming that the break-even is reached, there was an average per-patient profit of $1483 to $1897 even without an increase in reimbursement fees [16]. Even a small increase in the percentage of Medicaid patients treated per orthodontic provider could help address the challenge of improving access to care for the number of Medicaid-eligible children nationwide. Another possible proposed solution includes a more favorable income tax rate for providers who increase their treated Medicaid population [12].

The other most commonly cited factor providers state for declining Medicaid participation is the concern for more frequent appointment failures in Medicaid patients compared to non-Medicaid patients. The average broken appointment rate at a Medicaid clinic as reported by the American

Dental Association is 30% [44]. A study done looking at the tally of appointments at Virginia Commonwealth University Department of Orthodontics found that Medicaid patients did have a higher rate of failure of appointments (15.4% compared to 8.3% of non-Medicaid patients) [22]. Another study calculating attendance for orthodontic clinics in the Greater Boston area found that participants with Medicaid insurance were 4 times less likely to attend appointments compared to their non-Medicaid counterparts and furthermore, the odds of attending appointments decrease significantly every 6 months of increased treatment duration [23]. However, even though Medicaid patients do show a higher failure rate, another study based in Washington showed that for early phase 1 orthodontic treatment, Medicaid patients did not have worse outcomes measured by the peer assessment rating (PAR) compared to private-pay patients despite having significantly more appointments and poorer oral hygiene [45]. Even though treatment outcome might not be significantly affected by these factors, the high appointment failure rates have contributed to limited provider participation in Medicaid, which in turns limits access to care for Medicaid patients. As a result, it is important to identify the underlying reasons why Medicaid patients frequently miss their appointments in order to find permanent and effective solutions that will decrease appointment failures for Medicaid patients and encourage Medicaid participation by nonparticipating providers. Of the few studies done at the New Orleans Public Health Service Hospital and Massachusetts General Hospital, the most commonly cited reasons for failing appointments include communication (23-34%) , geographic separation (8-20%), forgetting (11-14%), illness (18-20%), and transportation problems (7%). [46,47] Possible solutions to promote better appointment keeping behavior might require innovative interventions at the personal, clinical, and state level. One proposed solution includes a minimal out-of pocket expense by Medicaid patients with the reasoning that without a financial investment for the

services rendered, patients are not as motivated to keep their appointments [48]. In addition to the out-of-pocket fee, there was also an emphasis in educating patients as to why keeping their appointments is important for their treatment, as well as providing other resources such as transportation reimbursement and more appointment reminders.

In addition to broken appointments, Medicaid patients are also significantly more likely to be dismissed from treatment (19% compared to 4% for their non-Medicaid counterparts), mostly due to noncompliance [49]. Approximately one in five Medicaid patients do not complete their orthodontic treatment as originally prescribed, either because the appliance was removed early or the patient never returned to complete his or her treatment. While they have the same average number of appointments, the treatment duration for Medicaid patients is significantly longer at 29 months compared to 25 months for self-pay patients. Many orthodontic providers share these concerns with accepting Medicaid patients, hence future proposed solutions should target and address factors of noncompliance and increased treatment time, either with patient education or increased compensation for the orthodontic providers' time and resources.

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Appendix A

IRB MEMO

Research Integrity Office
3181 SW Sam Jackson Park Road - L106RI
Portland, OR 97239-3098
(503)494-7887 irb@ohsu.edu

APPROVAL OF SUBMISSION

June 5, 2023

Dear Investigator:

On 6/5/2023, the IRB reviewed the following submission:

IRB ID:	STUDY00025819
Type of Review:	Initial Study
Title of Study:	A mixed methods analysis of Oregon orthodontists' participation in and perception of the Oregon Health Plan Medicaid program
Principal Investigator:	Lyndie Foster Page
Funding:	None
IND, IDE, or HDE:	None
Documents Reviewed:	• Interview Guide • Code Book • Consent Form - Information Sheet • Introduction Email • Protocol Template- Minimal Risk Study-Choy • Survey

The IRB granted final approval on 6/5/2023. The study requires you to submit a check-in before 6/3/2026.

Review Category: Exempt Category #2(iii)

Copies of all approved documents are available in the study's **Final** Documents (far right column under the documents tab) list in the eIRB. Any additional documents that require an IRB signature (e.g. IIAs and IAAs) will be posted when signed. If this applies to your study, you will receive a notification when these additional signed documents are available.

Ongoing IRB submission requirements:

- Six to ten weeks before the eIRB system expiration date, submit a check-in..
- Any changes to the project must be submitted for IRB approval prior to implementation.
- Reportable New Information must be submitted per OHSU policy.
- Submit a check-in to close the study when your research is completed.

Guidelines for Study Conduct

In conducting this study, you are required to follow the guidelines in the document entitled, "Roles and Responsibilities in the Conduct of Research and Administration of Sponsored Projects," as well as all other applicable OHSU IRB Policies and Procedures.

Requirements under HIPAA

If your study involves the collection, use, or disclosure of Protected Health Information (PHI), you must comply with all applicable requirements under HIPAA. See the HIPAA and Research website and the Information Privacy and Security website for more information.

IRB Compliance

The OHSU IRB (FWA00000161; IRB00000471) complies with 45 CFR Part 46, 21 CFR Parts 50 and 56, and other federal and Oregon laws and regulations, as applicable, as well as ICH-GCP codes 3.1-3.4, which outline Responsibilities, Composition, Functions, and Operations, Procedures, and Records of the IRB.

Sincerely,

The OHSU IRB Office

Appendix B

Welcome to my survey!

Thank you so much for being a part of my research and helping our profession continue to improve access to care for patients!

As you might know, effective Jan 1, 2023, the Oregon Health Plan (OHP) has expanded orthodontic coverage to include handicapping malocclusions with a Handicapping Labio-Lingual Deviations (HLD) index of 26 or higher for beneficiaries under 21 years old. Whereas prior only children with cleft lip and palate or severe craniofacial anomalies qualified for coverage, now a greater population of OHP members have access to orthodontic care. For more information, please refer to this article (https://cascadebusnews.com/new-oregon-medicaid-orthodontic-benefit-effective-january-1-2023/).

This survey is designed to assess Oregon orthodontists' perceptions and attitudes toward the Medicaid program and its beneficiaries. We hope this will provide insight into what policy changes might need to be addressed to improve the utilization of the program and increase access to orthodontic care for those who meet the Medicaid criteria.

This survey will take about 5-15 minutes. Please note that all responses are completely anonymous. If you are interested, please read the attached Consent and Information Sheet prior to completing the survey. Completion of the survey will indicate your consent to participate in the survey.

At the end of the survey, there will be an optional space to leave your email if you are interested in participating in a virtual interview on Zoom to further share your insights and perspective about the OHP and its recent expansion. A $50 debit card will be provided to you for your time.

If you have any concerns or questions, please feel free to contact me at choyc@ohsu.edu.

Thank you again for your time and contribution to this research!

Best regards,

Dr. Cherry Choy

OHSU Orthodontic Resident 2024

eIRB Number: STUDY00025819

Appendix C

Information Sheet

IRB#0025819

TITLE: A mixed methods analysis of Oregon orthodontists' participation in and perception of the Oregon Health Plan Medicaid program

PRINCIPAL INVESTIGATOR: Lyndie A Foster Page [971-284-3295, fosterpa@ohsu.edu]

CO-INVESTIGATORS: Cherry Choy [(206)694-3727, choyc@ohsu.edu]

WHY IS THIS STUDY BEING DONE?:

You have been invited to be in this research study because you are an orthodontic provider in the state of Oregon. The purpose of this study is to learn about Oregon orthodontists' perception of and attitudes towards the Medicaid program and its beneficiaries.

Data collected from/about you in this study will not be used and/or shared for future research.

WHAT PROCEDURES ARE INVOLVED IN THIS STUDY?:

We will ask you to complete a short survey with questions involving practitioner and practice demographics as well as experience with and opinion on the Oregon Health Plan and its beneficiaries. After completing the survey, we will ask if you are interested in providing more information by volunteering to participate in a 20-60 minute interview to discuss and elaborate on your experiences and opinions. If you choose to participate in the interview, you will receive a $50 debit card and we may collect your name and address to send you the debit card.

This survey will take approximately 5-15 minutes to complete. All responses will be completely unidentifiable. The survey will not have any identifiers linking your responses back to you or any other participants. However, volunteers for the interview can provide their email at the end of the survey for scheduling purposes. All interviews will be recorded and anonymized. The interviews will not have any identifiers linking your responses back to you or any other participants.

If you have questions, concerns, or complaints regarding this study now or in the future, or you think you may have been injured or harmed by the study, contact Dr. C. Choy at (206)694-3727.

WHAT RISKS CAN I EXPECT FROM TAKING PART IN THIS STUDY?:

Although we have made every effort to protect your identity, there is a minimal risk of loss of confidentiality. If you choose to participate in the interviews, there is minimal risk that personal identifiers can be revealed such as name, email addresses, and/or physical address. Participants also risk a minimal time burden in completing the survey as well as the semi-structured interview for those who wish to participate.

WHAT ARE THE BENEFITS OF TAKING PART IN THIS STUDY?:

You will likely not benefit from being in this study. However, by serving as a subject, you may help us learn how to benefit patients in the future.

WHAT ARE THE ALTERNATIVES TO TAKING PART IN THIS STUDY?:

You may choose not to be in this study.

WILL I RECEIVE RESULTS FROM THIS STUDY?

The results of research tests will not be made available to you because the research is still in an early phase and the reliability of the results is unknown. However, the results of the research may be published in the future.

WHO WILL SEE MY PERSONAL INFORMATION?:

In this study we are not receiving any identifiable information about you so there is little chance of breach of confidentiality. However, if you choose to participate in the interviews and provide your email, name and address, we will take steps to keep your personal information confidential, but we cannot guarantee total privacy. However, we will do our best to keep your information confidential by keeping it coded and on an encrypted computer. Furthermore, only members of the study team will have access to your personal information to schedule the interviews and mail the $50 debit card. Personal information will be destroyed upon completion of the semi-structured interviews and distribution of the vouchers.

WILL ANY OF MY INFORMATION OR SAMPLES FROM THIS STUDY BE USED FOR ANY COMMERCIAL PROFIT?

Information about you or obtained from you in this research may be used for commercial purposes, such as making a discovery that could, in the future, be patented or licensed to a company, which could result in a possible financial benefit to that company, OHSU, and its researchers. There are no plans to pay you if this happens. You will not have any property rights or ownership or financial interest in or arising from

products or data that may result from your participation in this study. Further, you will have no responsibility or liability for any use that may be made of your samples or information.

WHAT ARE THE COSTS OF TAKING PART IN THIS STUDY?:

It will not cost you anything to participate in this study. However, volunteers who complete the semi-structured interviews will be offered a $50 debit card. After the interview, volunteers can provide their name and physical address for mailing the debit card.

WHERE CAN I GET MORE INFORMATION?:

This research is being overseen by an Institutional Review Board ("IRB"). You may talk to the IRB at (503) 494-7887 or irb@ohsu.edu if:

- Your questions, concerns, or complaints are not being answered by the research team.
- You want to talk to someone besides the research team.
- You have questions about your rights as a research subject.
- You want to get more information or provide input about this research.

You may also submit a report to the OHSU Integrity Hotline online at https://secure.ethicspoint.com/domain/media/en/gui/18915/index.html or by calling toll-free (877) 733-8313 (anonymous and available 24 hours a day, 7 days a week).

DO I HAVE TO TAKE PART IN THIS STUDY?

You do not have to join this or any research study. If you do join, and later change your mind, you may quit at any time. If you refuse to join or withdraw early from the study, there will be no penalty or loss of any benefits to which you are otherwise entitled.

The participation of OHSU students or employees in OHSU research is completely voluntary and you are free to choose not to serve as a research subject in this protocol for any reason. If you do elect to participate in this study, you may withdraw from the study at any time without affecting your relationship with OHSU, the investigator, the investigator's department, or your grade in any course. If you would like to report a concern with regard to participation of OHSU students or employees in OHSU research, please call the OHSU Integrity Hotline at 1-877-733-8313 (toll free and anonymous).

HOW DO I TELL YOU IF I WANT TO TAKE PART IN THIS STUDY?

By completing and submitting the survey, you are consenting to participate in this study. If survey is not received by the close date, it will be assumed that you chose not to participate in the study. By providing your email to schedule, your interest in participation is assumed. If you do not provide your email in the survey, it will be assumed that you chose not to participate in the semi-structured interview.

Appendix D

Select the gender with which you mostly closely identify.

- ○ Male
- ○ Female
- ○ Non-binary / third gender
- ○ Prefer not to say

Select your age group.

- ○ Under 25 years
- ○ 25 - 34 years
- ○ 35 - 44 years
- ○ 45 - 54 years
- ○ 55 - 64 years
- ○ 65 years or over

Select the race with which you most closely identify. Select all that apply.

- [ ] White
- [ ] Black or African American
- [ ] American Indian or Alaska Native
- [ ] Asian
- [ ] Native Hawaiian or Pacific Islander
- [ ] Other

Select your ethnicity.

- ○ Hispanic, Latino, or Spanish origin
- ○ Not Hispanic, Latino, or Spanish origin

→

The following best describes your main practice:

- ○ Solo Private Practice
- ○ Partner or Group Practice
- ○ Corporate Practice
- ○ Hospital
- ○ University
- ○ Other

Enter the zip code of your main practice.

The following best describes the location of your main practice:

- ○ Urban
- ○ Suburban
- ○ Rural

The following best describes the years you have been practicing orthodontics:

- ○ 0-5 years
- ○ 6-10 years
- ○ 11-15 years
- ○ 15+ years

← →

How did you learn of Oregon Health Plan's recent expansion of orthodontic coverage to include handicapping malocclusion?

- ○ Received information directly from Oregon Health Plan
- ○ Received information from other sources (peers, OSSO, conferences, newsletter). Please list source below:

[ ]

- ○ Have not received any information

For patients with Oregon Health Plan's coverage, your participation is best described as:

- ○ Currently accept
- ○ Formerly accepted
- ○ Never accepted

← →

Are you planning on accepting patients with Oregon Health Plan's coverage who meet the new handicapping malocclusion criteria?

- ○ Yes
- ○ No
- ○ Unsure

←

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What is the maximum number of patients with Oregon Health Plan's coverage that you will treat annually?

- ○ 1-10
- ○ 11-20
- ○ 21-30
- ○ 31-40
- ○ 41-50
- ○ 51-60
- ○ 61-70
- ○ 71-80
- ○ 81-90
- ○ 91-100
- ○ More than 100 (Please enter estimated number below)

Do you currently treat patients from underserved communities with or without support from nonprofit organizations (A Smile for Kids, Smile Changes Lives, AAOF Donated Orthodontic Services)?

- ○ Yes
- ○ No

Did your orthodontic residency treat Medicaid patients?

- ○ Yes
- ○ No
- ○ Unsure

← →

Do the following factors affect your decision to accept or not accept patients with Oregon Health Plan's coverage?

	Not a factor	A minor factor	A major factor
Unclear Medicaid provider enrollment process	○	○	○
Need for prior authorization	○	○	○
Low fee reimbursement	○	○	○
Delays or denials in receiving payment	○	○	○
Potential loss of coverage during treament	○	○	○
Difficulty accessing customer support	○	○	○
Frequent changes in Medicaid regulations	○	○	○

Please list any other factors regarding the Medicaid program that affect your decision to accept or not accept patients with Oregon Health Plan' coverage.

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Do the following possible common beliefs about Medicaid beneficiaries affect your decision to accept or not accept patient's with Oregon Health Plan's coverage?

	Not a factor	A minor factor	A major factor
Failure to show up for appointments	○	○	○
Tardiness to appointments	○	○	○
Last minute cancellations	○	○	○
Uncooperative behavior	○	○	○
Poor oral hygiene & more active disease	○	○	○
More emergency appointments (ie. appliance breakage)	○	○	○
Increased treatment complexity for handicapping malocclusion	○	○	○
Longer treatment time for handicapping malocclusion	○	○	○
Difficulty with coordination with other dental specialist (ie. orthognathic surgery)	○	○	○

Please list any other factors regarding Medicaid beneficaries that affect your decision to accept or not accept patients with Oregon Health Plan's coverage.

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What would you consider a fair Medicaid reimbursement rate for Phase 1 orthodontic treatment?

- ○ Less than $2000
- ○ $2000-2499
- ○ $2500-2999
- ○ $3000-3499
- ○ $3500-3999
- ○ $4000-4499
- ○ $4500-4999
- ○ $5000-5499
- ○ $5500-5999
- ○ $6000 or more

What would you consider a fair Medicaid reimbursement rate for Phase 2 orthodontic treatment?

- ○ Less than $2000
- ○ $2000-2499
- ○ $2500-2999
- ○ $3000-3499
- ○ $3500-3999
- ○ $4000-4499
- ○ $4500-4999
- ○ $5000-5499
- ○ $5500-5999
- ○ More than $6000

Would the following factors encourage you to accept/accept more patients with Oregon Health Plan' coverage?

	Not a factor	A minor factor	A major factor
Reimbursement schedule of one time payment at start of treatment instead of quarterly payments	○	○	○
Extension of reimbursement past 24 months for complex cases	○	○	○
Standardized qualifiers to reduce ambiguity for patient approval	○	○	○
Streamlined submission process for case approval	○	○	○
Easily accessible Oregon Health Plan Customer Support for training and assistance	○	○	○

Please list any other factors that would encourage you to accept/accept more patients with Oregon Health Plan's coverage.

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Please use this space to provide any additional information that you feel is relevant to the topic of Oregon Health Plan in Oregon orthodontic practices. This will be especially valuable for highlighting any factors not accounted for in the survey.

Thank you so much for your time. If you are willing to share more of your perspective with us in a 20-60 minute semi-structured interview via Zoom, please use this space to provide your email and we will contact you to schedule a date and time at your convenience.

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Appendix E

Semi- Structured Interview Guide

REVIEW ANY LOGISTICAL INFORMATION

Hi, my name is _____ and I'm going to be speaking with you today about OHP's recent expansion in covering handicapping malocclusion for children and adolescents under 21 of age.

Introduction: The goal of this study is to learn what providers think about OHP's program and policies and what encourages or discourages provider's acceptance of OHP patients for treatment.

We also want to learn your views on how OHP can better support its patients and in network providers to increase accessibility to care and quality of care by working with Oregon orthodontists and their staff.

Before we begin, there are a few things that I want to tell you about. Please feel free to ask any questions.

1. This interview will take about 20-60 minutes. If you feel uncomfortable in any way with any of my questions, I will fully respect your decision to stop the interview at any time. As a way of thanking you for your time, we will provide you with a $50 ClinCard.
2. Our interview will be recorded and kept private. I record all interviews for this study to help me make sure I have complete and correct information. When the interview is transcribed into a written form, your names will not be part of the written form. The recordings will not be used for any other purpose other than this study and will be destroyed at end of the study. I will send you a copy of your transcript once transcribed so you can check it for accuracy.
3. As much as possible, please try to avoid speaking with other people during our discussion, since that can interfere with the taping of the interview. Please also understand that everything we discuss in this meeting should not be shared with individuals outside this group, so as to maintain confidentiality.
4. Please feel free to share your feelings and opinions with me. There are no wrong or right answers. I am very interested in hearing your point of view.
5. Are there any questions before we begin? We have a lot to discuss, so let's get started. I will start recording our interview now.

TURN ON RECORDER

I. Knowledge/experience and misconceptions about the OHP program/patients

Icebreaker: Great. First of all, I will ask some general questions about the OHP program

1. ***We will begin by talking about your knowledge and experience regarding the OHP program and patients.***

PROBE: Could you describe your experiences with the OHP program?

PROBE: How are you currently accepting or have previously accepted patients with OHP? If so, how was your experience with treating OHP patients?

PROBE: Have you heard about the new expansion to include coverage for handicapping malocclusions, in addition to the previously covered cleft lip/palate? If so, where did you hear this information from? Why and in what way do you feel that it is a positive or negative change? How did you feel about this change and did you feel that you have enough information/support to successfully navigate these changes?

II. Barriers/facilitators with Medicaid program and patients

2. **Next, I would like to learn about any factors that may influence your decision to accept or not accept Medicaid/OHP patients**

PROBE: From the survey it seems like you had some concerns regarding (reference survey responses regarding barriers with Medicaid program), can you tell me more about that?

PROBE: From the survey it seems like you also had some concerns regarding (reference survey responses regarding barriers with Medicaid patients). How does your experience with the OHP patient pool have an influence on your decision whether to accept OHP or not? How so?

PROBE: Tell me how or if other providers or professional organizations influence your decision to accept OHP or not? and if so how?

PROBE: How would you say the area you practice in influence your decision to accept OHP or not? How so?

PROBE: Tell me if your staff have previous experience or training on OHP? Can you discuss if your staff feel comfortable with the OHP's patient approval and reimbursement process? If you or your staff have questions or run into issues with OHP, where would you or your staff go to find the information/answers? Are there any current OHP policies that make it easier or harder for you and your staff to accept OHP patients? If so, which ones?

PROBE: In what way would you say you or your staff have any positive or negative encounters with OHP patients in the past? In what way do these interactions influence your decision whether or not to accept OHP in your practice?

III. Current strategies employed in practice and possible future recommendations for treating OHP patients

For this last section, we would like to hear your suggestions and recommendations for providers in treating OHP patients and expanding acceptance of OHP

PROBE: If you currently accept OHP, are there any strategies you employ or recommendations you could share with a fellow provider who is also interested in starting to accept OHP in his/her clinic to make their transition smoother?

PROBE: Who in your clinic is trained to handle the administrative aspect of OHP? How were they trained? Would any additional training or customer support from OHP be helpful?

PROBE: Is there anything you would like OHP to change or include in their program that you think would encourage acceptance among providers and increase access to care for OHP patients?

Do you have any other last thoughts about anything we talked about (or anything else you would like to add) before we finish?

Thank you for your time and participation.

ASK FOR/CONFRIM ADDRESS TO MAIL GIFT CARDS and transcript.

Appendix F

Codebook
Version 4

S.1 Knowledge/experience about the OHP program/patients (Code all knowledge/experience participants express regarding the OHP program and patients)

S.1.a Knowledge/experience regarding OHP program
S.1.b Knowledge/experience regarding OHP patients

S.2 Misconceptions about the OHP program/patients (Code all knowledge participants express regarding the OHP program and patients)

S.2.a..Misconceptions regarding OHP program
S.2.b Misconceptions regarding OHP patients

S.3 Barriers (Code all references to possible factors discouraging providers from accepting patients with OHP coverage)

S.3.a Barriers with Medicaid program

S.3.a.i Unclear OHP provider enrollment process (specifically provider Medicaid enrollment)
S.3.a.ii Need for prior authorization/Issues with HLD (includes admin process for case approval)
S.3.a.iii Low fee reimbursement
S.3.a.iv Difficulty accessing customer support
S.3.a.v Delays or denials in receiving payment
S.3.a.vi Difficulty coordinating with other specialties
S.3.a.vii Increase time/burden for admin staff/resources
S.3.a.viii Other barriers with OHP program

S.3.b Barriers with Medicaid patients

S.3.b.i Last minute cancellation/Failed appointments
S.3.b.ii Tardiness to appointments
S.3.b.iii More emergency appointments (ie. Appliance breakage)
S.3.b.iv Uncooperative behavior
S.3.b.v Poor oral hygiene & more active disease
S.3.b.vi Increased treatment complexity/time for handicapping malocclusion
S.3.b.vii Other barriers with patients

S.3.c Barriers not associated with OHP program or patients
S.3.c.i Lack of knowledge/information in orthodontic community
S.3.c.ii Provider fear of overcommitting
S.3.c.iii Financial viability for practice
S.3.c.iv Ethical behavior concern
S.3.c.v Fear of loss of control/autonomy/personal choice

S.4 Facilitators (Code all references to possible factors encouraging or motivating providers to accept patients with OHP coverage)

S.4.a Facilitators associated with OHP program

S.4.a.i Reimbursement rate (including screening)
S.4.a.ii One-time payment reimbursement schedule
S.4.a.iii Standardized qualifiers to reduce ambiguity for patient approval
S.4.a.iv Streamlined submission process for case approval
S.4.a.v Easily accessible OHP/CCO Customer Support for training and assistance
S.4.a.vi Other facilitators associated with OHP program (including ASK+OHP workgroup)

S.4.b Facilitators associated with factors outside of OHP program

S.4.b.i Professional responsibility/autonomy/values
S.4.b.ii Personal Choice/Making your own decisions
S.4.b.iii Community Service/Personal enjoyment
S.4.b.iv Working for DSO/hospital
S.4.b.v Increased population of eligible patients with OHP coverage
S.4.b.vi Working with ASK
S.4.b.vii Patient factors (patient appreciation, motivation, family support, attendance/compliance)
S.4.b.viii Other facilitators outside of OHP program

S.5 Current strategies employed in practice that help in treating OHP patients (Code all references to any current strategies provider or their staff utilizes in their practice for applying for OHP approval/reimbursement and treating OHP patients)

S.6 Recommendations

S.6.a Recommendations to OHA to improve practitioner participation (Include what has been successful in other states)
S.6.b Recommendations for orthodontists interested in participation in OHP

Appendix G

Table 15. Representative Quotes Regarding Barriers to OHP Participation

Representative Quote Regarding Barriers to OHP Participation
Administrative Concerns with OHP
1. Preauthorization inconsistencies with different CCOs:
Currently accept (57%): "There has been some slight variations and requirements from each CCO, whether it's ODS, Capital, Cascade Health Alliance, Advantage…exactly what they require to submit prior to authorization. So I think for offices that are dealing with multiple insurance companies all managing OHP, that can be confusing, particularly at the beginning to dial it all out."
Formerly accept/Never accept: None
2. Issues with HLD Index
Currently accept (100%): "The HLD Index works okay, but I think there's a better way. The automatic qualifiers I feel like it is a better scale or criteria to judge who deserves this benefit and who doesn't so. The point system is bias towards, for instance, crowding, but it leaves out patients who have bilateral posterior crossbites. It definitely leaves room for improvement."
Formerly accept/Never accept (66%): "I found out that the paperwork was extremely complicated. I took the paperwork that I had, I guess they modeled after the California model..I printed off that. I ran it through on a couple of patients, just to see what it was all about and it was so time consuming to figure out all the numbers and get everything just right. And then you found out that, you know, you've got something that's 1 point off and yet you look at it and go, ok, everything on this kid, for example, they have to already have gingival recession. Well, you know, this kid's only maybe 11 years old, and they may not have gingival recession, but if they're biting in an under bite, they're going to have gingival recession by the time they're 18 and then it's too late or 21, whenever you can't do it anymore. So any of those kinds of things just sort of really annoying that you can't, you know, see a debilitating malocclusion and with the knowledge that you have having done this for many years, you know, this is not just an aesthetic tune up for this kid to be able to smile better. And so that's frustrating."
3. Reimbursement Rate
Currently accept (57%): "That's not a fair compensation for some of the cases. But here [in a hospital setting], you know, it doesn't make a difference to me cause I'm not compensated based on that."
Do not accept (66%): "You know, because not only are they asking the providers to take a less money for a case, but they're also saying spend more of your resources trying to navigate our difficult situation."
4. Difficulty coordinating with dental specialist
Currently accept (71%): "It took a while for me to figure out whether extractions or expose and bonds associated with orthodontics would be covered by OHP. Same for surgical cases. It seems like it should all be covered, but I'm still uncertain about the necessary steps to go through and who will be accepting those cases on the surgeons end."
Do not accept (66%): "I think that's a really big deal because again, these are the difficult cases that often require you communicating really well with the dentist. There might be an impacted canine. Where are they going to go for that? Is that going to be readily available? Are they going to have to go from [rural Oregon] to Portland to have a canine exposure with a doctor I've never worked with and then the doctor puts on the gold chain and the first time I touch on, it falls off and then I get blamed for that obviously. So, those kinds of things are really hard to imagine how that's going to work."
Concerns with OHP Patient's Behavior and Treatment
* Only patient concern bought up by providers who currently accept OHP is increased treatment complexity
1. Increase treatment complexity
Currently accept (14%- 1 provider): "In general, the average difficulty for cases that I'm seeing is a little higher than before we've accepted OHP. It takes longer to treat those cases as well because a lot of them need extractions or have impacted canines that take longer to treat and the coordination with specialists is a little tricky because for I have to submit a separate referral that will be processed through OHP, instead of just a generic referral letter. It takes longer for the OHP referral to be sent to the dentist or specialist who is doing the procedure. As far as I know, it doesn't always go to the one oral surgeon you commonly work with. It could go to anybody else who takes OHP in the area."

Do not accept (66%): If I choose to take care of a severe cleft palate kid , I know that I'm not going to make money on this. And this is not going to be a one and a half year treatment case. I'm just going to do my best to do it, but if I had an entire practice of that, I probably couldn't keep the practice open...Some of the new doctors coming out might love to have a patient load that comes in like this, but it could be overwhelming to them if you're not careful having these really severe malocclusions that are really hard. And you're going to spend a lot more time with these kids than you would with other patients.

2. Last minute cancellations and failed appointments

Currently accept (0%): None

Do not accept (66%): “I find that probably 90% of the time, the missed appointment is not the kid's fault. It's the parent’s fault. So I think if you just set some parameters at the beginning with these patients, and again, if they know that they're getting a freebie, sometimes they don't care.”

3. Other patient related concerns: * Only expressed by 1 provider

Currently accept (0%): None

Do not accept (33%- 1 provider): “It’s not across the board on everybody, but yes, on average, those factors were way higher in the OHP population…missed appointments, broken brackets, poor oral hygiene.”

Other Barriers Non-related to OHP Administrative Concerns and Patient Behavioral or Treatment Concerns

1. Lack of information regarding orthodontic coverage in the orthodontic community

Currently accept (57%): “No, I heard nothing. I got nothing from OHP or OHA or any of the bodies that were responsible for this rollout. So I don't really know how other orthodontists may have gotten this information cause I’m sure that my information came through ASK.”

Do not accept (66%): “I never tried, but you shouldn't be my OHP resource, but I would ask you [interviewer]. Who else would I ask? How do they communicate with us? How do we communicate with them? There's no lines of communication.”

2. Provider fear of overcommitting

Currently accept (0%):

Do not accept (66%): “If I have to become the so called OHP orthodontist in my area, I don't know if I want that headache because now I'm going to be getting phone calls from everybody, and I can't take everybody. So I would love to see the orthodontists in Oregon come together and realize that, hey, if we all just share the load and we all look at this as a way to be helpful, instead of just a way to make money, then we would be able to take care of these kids, but that's not going to happen. So, because, you know, our economy is not doing great and fees are having to go up and overhead going up. So it's going to be a challenge. It really is. But, you know what, what you don't want to see happen is that model where just one orthodontist or one DSO or one company takes all this on and then these kids still get put in line and they never get to care.”

4. Loss of control, autonomy, and personal choice

Currently accept (0%):

Do not accept (66%): “If you made it simple, and you told me that I could take this little boy with a severe malocclusion, get him approved without spending hours and hours and I could get reimbursed $3000 dollars, I would treat him. If I got reimbursed nothing for a case that severe, I'll still treat him. But again, you can only have so many of those and really run a practice. I feel like I am the one who gets to choose if I do it for nothing and I feel great about it. When I don't get to choose, I don't feel so good about it.”

Table 16. Representative Quotes Regarding Facilitators Encouraging OHP Participation

Representative Quote Regarding Facilitators Encouraging OHP Participation
OHP Specific Facilitators encouraging OHP Participation
1. Reimbursement Rate for comprehensive treatment/One-time payment schedule
Currently accept/Private Practice (100% private practice): “It's enough for me to run my office and feel I'm being compensated. I don't have a collection problem. So I'm not worried about somebody paying their bill, and I think the fact that they pay upfront is great and really aids in cash flow. And, again, I think it can become problematic when we begin to have more transfer cases but I think it's reasonable compensation coming from a public health program.”

Currently accept/DSO (100% DSO): “I don't really have an opinion on the reimbursement rate. One thing at [DSO] is that doesn't affect us and our compensation. So I can say that is fair, but then I don't know if that would be accurately reflecting the rest of the community.”

Formerly accept/Never accept (33%): “It's on the low side, but it's better than nothing. Obviously…it is nice that you get it up front…I think it's doable. It's something that I would consider doing if I had more time.”

2. Reimbursement for exam

Currently accept (28%): “We are getting paid $300 for the exam and most of us do this for free for all of their patients. So even if the patients are not covered, we getting $300. I can't imagine that staff is making 300 bucks a day, you know what I'm saying? It's like, so you do one OHP exam and you are paying for the assistant.”

Formerly accept/Never accept (33%): “In private practice setting, then you'd have to open an exam slot for something that may or may not qualify and spend time getting enough records that you cam then fill this out. So, a suggestion would be that they need to compensate the orthodontists and private practice for the exam.”

3. Streamlined submission process for case approval

Currently accept/Private Practice (100% private practice): “At the OHP Workforce meeting, I found it fascinating where people were talking about this administrative burden to submit cases. It’s like taking all the records. They're not doing that much more. They're doing an HLD index which they're doing wrong. I mean most orthodontists take pictures, they take an xray, and they do an exam. The only thing they have to do extra is somehow scan and send that to the DSO, which is nothing more than what they do for any other insurance company, so I don't understand the administrative burden, and the only other thing maybe again is the HLD, which you can do in a minute and a half at most.”

Currently accept/DSO (50% DSO- general dentists does the screenings): “Yeah, so I've seen some of the general dentists, they sit down, they have the models in their hands and they score the HLD. There's people in the company who are working closely with OHP, they're the ones who do the preauthorization approval or denial. I don't think they've had any problems with all that.”

Formerly accept/Never accept (33%): “I think it appears that Oregon is a little bit more streamlined. So I think it is a lot easier. However, there is a learning curve that we would have to go through right? For any new type of process we'd have to get systems in place. I think Oregon is much better just from talking to the CCO representative and learning about it.”

Provider Specific Facilitators encouraging OHP Participation

1. Professional Responsibility

Currently accept (71%): “I think it really does come down to a bit of a professional duty, a professional obligation. You know, orthodontists, generally speaking, are fairly well compensated for the work they do, so if they take a hit on some of these patients in order to serve the state, I think that's okay. Or I would encourage them to do those best they could. I understand if people choose not to do that. But I do think that's kind of the best motivation there is. This idea of sort of the duty to the patient population of our state. Having said that again, I would go back to I think it's imperative that OHA makes it as easy as possible.”

Do not accept (33%): “I would love to see the orthodontists in Oregon come together and realize that, hey, if we all just share the load and we all look at this as a way to be helpful, instead of just a way to make money, then we would be able to take care of these kids, but that's not going to happen. So, because, you know, our economy is not doing great and fees are having to go up and overhead going up. So it's going to be a challenge.”

2. Sense of Personal Fulfillment in Service of the Community

Currently accept (57%): “I never really had a plan to go into that [treating Medicaid patients]. But I feel like that was just a rewarding part of my career so far. I really enjoyed it. I think I just like it. You know, I'm not 1 of those who want to shun it or to try to avoid it as much as possible. I don't know how many out there are like me. But, yeah, I think I've always liked it.”

Do not accept (66%): “I love what I do and I just want to help all these kids that are needy who are really in a tough spot. I just know there's a lot of orthodontist out there that feel just like me, but they're also so overwhelmed with just running their practice that it makes it really hard to incorporate this into a busy practice when you're already busy enough.”

3. Personal choice

Currently accept (57%): “You could also limit the number of OHP patient in any given month and allow it to trickle in until you got comfortable and until you can really see what your experience is with that. I don't think anyone's practice is going to be overrun or they're going to be forced to take too many OHP patients that is not gonna work in their office.”

Do not accept (66%): “I just know there's a lot of orthodontists out there that feel just like me and want to help, but they're also so overwhelmed with just running their practice that it makes it really hard to incorporate this into a busy practice when you're already

busy enough. And that fear of 'I don't want to be the only OHP orthodontist this city.' Well, I'm not afraid of that as long as I'm in control of it."

4. Employment with DSO

Currently accept (100% of DSO Providers): "Yeah, through [the DSO], once they got a plan going, then they rolled out a policy for our whole ortho program that all the orthodontists at [the DSO] were aware of the policy, and we followed along a plan, a treatment protocol for our OHP patients."

5. Experience with ASK

Currently accept (57%): "I mean, all orthodontists use ASK…I shouldn't say all, but a lot of us who have done this for a while. It's been very good to us. It's a great profession. We feel really good about helping people and making them feel better about themselves. And so, you know, we all want to give back and so I've done the ASK program for years and years. We started doing that 15- 20 years ago and then now, this program came along, so we want to try to help some of these kids if we can."

Do not accept (33%): "I think it would be amazing if I can treat OHP patients the same way I treat ASK patients. I look at [an ASK representative] as almost like one of my employees, but I don't have to pay her payroll taxes. She just takes the bull by the horns and does it and then I have a staff member that obviously communicates with her and I often do too, but they take that load off of my staff. I mean, you haven't probably been in private practice yet, but you've somebody who has to get on the phone. And now a lot of it is done on the websites and stuff, but it used to be that you'd have to get on the phone and wait for the insurance company. And you'd have to pay a staff member to sit there and do that. I mean, if I had to do that for OHP cases, I couldn't have the staff person to do it. If you treated one case, that would be one thing, but if you're going to do this, you're going to probably do 3 or 4 cases and now, you're just eating up a lot of administrative time. So, yes, having [an ASK representative] or a person like her assigned to help coordinate all of that red tape would really help, I think.

6. Experience with Medicaid patients

Currently accept (85.7%): "There is no difference between OHP patients and patients with private insurance. There's 0 difference. They're all good patients. There are some that take great care of their teeth and there are some that don't take care of their teeth. But there's no obvious difference between the 2. You know, they are teenagers. And, yeah, I think it's great. I feel like a lot of them, they're appreciative, they're very appreciative of the opportunity to get braces. The kids are great. I just never had an issue myself. "

Do not accept (33%): "I'll just say one thing about treating Medicaid patients. In general, it's a privilege to treat them. In the past, when I was treating Medicaid patients on Fridays, it was 1 of the best days of the week to go in there because most of the patients are very thankful and my staff enjoyed it too. You know, that was their favorite day too, because overall, it's just fun to treat them because it's a great thing to do in general. There's just some challenges so you get some challenging patients that are it's no fun, but the majority of the patients you treat, it's wonderful."

Table 17. Representative Quotes Regarding Recommendation from Orthodontists to Increase Participation

Representative Quote Regarding Recommendation from Orthodontists to Increase Participation
1. Recommendations to OHP
From Currently Accept Providers:
Clarify Process for Transfer Cases: "I think the first steps, it'd be great to have providers that would make the care accessible. The second is to have some clarity. I think one of the problems that is going to come up or is beginning to come up is when people leave an area and transfer to another because one thing that's nice about the benefit is they pay you up front in full. The only thing they don't pay you for is retainers until you do the debond. But in the case of somebody transferring, you know, who says how do you divide the payment? This I think is gonna be kind of interesting."
Replace HLD Index with Automatic Qualifiers: "I like the idea of using automatic qualifiers which looks at the quality of the malocclusion, as opposed to measurements that are a little bit arbitrary and it doesn't give the holistic picture. So if you're just kind of adding up points that could be misleading, either one way or the other. So it's not great. So automatic qualifiers give a more qualitative and therefore more accurate description of what malocclusion the patient has."
Designate Screenings to Orthodontists: "I think the best thing would probably be to have the general dentist who do OHP just refer patients to the orthodontists. They don't need to try to qualify them beforehand. Hand them over. Let us qualify them. Let us look at

them. Not spend extra money on the dentist doing them because most of the ones I've talked to said, 'Why do they want us to do these? We don't even know what we're looking for. We're not orthodontists.' That's what all the dentists are telling me. They're like, we have to do this, but I don't even know what I'm looking for. So, it's kind of a waste of money."

Improve Reliability and Access to Specialty Referrals: So, in general, the average difficulty for cases that I'm seeing is a little higher with OHP. It takes longer to treat those cases as well because a lot of them need extractions or have impacted canines that take longer to treat and the coordination with specialists is a little tricky because I have to submit a separate referral that will be processed through OHP, instead of just a generic referral letter. It takes longer for the OHP referral to be sent to the dentist or specialist who is doing the procedure. As far as I know, it doesn't always go to the one oral surgeon you commonly work with. It could go to anybody else who takes OHP in the area. So I think it would be good if that referral process had some more stability."

Reimbursement based on Complexity: "One positive change would probably be increasing the reimbursement rate, just increasing the base value and then maybe including a few different tiers, so the more complex the case, the higher the reimbursement."

Prioritize Communication and Community Outreach: "Given the fact that that I think it's a fair assumption that there's going to be some resistance in the orthodontic community seeing these patients, I feel that OHP should almost overcorrect. They should almost overcompensate in terms of the communication, in terms of the information provided, whether that means holding seminars, whether that means sending people to dental society meetings, to inform the dentist that A) this program exists and B) letting them know sort of what's going to be required for these patients And even maybe having specific people available to answer questions and to support them through the process…I think it's going to be those first few patients that an orthodontist is seeing that's are going to be the hardest. So, if there is a way for them to support dentists through that process and make them realize yeah, even if the reimbursements are less, if they can take the logistics hurdles out of the way, I think it's more likely that orthodontists would take these patients on."

Addition of Phase 1 Coverage: "There's nothing with phase 1 early interceptive type treatment and I think that needs to be addressed. We need to have some sort of opportunity for these phase 1 kids to be treated because we can treat them phase 1 orthopedically, we can make phase 2 a lot easier for them and more efficient and more cost effective."

From Currently Not Accepting Providers:

Simplification of Screening Process: "I know my staff are very capable, but they're certainly not capable of filling out the HLD form. That form is harder than doing your board exams…I could train a staff member to fill the form, but I don't know that I would want to do it to that detail. I would rather have it be as simple."

Ability to Charge Patients a No-show Fee: "Yeah, it would be nice to be able to charge a no show fee. I don't usually charge a nominal fee in my office, but I had to do it my low-cost office because we had a ton of no shows and once I implemented that no show fee, I became profitable."

Maximize Efficiency of Systems: "Not only are they asking the providers to take a less money for a case, but they're also saying spend more of your resources trying to navigate our difficult situation. So, I do think that it's important for their system to try to make it as efficient for the provider as possible to apply and get the money, especially if the money's going to be lower than fair market rates."

1. Recommendations to Orthodontic Peers

From Currently Accept Providers:

Familiarize Yourself with the HLD index: "Truthfully I don't know how much you've used the index, but once you learn how to do it, it's a one to 2 min process. It's really pretty straightforward and easy to do. I think so. Specifically for orthodontists."

Seek Support from OHP Providers: "I would speak to an office who's already doing it successfully and request support from their administrative staff, and usually each office has a key person who's managing it. So I think like my office manager would be happy to share her experience with other providers."

Start with 1-2 OHP Patients and Having Systems in Place: "My advice would be maybe to try one patient first and work through the process and make sure that questions are being answered. Make sure that you created a system for that. It might be somebody in the office who's going to manage this logistically to make sure that that they're getting the responses that are needed."

Personal Choice to Help the Community: "A lot of private practices might be more profit driven or production driven. And so that is basically how much compensation they're going to be getting for this, so that would be the biggest barrier, I would imagine. I think a lot of it is going to be up to the providers and what they feel is their moral obligation to help the community in this way. And that's up to the individual provider. And I don't know if it's something that you can just expect people or even change their viewpoints on. It's kind of a big ask. I think if they are willing to accept the compensation and they are willing to see OHP patients and their variety of severe malocclusion and they're willing to take on the challenge of these case that are considered more challenging, if they're willing to take on that challenge, I think, there is no difference between OHP patients and patients with private insurance."