Iowa Wellness Plan Summative Evaluation Report

For the Period Ending 12/31/19

For Submission to the Iowa Medicaid Enterprise and
The Centers for Medicare and Medicaid Services

Public Policy Center
The University of Iowa
May 1, 2020

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This report provides data for the evaluation of the Iowa Wellness Plan for the period ending December 31, 2019.
The report is divided into three sections, based on the data available for this time period as specified in the evaluation plan:

Section 1

Dental Wellness Plan Evaluation: Annual Report 2019

This section presents the results for outcomes for the Dental Wellness Plan (DWP) 2.0 (fiscal year 2019). Comparisons are made with year 1 of the program (fiscal year 2018) in addition to outcomes from the year preceding DWP 2.0 implementation (fiscal year 2017). Due to the significant programmatic changes to DWP from 1.0 to 2.0, and a coinciding change in the evaluation protocol, comparisons to prior years were not considered appropriate for this report.

Section 2

Healthy Behaviors Program: Disenrollment Survey Report 2019

This section of the report provides the results for a survey of members who were disenrolled from the Iowa Wellness Plan for not having completed their healthy behaviors (A health risk assessment and annual wellness exam). Because this is a point in time snapshot of the program with the current managed care plans, and the significant programmatic changes from the past, a comparison to previous results for this survey were not considered appropriate for this report.

Section 3

Healthy Behaviors Incentive Program: Completion and Outcomes Report

This section of the report provides an analysis of data from the evaluation of the Healthy Behaviors Program for the Iowa Wellness Plan for the period from January 1, 2014 to December 31, 2018. This report has three main objectives. First, we document rates of healthy behavior completion among IHAWP members using 2014 to 2018 data. This will further our understanding of overall rates of compliance with the HBI program requirements five years into the program. Second, we model healthy behavior completion as a function of several member-level characteristics. This will further our understanding of which members are most and least likely to complete the healthy behaviors. This is important, because the members who are least likely to complete the healthy behaviors are at greater risk of being charged monthly premiums and potentially being disenrolled from Medicaid. Third, we model several measures of health care utilization as a function of whether a member completed both healthy behaviors in the prior year. This will further our understanding of the potential for the healthy behaviors that are being required to influence patient outcomes.

Section 1

DWP Evaluation: Annual Report 2019

Evaluation of Iowa's redesigned Dental Wellness Plan (DWP 2.0): access, quality, and oral health outcomes for FY2019

Susan McKernan
Assistant Professor and Research Fellow*
Preventive & Community Dentistry**

Julie Reynolds
Assistant Professor and Research Fellow*
Preventive & Community Dentistry**

Elizabeth Momany
Associate Research Scientist*

Aparna Ingleshwar
Graduate Research Assistant
Health Policy Research Program*

Peter Damiano
Director and Distinguished Research Fellow*
Bernstein Professor, Preventive & Community Dentistry**

University of Iowa Public Policy Center

***University of Iowa College of Dentistry and Dental Clinics*

Executive Summary

In July 2018, Iowa integrated its fee-for-service adult dental Medicaid program with the Iowa Dental Wellness Plan (DWP). Originally, the DWP provided benefits to the Medicaid expansion population only. This new unified adult dental program, DWP 2.0, provides comprehensive benefits to members during their first year of enrollment. Thereafter, members are required to complete two healthy behaviors annually in order to maintain full dental benefits and avoid monthly premiums: an oral health self-assessment and a preventive dental visit. Several populations are exempt from monthly premiums, and thus exempt from the healthy behavior requirements, including 19 and 20 year-olds with EPSDT coverage, pregnant women, Native Americans, and several other categorically eligible Medicaid populations. Beginning in September 2018, a $1,000 annual benefit maximum was implemented for all adults in the DWP 2.0 program, except for the EPSDT population.

Methodology

This evaluation considers outcomes for year 2 of DWP 2.0 – fiscal year (FY) 2019. Comparisons are made with year 1 of the program (FY2018) and with outcomes from the year preceding implementation (FY2017). Comparisons across the three years are limited to adults eligible for 11-12 months out of the year via the Family Medical Assistance Program (FMAP) and through Medicaid expansion. Data for this evaluation come from a 2019 survey of Iowa dentists and administrative claims and enrollment data from Iowa Medicaid Enterprise. The study population included 157,568 enrollees aged 19-64 years. Results are summarized below by research question.

What are the effects of DWP 2.0 on member access to care?

- Thirty-three percent utilized any dental care during the year, including 31% who received the required preventive dental visit.
- Rates of annual preventive dental visits have decreased slightly from 2017 (37%) to 2019 (31%).
- People who were new to the program were slightly less likely to have had an annual preventive dental visit; 26% of new members had an annual preventive dental visit within 12 months of enrollment in DWP 2.0.
- The most frequently received preventive or diagnostic dental services provided to the study population included cleanings (i.e. dental prophylaxis), exams, and x-rays.
- Since 2017, emergency department (ED) utilization in this population has remained relatively stable (about 1.3%). ED visits for non-traumatic dental conditions are an indicator of poor access since these visits are considered avoidable with routine dental care.
- Rates of follow-up with a dentist after ED visits are also considered to be an indicator of access since patients should follow-up with a dentist to receive definitive care. In 2019, rates of 30-day follow-up were approximately 30% and have decreased slightly since 2017 and 2018.

What are provider attitudes towards the DWP 2.0?

- 29% of dentists responding to the 2019 survey reported that they accepted new DWP 2.0 patients—decreasing from 42% in 2016 and 38% in 2017.
- The majority of participating dentists (79%) reported that they accepted patients from only one of the two dental carriers in Iowa.
- Based on administrative data, 67% of dental providers who participated in DWP 1.0 in 2017 were participating in DWP 2.0 in 2019.
- In 2019, 77% of surveyed dentists reported a negative attitude towards the DWP 2.0 program—an increase from 55% of dentists in 2016. However, the majority (87%) expressed a positive attitude towards the requirement for an annual preventive dental visit.

- 91% of dentists reported that reimbursement rates were a major problem. Dentist comments indicated that they felt doubly burdened by low reimbursement for services coupled with the administrative requirements of tracking eligibility, benefit levels, healthy behaviors, and remaining annual benefits.

What are the effects of the benefit structure – including healthy dental behavior requirements, cost sharing, and reduced benefits – on DWP 2.0 member outcomes?

- 23% of DWP 2.0 members in the program from 2018-2019 had an annual preventive dental visit in both years.
- At the end of 2019, 17% of DWP 2.0 members had completed both a preventive dental visit and an oral health self-assessment.
- Most measures associated with this research question were not assessed in this report since there was no new DWP 2.0 member survey data in 2019. Outcomes are included in the previous 2018 report. The 2019 survey of members was underway at the time that the current report was completed.

What are the effects of DWP 2.0 member outreach and referral services?

- Among survey respondents, 81% of dentists who had participated in DWP at some point since August 2017 reported that DWP 2.0 patients had more broken appointments compared to their non-DWP adult patients.
- Three in four services provided to the study population were for diagnostic and preventive services. Restorative procedures, including amalgam and composite fillings, were the next most common services. Surgical procedures overwhelmingly were for tooth extractions.
- Although 80% of members with preventive dental visits in 2018 and 2019 saw the same dentist for both visits, only 54% of members with a 2018 visit also had a 2019 visit.

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Overview of the Iowa Dental Wellness Plan (DWP) 2.0

The Iowa Wellness Plan 1115 demonstration was implemented in January 2014. Soon thereafter, on May 1, 2014, the Centers for Medicaid and Medicare Services (CMS) approved Iowa's request to amend the Iowa Wellness Plan to include a Dental Wellness Plan (DWP) component, which provided dental benefits to the ACA expansion population. DWP 1.0 provided tiered dental benefits to the adult expansion population, aged 19-64, based on completion of periodic dental exams every 6-12 months.

On July 27, 2017, CMS approved a modification to the 1115 demonstration that permitted the State to implement an integrated dental program for all Medicaid beneficiaries aged 19 and over, including the ACA expansion population, parent and other caretaker relatives, and mandatory aged, blind, and disabled individuals. As of September 2018, Iowa implemented a benefit maximum of $1,000 for DWP 2.0.

Dental Wellness Plan 2.0

DWP 2.0 provides the same benefits to all adult members (i.e., regardless of the reason for enrollment) their first year of enrollment. However, members are required to annually (including their first year of enrollment) complete two healthy behaviors in order to maintain full dental benefits during subsequent years and avoid premium charges. The required healthy dental behaviors include:

1. An oral health self-assessment
2. An annual preventive dental visit

Delivery System

DWP 2.0 benefits are provided by a managed care delivery system via Prepaid Ambulatory Health Plans (PAHPs). The State is currently contracted with two private carriers to deliver DWP benefits: Delta Dental of Iowa (Delta Dental) and MCNA Dental (MCNA). Beginning July 1, 2017, non-exempt (see below) adult Medicaid members were transitioned from the fee-for-service delivery system to one of these two PAHPs; existing Medicaid fee-for-service members were assigned evenly between the two plans. Currently, newly eligible individuals are assigned evenly between the two plans. Members have the option to change PAHPs within the first 90 days of enrollment without cause. After 90 days, members may change carriers for "Good Cause" reasons – for example, if the enrollee's dentist is not in the original carrier's network or lack of access to services.

Oral Health Self-Assessment

The oral health self-assessment can be completed online or over the phone. Delta Dental offers members a "LifeSmile Score" based on the PreViser Corporation's self-administered risk assessment. MCNA provides members with a modified version of the American Dental Association's Caries Risk Assessment Form; completed forms must be emailed to MCNA. Alternately, members can complete the self-assessment over the phone. In addition to the oral health self-assessments, risk assessments completed by dental providers (i.e., CDT codes D0601, D0602, D0603) also count towards completion of a member's oral health self-assessment.

Preventive Dental Visit

The annual preventive dental visit requirement includes all evaluations and some preventive services. The complete list of qualifying services is provided in Table 1.

Table 1. Services that qualify for health behavior preventive dental visit

CDT	Description of service
D0120	Periodic oral evaluation – established patient
D0140	Limited oral evaluation – problem focused
D0150	Comprehensive oral evaluation
D0180	Comprehensive periodontal evaluation
D1110	Prophylaxis (dental cleaning)
D4346	Scaling– full mouth
D4910	Periodontal maintenance

Monthly Premiums

After their first year in the program, members over 50% of the federal poverty level (FPL) who fail to complete the two healthy behaviors are required to pay $3 monthly premiums to maintain full benefits during the second year. Failure to make monthly premium payments for 90 days results in a reduction of benefits from full to basic dental services for the remainder of the enrollment year.[1] Enrollment years are specific to each member and based on the month the member was initially eligible[2]. Basic benefit covered services include services that qualify for the healthy behavior dental visit, complete and partial dentures, diagnostic services, and emergent services (e.g., extractions, incision and drainage of abscesses). If members are unable to pay the monthly premiums, they may claim financial hardship to be released from this obligation; hardship claims must be made each month to receive the exemption.

Goals of the Iowa DWP 2.0

This new integrated dental program is expected to address problems created when individuals transition through different eligibility categories. [3] The changes in benefit structure (i.e., elimination of tiered benefits, full dental benefits available in year 1 of eligibility) were designed to address concerns that few members had been eligible for tier two and tier three benefits in the DWP 1.0 program.

This report evaluates four goals of DWP 2.0

Goal 1. Ensure members' access to and quality of dental services
Goal 2. Allow for the seamless delivery of services by providers
Goal 3. Improve the oral health of DWP members by encouraging engagement in preventive services and compliance with the treatment goals
Goal 4: Encourage member linkage to a dental home

Populations Exempt from DWP 2.0 Monthly Premiums

[1] "Notice of Iowa Department of Human Services Public Comment Period to Amend the 1115 Iowa Wellness Demonstration Waiver – Dental Wellness Plan" https://dhs.iowa.gov/sites/default/files/DWP_Public_Notice_Final_05.01.17.pdf?120420192219

[2] "Informational Letter No.1940-MC-FFS-D" August 16, 2018. https://dhs.iowa.gov/sites/default/files/1940-MC-FFS-D_DentalWellnessPlanHealthyBehaviors_and_PremiumPaymentsFAQ.pdf?121320191651

[3] *Id.* at 6.

It should be noted that several adult Medicaid populations will not be charged premiums, and therefore will not have benefits reduced for failure to complete the healthy behaviors.[4] Specifically, the following members are exempt from premiums:

- Individuals with income less than 50% FPL
- 19 & 20 year-olds with EPSDT coverage
- Pregnant women
- Individuals whose medical assistance for services furnished in an institution is reduced by amounts reflecting available income other than required for personal needs
- 1915(c) home and community-based waiver members
- Individuals receiving hospice care
- Native Americans who are eligible for services by Indian Health Services or under contract health services
- Breast and cervical cancer treatment program members
- Medically frail members (i.e. medically exempt)

Previously, adult Medicaid members in the fee-for-service program were responsible for a $3.00 visit copayment; however, there is no copayment required for dental services in the DWP 2.0.

Annual Benefit Maximum

Consistent with the previous fee-for-service State Plan and DWP 1.0, there was originally no annual maximum with DWP 2.0. However, beginning September 1, 2018, a $1,000 annual benefit maximum was implemented for all adults in the DWP program, with the exception of members age 19-20 who are exempt via EPSDT. Dental services excluded from the annual maximum include services that qualify for the healthy behavior dental visit, along with additional preventive, diagnostic, and emergency dental services. Complete and partial dentures are also excluded from the annual benefit maximum. Annual benefit maximums reset at the beginning of each fiscal year (i.e., July 1st) for all DWP 2.0 members, unlike the healthy behavior requirements, which align with enrollment years.

[4] *Id.* at 4.

Evaluation Questions and Hypotheses

Hypothesis	Measures	Inclusion in 2019 report
Research Question 1. What are the effects of DWP 2.0 on member access to care?		
1.1: DWP 2.0 members will have equal or greater access to dental care than either Iowa Wellness Plan (IWP) or Medicaid State Plan (MSP) members had prior to July 1, 2017.	Measure 1: Annual preventive dental visit (to meet healthy behavior requirements)	Yes-Administrative data
	Measure 2: Utilization of dental care	Yes -Modified from original specifications to include information based on administrative data
	Measure 3: Unmet need for dental care	No-2018 is the most recent consumer survey
1.2: DWP 2.0 members will be more likely to receive preventive dental services than either IWP or MSP members were prior to July 1, 2017.	Measure 4: First preventive dental visit	Yes-Administrative data
	Measure 5: Any diagnostic or preventive dental care	Yes-Administrative data
1.3: DWP 2.0 members will have equal or lower use of emergency department services for non-traumatic dental care than either IWP or MSP members had prior to July 1, 2017.	Measure 6: Use of emergency department for non-traumatic dental care	Yes-Administrative data
	Measure 7: Access to dental care	No-2018 is the most recent consumer survey
1.4: DWP 2.0 members will have equal or better quality of care than either IWP or MSP members did prior to July 1, 2017.	Measure 8: :Emergency department use	No-2018 is the most recent consumer survey
	Measure 9: Consumer quality rating	*No*
	Measure 10: Proportion of members who had to change regular dentists	*No*
	Measure 11: Regular source of dental care	*No*
	Measure 12: Experience changing dentists	*No*
1.5: DWP 2.0 members will report equal or greater satisfaction with the dental care provided than IWP or MSP members did prior to July 1, 2017.	Measure 13: Rating of regular dentist	No-2018 is the most recent consumer survey
	Measure 14: Rating of all dental care received	*No*
		No

Hypothesis	Measures	Inclusion in 2019 report
	Measure 15: Rating of DWP 2.0	
1.6 DWP 2.0 members will report better understanding of their benefits when compared to the IWP tiered structure.	Measure 16: Member awareness of healthy behavior requirements	No-2018 is the most recent consumer survey
1.7 The earned benefit structure will not be perceived by members as a barrier to care in comparison to IWP.	Measure 17: Difficulty completing healthy behavior requirements	No-2018 is the most recent consumer survey
	Measure 18: Member attitudes towards healthy behavior requirements	*No*
	Measure 19: Out-of-pocket dental costs	*No*
	Measure 20: Member experiences with covered benefits	*No*
Research Question 2. What are provider attitudes towards DWP 2.0?		
2.1 The DWP 2.0 benefit structure will not be perceived by dentists as a barrier to providing care.	Measure 21: Dentist willingness to accept new patients	Yes-2018 Survey of Iowa Dentists
	Measure 22: Dentist satisfaction with DWP 2.0	Yes-2018 Survey of Iowa Dentists
2.2 Over 50% of DWP 2.0 providers will remain in the plan for at least 3 years.	Measure 23: Proportion of long-term care dental providers	No-FY2019 (year 2) baseline data provided
Research Question 3. What are the effects of the benefit structure on DWP 2.0 member outcomes?		
3.1 The benefit structure for DWP 2.0 members will increase regular use of recall dental exams over the study period.	Measure 24: Self-reported oral health status	No-2018 is the most recent consumer survey
	Measure 25: Routine dental exams	Equivalent to Measure 4
	Measure 26: Recall visit	Yes-Administrative data
	Measure 27: Members' perceived impact of healthy behavior requirements	No-2018 is the most recent consumer survey
3.2 The benefit structure will not be seen as a barrier to care by DWP 2.0 members.	*Addressed by Measures 17-20 under Hypothesis 1.7	No-2018 is the most recent consumer survey
3.3 In year 2 of the DWP 2.0 and beyond, use of preventive dental care will be greater than in the first year of the program.	*Addressed by Measures 24-26 under Hypothesis 3.1	See Measure 4
3.4 DWP 2.0 policies will promote member compliance with healthy behavior activities.	Measure 28: Member compliance with both healthy behaviors	Yes-Administrative data

Hypothesis	Measures	Inclusion in 2019 report
Research Question 4. What are the effects of DWP 2.0 member outreach and referral services?		
4.1 DWP 2.0 member outreach services will address dentists' concerns about missed appointments.	Measure 29: Dentist perceptions of missed appointments	Yes-2018 Survey of Iowa Dentists
	Measure 30: Member outreach for healthy behavior requirements	No-2018 is the most recent consumer survey
4.2 DWP 2.0 member referral services will improve access to specialty care for DWP 2.0 members as compared to IWP and MSP members prior to July 1, 2017.	Measure 31: Care from a dental specialist	No-2018 is the most recent consumer survey
	Measure 32: Utilization of specialty dental services	Yes-Administrative data
	Measure 33: Timeliness of getting a dental specialist appointment	No-2018 is the most recent consumer survey
4.3 DWP 2.0 member outreach will improve DWP 2.0 members' compliance with follow-up visits, including recall exams, as compared to IWP and MSP members.	Measure 34: Care continuity	Yes-FMAP and IWP comparisons are not made due to churn between the 2 eligibility categories during FY2018 and FY2019
	Measure 35: Usual source of dental services	Yes-Administrative data
4.4 DWP 2.0 member outreach will improve members' access to a regular source of dental care.	Measure 36. Members with a regular dentist	No-2018 is the most recent consumer survey
	Measure 36: Timeliness of getting a routine dental appointment	*No*
	Measure 37: Finding a dentist who accepts DWP 2.0 insurance	*No*

Methodology

This report evaluates member and dentist experiences in the Iowa Dental Wellness Plan (DWP) 2.0 for FY2019 (July 2018 – June 2019). This corresponds to year 2 of the DWP 2.0 demonstration. Data about dentists' experiences was collected by the 2019 Survey of Iowa Dentists, conducted by the research team. Members' experiences were reported in the previous 2018 report. Administrative outcomes for members are assessed using a quasi-experimental design with non-equivalent groups. Administrative data, including claims and enrollment data, for FY2018 and FY2019 are used to answer research questions about the effects of eligibility and coverage policies on utilization.

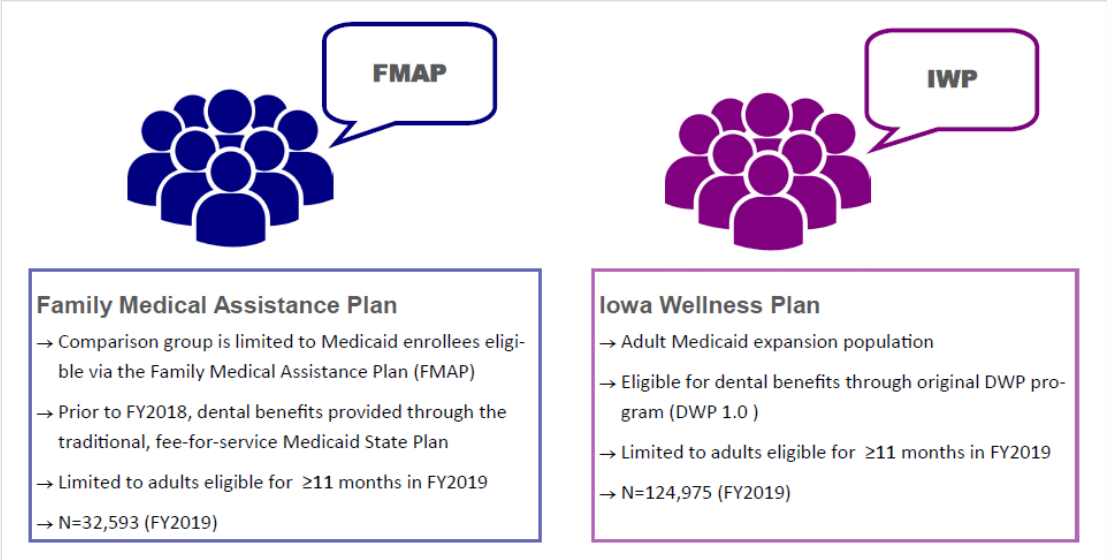
Comparison Strategy among DWP Members

Outcomes are reported by year for the DWP population. Additionally, several measures compare outcomes between different eligibility determination categories. The strategy to evaluate members' experiences defines comparison groups based on eligibility determination and year. DWP 2.0 members eligible via ACA expansion (the Iowa Wellness Plan(IWP)) are compared with other similar Medicaid members, aged 19-64. In order to limit heterogeneity among the "other" category, we make comparisons between IWP and the Iowa Family Medical Assistance Program (FMAP) population. The Iowa FMAP population includes adults aged 19-64 with incomes at or below approximately 51% FPL. For this evaluation, we have excluded individuals with FMAP eligibility who move into Transitional Medicaid if earned income has increased above 51% FPL.

In this report, we have limited the FY2019 comparison groups to members with at least 11 months of eligibility during the year. This strategy controls for the effects of time on the probability of utilization, eliminates complications related to monthly churn between eligibility categories (i.e. from FMAP to IWP), and results in more comparable study groups. A summary of these two comparison groups is provided in Figure 1.

Some outcomes (e.g., specialty dental services) are reported for members with at least 1 month of eligibility in either FMAP or IWP, in order to provide broader population-based information about the DWP 2.0 program. Exceptions are noted.

Figure 1. Evaluation comparison groups

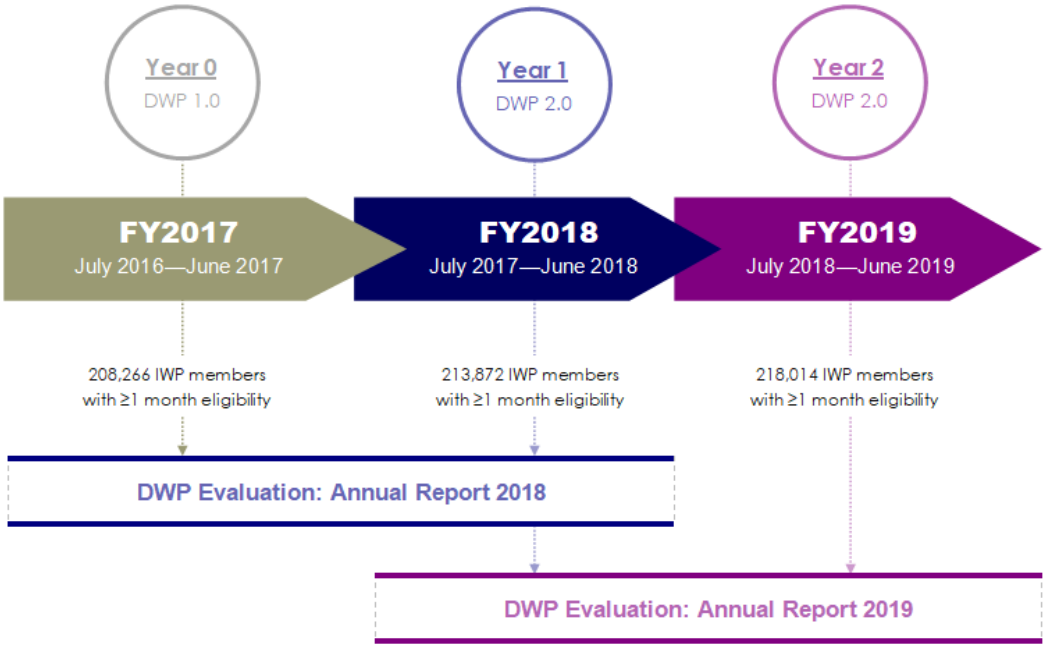


Evaluation Period

In order to evaluate trends over time, we will also make comparisons across years. In this report, we make comparisons between FY2018 (year 1 of DWP 2.0) and FY2019 (year 2) outcomes where possible. Outcomes for

FY2018, including pre-post comparisons with FY2017 have been reported previously.[5] These evaluation time periods are summarized in Figure 2. Hereafter, years are reported without the fiscal year notation, but should be assumed to correspond to these periods.

Figure 2. Evaluation time periods



Data Sources

Administrative Data

Administrative claims and enrollment data from Iowa Medicaid Enterprise for 2018-2019 are used to examine outcomes related to utilization of dental services, completion of healthy behavior requirements, utilization of emergency departments for non-traumatic dental care, and continuity of care.

2019 Iowa Dentist Survey

In April 2019, the Public Policy Center administered a mailed survey to all dentists in private practice in Iowa (n=1,287), excluding orthodontists. A reminder postcard was sent 1 week after the initial mailing, and a second survey was sent 2 weeks after the postcard. Dentist addresses and demographic data were drawn from the Iowa Dentist Tracking system (IDTS), which tracks state dentist workforce information and is part of the University of Iowa's Office of Statewide Clinical Education Programs. Survey topics included provider participation in DWP, awareness of policy changes, and experiences with the DWP program. Survey items were generally consistent with previous DWP provider surveys administered by the Public Policy Center.

Approximately 43% (n=547) dentists responded to the survey. Survey respondents were more likely to be older, general dentists, and in solo practice compared to non-respondents (Table 2). Poststratification weights were constructed to account for differences in age between respondents and the full population. Results for evaluation measures were weighted by age, however weighting did not change measure estimates; therefore, results are presented unweighted. Comparisons were made between the 2019 survey and previous surveys, where comparable data were available. Unless indicated otherwise, results from the provider survey include general dentists only (n=500), with specialists excluded.

[5] McKernan SC, et al. (2019). DWP Evaluation: Annual Report 2018. Available at: http://ppc.uiowa.edu/publications/dwp-evaluation-annual-report-2018

A copy of the survey instrument, including descriptive results, is provided in Appendix A. Free response comments are provided in Appendix B. Results are reported for general dentists only and are unweighted.

Table 2. Demographic and practice characteristics of survey respondents and all Iowa private practice dentists

	Survey respondents	Non-respondents	Total
	n=547	n=740	N=1287
Age			
<35 years	16%	17%	17%
35-44	24%	29%	27%
45-54	19%	18%	18%
55-64	24%	21%	22%
≥65	18%	15%	16%
Sex			
Female	32%	30%	31%
Male	68%	71%	70%
Specialty			
General dentistry	91%	83%	87%
Oral surgery	3%	5%	4%
Pediatric dentistry	2%	6%	4%
Endodontics	2%	4%	3%
Periodontics	1%	1%	1%
Prosthodontics	1%	1%	1%
Solo or Group Practice			
Solo practice	42%	34%	38%
Group practice	58%	66%	62%

Analytic methods

Descriptive methods

Descriptive statistics are used to describe characteristics of members in 2019. Data visualization techniques include alluvial diagrams, which reveal changes in the DWP 2.0 enrolled population over time. Specifically, alluvial diagramming allows us to view population shifts after year 1, when members who did not complete healthy behavior requirements were moved from full dental benefits to basic benefit levels.

Means testing

Bivariate analyses are used to compare simple rates for claims-based outcomes such as utilization of preventive care across member groups over time. Bivariate analyses are frequently used here to test differences between member groups on survey responses, as the number of respondents in these groups are rarely large enough to allow more complex tests such as ANOVA or regression modelling.

Multivariable modelling

Multivariable modelling is particularly useful to determine whether the dental plan/program has an effect on member utilization of care while controlling for other factors such as age, gender, location, and plan characteristics. Models adjust for variables in order to control for differences that may affect utilization of dental services such as age, race, percent poverty, county urbanicity, and length of enrollment.

In the 2018 DWP evaluation, we used difference-in-differences analysis to test the effects of DWP 2.0 implementation. In 2019, this methodology (i.e. pre-post comparisons) is no longer applicable. However, we are still interested in examining predictors of certain outcomes of interest (e.g., utilization of preventive dental visits).

Methodological Limitations

The provider survey asked dentists to provide information about program knowledge and attitudes; their responses may suffer from recall bias or social desirability bias. Additionally, dentists who responded to the survey may differ in their attitudes towards Iowa Medicaid. For example, dentists may be more likely to respond to a survey about Medicaid if they have strong opinions on the topic.

Analysis of administrative data has several inherent limitations. First, there are challenges associated with assigning members to a single eligibility category (e.g., FMAP or IWP). Members often switch between eligibility categories. This phenomenon is one of the factors that drove recent changes to the DWP program; a single, integrated DWP 2.0 program means that members' dental benefits do not also change from month to month. To address this issue, we required that members have continual enrollment in a single eligibility category for at least 11 months in the study period. While this improves homogeneity in the study population, it does potentially affect generalizability of our findings to DWP 2.0 as a whole. For example, these methods exclude individuals who enrolled later in the year and who switched between eligibility categories.

An additional limitation associated with administrative data is validity of data sources. Dental visits that meet the healthy behavior requirements can be identified using claims data as well as using DHS records based on self-report. These two sources of information are sometimes in disagreement. We found that claims data identified more healthy behavior completions than the DHS records did. Additionally, members have the option to self-report completion of healthy behaviors directly to IME (thus lacking claims documentation). We identified approximately 15% disagreement between DHS records and claims data, with claims data identifying almost 9,600 more members as having had a preventive dental visit when compared to the healthy behavior tracking data provided by DHS. Therefore, for this evaluation, we opted to use claims data as the "gold standard" for our analyses.

The Public Policy Center does not currently have access to DWP 2.0 provider network data. Thus, we are not able to examine how utilization of dental care is affected by provider availability. We have identified unique providers by NPI number. Results for Measure 23, which examines number of DWP 2.0 providers in 2018 and 2019, have several limitations. First, we are not able to identify whether dentists are located in Iowa or ~~another~~ other states. This has important implications for interpretation of results: these data cannot be used to estimate the proportion of dentists in Iowa who are participating providers for DWP 2.0. Second, we cannot provide information about dentist specialty. Finally, we assume that the NPI represents the individual rendering provider (Type 1 NPI) rather than the health care organization (Type 2 NPI). If the NPI reflects an organization, this measure may underestimate the number of individual dentists.

Finally, this evaluation does not include updated member survey data. The 2019 DWP 2.0 member survey is currently being fielded (as of December 2019). Results will be included in the 2020 evaluation.

DWP 2.0 Member Demographics

Table 3 compares demographic characteristics for DWP 2.0 members with at least 1 month of eligibility in 2019 compared to members with 11-12 months of eligibility. The two populations are very similar (and not mutually exclusive). However, members with 11-12 months of eligibility were more likely than members with at least 1 month of eligibility to be exempt from monthly premiums requirements and to have utilized any dental care during the year.

Table 4 shows demographic characteristics of the 2019 comparison groups – members with at least 11 months of eligibility and eligible for dental benefits via the Family Medical Assistant Program (FMAP) versus the Iowa Wellness Plan (IWP). The FMAP comparison group skews heavily female: 80% of this population is female, compared to 52% of the IWP population. Mean age of the IWP population was slightly older than the FMAP population (39 vs. 34 years, respectively).

Individuals in the FMAP population were also more likely to be exempt from the healthy behavior requirements and premium obligations due to low incomes. Similarly, the most common reason for premium exemptions among the IWP population was income, accounting for 86% of IWP exemptions.

DWP 2.0 member flow through the program

Figure 3 shows the flow of DWP 2.0 and the Medicaid fee-for-service members from July 2017 (the first month of DWP 2.0) through June 2019 (the end of 2019). Although DWP 2.0 was effective July 1, 2017, the alluvial diagram shows that the transition from the fee-for-service Medicaid State Plan was still occuring through August 2017. Members who did not complete the required healthy behaviors in year 1 of enrollment (2017) began to be moved to the basic benefit levels 6 months later – in December 2018. Since then, the proportion of members with basic benefits has increased slightly. As of June 2019, approximately 7% of DWP 2.0 members were receiving basic benefits. Individuals in the gray category represent members who became ineligible or were not yet eligible during the month shown. For example, an adult who became eligible for Medicaid in June 2018 is in the gray category for the months from July 2017 through May 2018.

Table 3. Demographics for DWP 2.0 members by months of eligibility in 2019‡

	Eligible ≥1 month	Eligible 11-12 months
Total members	N=286,108	N=157,568
Mean age (years)	36 (SD 12.4)	38 (SD 12.5)
Eligibility		
FMAP	23%	21%
IWP	77%	79%
Sex		
Female	58%	58%
Male	42%	42%
Race/Ethnicity		
Non-Hispanic White	62%	64%
Non-Hispanic Black	10%	9%
Native American	2%	2%
Asian	2%	2%
Pacific Islander	.5%	.5%
Hispanic	5%	4%
Multi-racial Hispanic	2%	1%
Multi-racial Other	1%	1%
Unknown	17%	16%
Income (% FPL)		
0%	48%	48%
1-49%	11%	12%
50-99%	24%	26%
≥100%	17%	14%
Urbanicity		
Urban	66%	65%
Large rural city/town	16%	17%
Small rural town	11%	10%
Isolated small rural town	8%	8%
Exempt from premium requirements	37%	55%
Any dental utilization, 2019	22%	33%

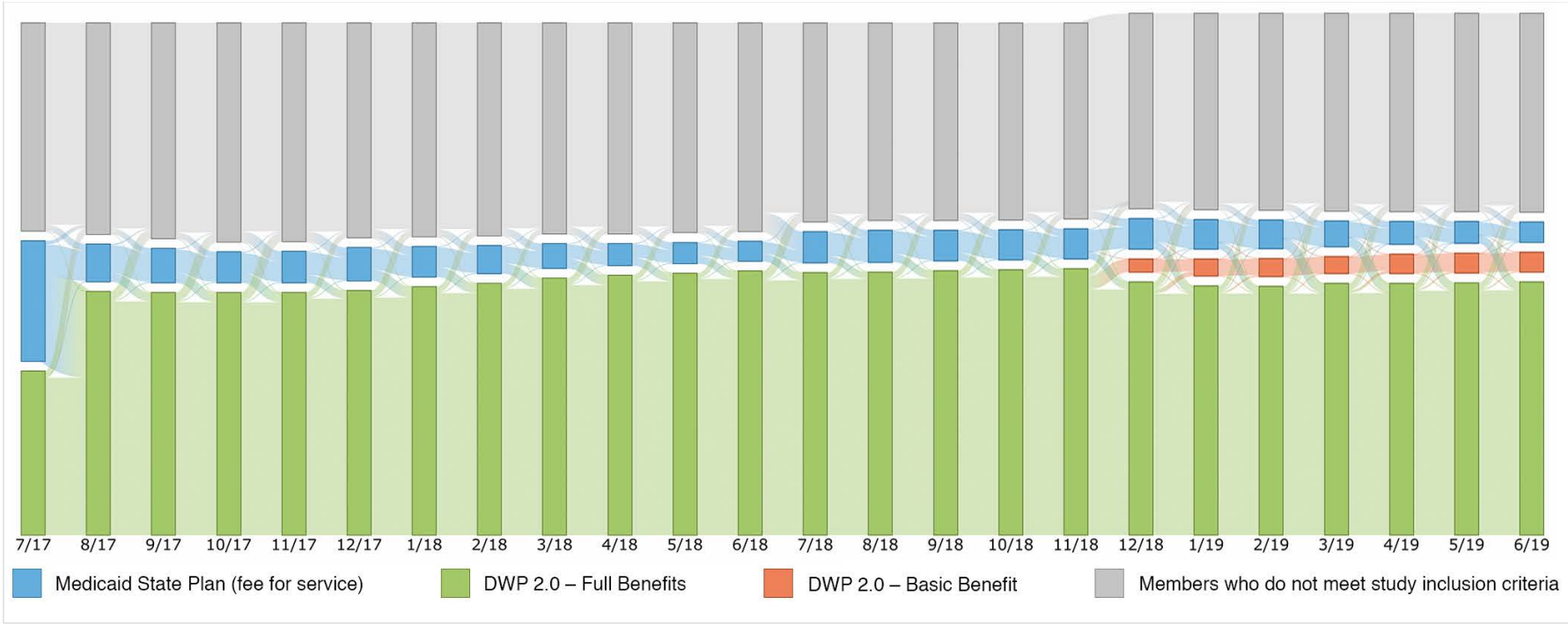
Percentages may not sum to 100 due to rounding.
‡Populations are not mutually exclusive.

Table 4. Demographics for DWP 2.0 members with ≥11 months of eligibility in 2019 by eligibility group

	Family Medical Assistance Plan (FMAP)	Iowa Wellness Plan (IWP)
Total members	N=32,593	N=124,975
Age (years)		
19-20	2%	5%
21-24	10%	13%
25-34	43%	26%
35-44	33%	21%
45-54	11%	18%
55-64	2%	17%
Sex		
Female	80%	52%
Male	20%	48%
Race/Ethnicity		
Non-Hispanic White	65%	64%
Non-Hispanic Black	11%	8%
Native American	2%	2%
Asian	2%	3%
Pacific Islander	1%	1%
Hispanic	4%	4%
Multi-racial Hispanic	2%	1%
Multi-racial Other	1%	1%
Unknown	12%	17%
Income (% FPL)		
0%	72%	42%
1-49%	28%	8%
50-99%	1%	32%
≥100%	0%	17%
Urbanicity		
Urban	64%	66%
Large rural city/town	17%	16%
Small rural town	11%	10%
Isolated small rural town	8%	8%
Exempt from premium requirements	87%	46%
Any dental utilization, 2019	33%	33%

Percentages may not sum to 100 due to rounding

Figure 3. Flow of Medicaid and DWP 2.0 members across programs and benefit levels, 2018-2019



Results

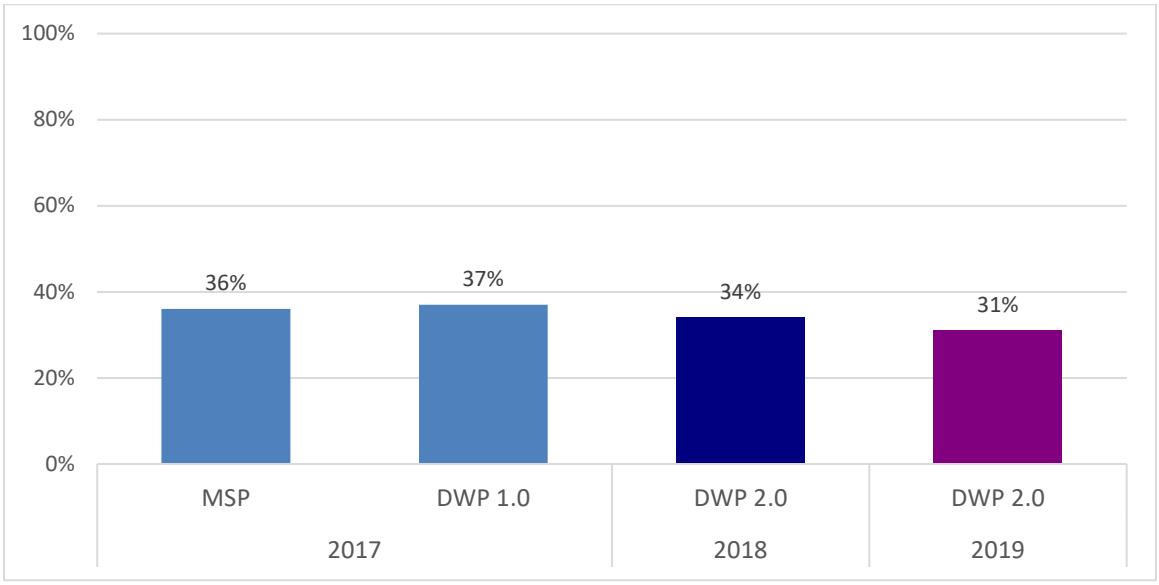
Question 1 - What are the effects of DWP 2.0 on member access to care?

Hypothesis 1.1: DWP 2.0 members will have equal or greater access to dental care than either Iowa Wellness Plan (IWP) or Family Medical Assistance Plan (FMAP) members had prior to July 1, 2017 (i.e. implementation of DWP 2.0).

Measure 1a: Annual preventive dental visit (to meet healthy behavior requirements)

Figure 4 depicts the trend in preventive dental visits from 2017-2019. Utilization of preventive dental visits have decreased slightly over time. In 2017 approximately 36% of members (inclusive of the two comparison groups, FMAP and DWP 1.0) had a preventive dental visit. In 2019, 31% of members had a preventive dental visit. No difference in rate of utilization was noted for IWP versus FMAP comparison groups. Since implementation of DWP 2.0, the proportion of members completing a preventive dental visit has decreased slightly.

Figure 4. Healthy dental behavior (HDB) – completion of preventive dental visit (claims-based)

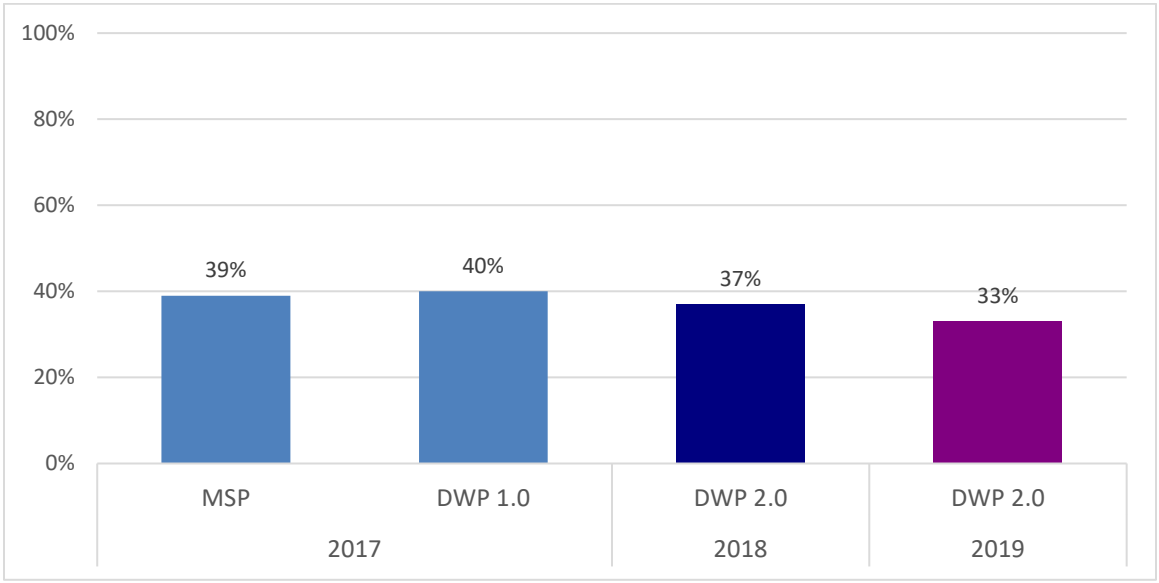


Proportions reported for DWP 2.0 refer to a program overall rate, i.e., includes former DWP 1.0 and FMAP populations.

Measure 2: Utilization of any dental care

In 2019, 33% of DWP 2.0 members in the study population had a dental visit of any type. Overall, claims-based analysis of dental utilization shows a small decline – decreased from 37% in a comparable population in 2018. No difference in rate of utilization was noted for IWP versus FMAP comparison groups. Prior to the implementation of DWP 2.0 (2017), a slightly greater proportion of FMAP and former DWP 1.0 members had a dental visit for any reason (Figure 5). In 2019, only 2% of the study population (n=3,349) had a dental visit of any type and did not also have a preventive dental visit.

Figure 5. Members with any dental visit by year (claims-based)



Proportions reported for DWP 2.0 refer to a program overall rate, i.e., includes former DWP 1.0 and FMAP populations

Hypothesis 1.1 summary

In 2019, slightly fewer than one-third of DWP 2.0 members received the preventive dental visit for the required healthy behaviors. Approximately 1 in 3 members had a dental visit for any reason. No difference in rates of utilization were noted for IWP versus FMAP comparison groups.

Since implementation of DWP 2.0, dental utilization has decreased slightly from DWP 1.0 levels. This trend was noted in 2018 and continues in 2019. No differences were noted between the IWP and FMAP comparison groups.

Hypothesis 1.2: DWP 2.0 members will be more likely to receive preventive dental visits than either DWP 1.0 or FMAP members were prior to July 1, 2017.

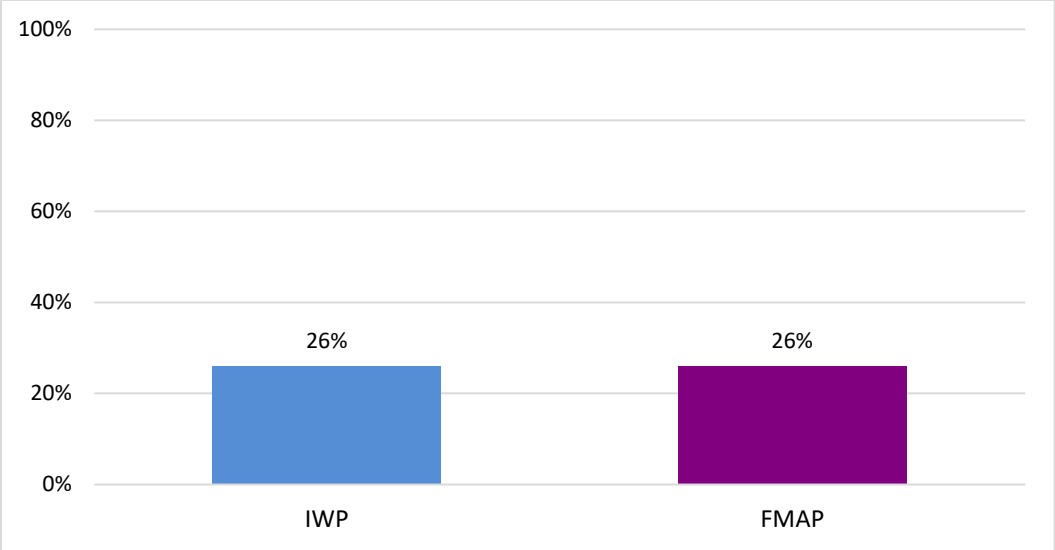
This hypothesis is tested using administrative data to examine utilization of preventive dental exams for new members. This hypothesis examines utilization of the preventive dental exam to qualify for DWP 2.0 healthy behavior requirements.

Measure 4: First annual preventive dental visit for new Medicaid enrollees (to meet healthy behavior requirements)

This measure indicates the proportion of adults who received a preventive dental visit within the first 12 months following new enrollment. Members were defined as newly enrolled if they had not been in any Medicaid program for the 6 months prior to enrollment in 2018. Members were included in the measure if they were eligible for DWP for 11-12 months in 2019.

There were no differences in utilization of preventive dental visits between newly eligible IWP and FMAP individuals in DWP 2.0 (Figure 6). Overall, 26% of the newly-enrolled study population received a preventive dental visit within 12 months of enrollment.

Figure 6. Proportion of adults with a preventive dental visit within 12 months of new enrollment



Measure 5: Any diagnostic or preventive dental care

This measure is slightly more inclusive than Measure 1, which only considers diagnostic and preventive services that qualify for the healthy behavior preventive dental visit. Results were almost identical to Measure 1: 31% of DWP 2.0 members in the study population received any diagnostic procedure (CDTs D0100-D0999) and 32% receive any preventive service (CDT D1000-1999). The ten most frequently received preventive or diagnostic services among members eligible for 11-12 months in 2019 are shown in Figure 7.

Figure 7. Most frequent diagnostic and preventive services

CDT	Description	Percent of all diagnostic and preventive services
D1110	Prophyaxis	15.1%
D0120	Periodic oral evaluation	13.7%
D0220	Intraoral radiograph - periapical (first)	11.2%
D0274	Bitewing radiographs – 4	9.2%
D0140	Limited oral evaluation - problem focused	8.0%
D0230	Intraoral radiograph - periapical (each additional)	7.5%
D1206	Topical fluoride	5.8%
D0150	Comprehensive oral evaluation	5.7%
D0330	Panoramic radiograph	4.3%
D0210	Intraoral - complete series of radiographs	4.2%

Based on total number of diagnostic and preventive services provided to members with 11-12 months of eligibility in 2019.

Hypothesis 1.2 summary

In 2019, new DWP 2.0 members were slightly less likely to have received a preventive dental visit compared to members who were not newly eligible (26% vs. 32%, respectively). The most frequently received preventive dental services included cleanings (i.e. dental prophylaxis), exams, and radiographs.

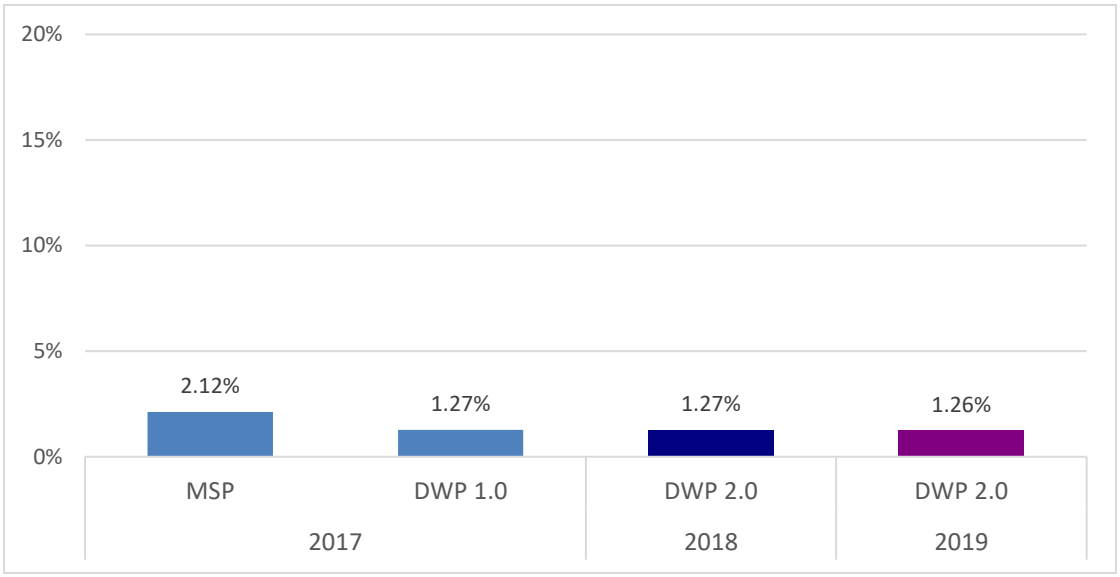
Hypothesis 1.3: DWP 2.0 members will have equal or lower use of emergency department (ED) services for non-traumatic dental conditions than either DWP 1.0 or FMAP members had prior to July 1, 2017.

This hypothesis examines utilization of emergency dental services using administrative data. The second part of this measure assesses rates of follow-up with a dentist after the ED visit. A majority of ED visits for non-traumatic dental conditions in the U.S. are either semi-urgent or non-urgent, posing financial implications for the healthcare system.[6] Additionally, a majority of these dental conditions are treated more effectively in ambulatory care settings. Patients treated for non-traumatic dental conditions in the ED often fail to receive definitive treatment; thus, follow-up with a dentist is typically required to receive appropriate care.

Measure 6a: Use of emergency department for non-traumatic dental care

In 2019, 1.26% of the study population had an ED visit for a non-traumatic dental condition – relatively unchanged since 2018 and 2017 (Figure 8).

Figure 8. Members with an emergency department (ED) visit for non-traumatic dental conditions



Proportions reported for DWP 2.0 refer to a program overall rate, i.e., includes former DWP 1.0 and FMAP populations.

Figures 9 and 10 provide the rates of non-traumatic dental ED visits for former MSP members and DWP 1.0 members for the year prior to implementation of DWP 2.0 (2017) and years 1 and 2 of the program. Rates are expressed as the number of ED visits per 1,000 months of eligibility. Overall, rates are highest for FMAP members aged 19-44 (Figure 9). Although the overall ED rates are quite low for members age 45-64 (Figure 10), they were slightly higher for those eligible via FMAP in 2018 and 2019.

Measure 6b: Follow-up with dentist after ED visit

Figure 11 shows rates of follow-up dental visits after ED visits for non-traumatic dental conditions. Rates of follow-up within either 7 days or 30 days have decreased for both comparison groups since 2017. Rates of follow-up in the 2017 DWP 1.0 program were 38% overall. In 2019, 20% of members had followed up with a dentist within 7 days and 29% followed up with a dentist within 30 days of an ED visit.

[6] Wall T, Nasseh K, Vujicic M. Majority of dental-related emergency department visits lack urgency and can be diverted to dental offices. *Health Policy Institute Research Brief* 2014. https://www.ada.org/~/media/ADA/Science%20and%20Research/HPI/Files/HPIBrief_0814_1.ashx.

Figure 9. Rates of dental emergency department visits for non-traumatic dental conditions per 1,000 member months for members aged 19-44 years by group and year

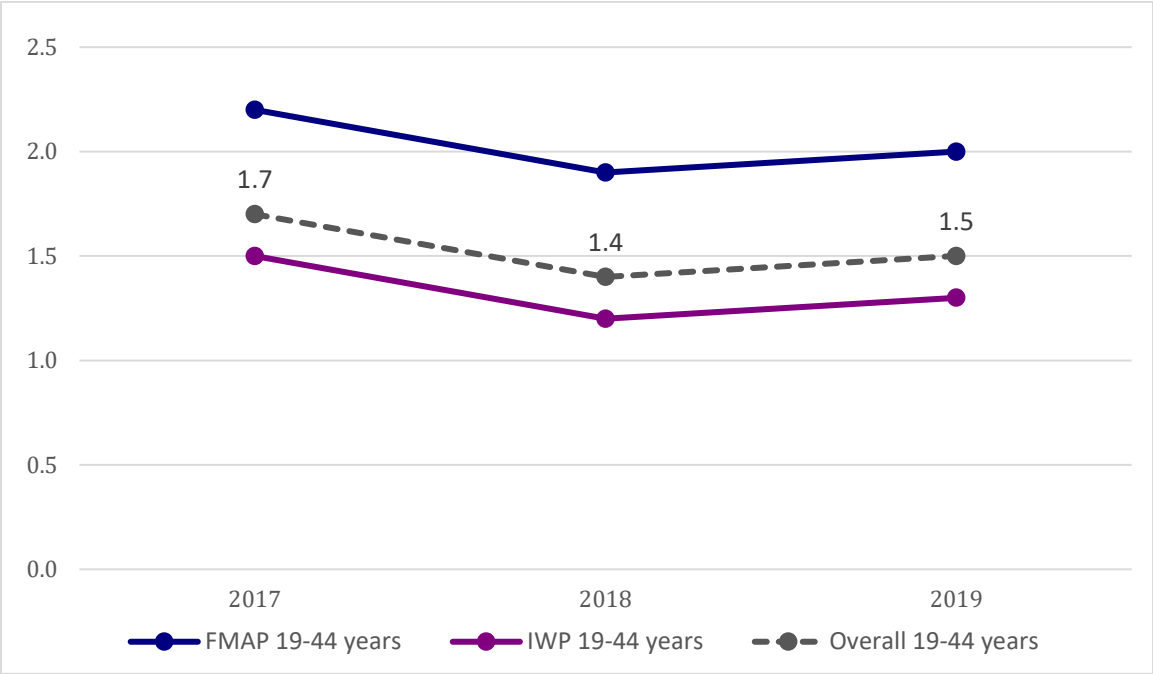


Figure 10. Rates of dental emergency department visits for non-traumatic dental conditions per 1,000 member months for members aged 45-64 years by group and year

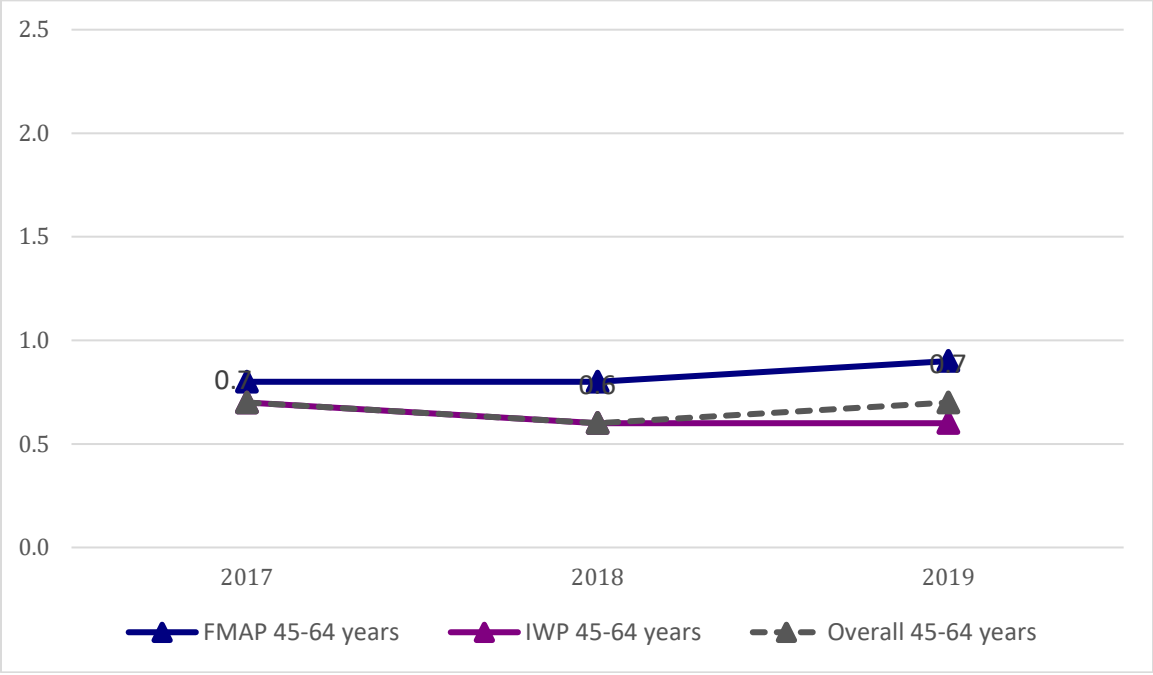
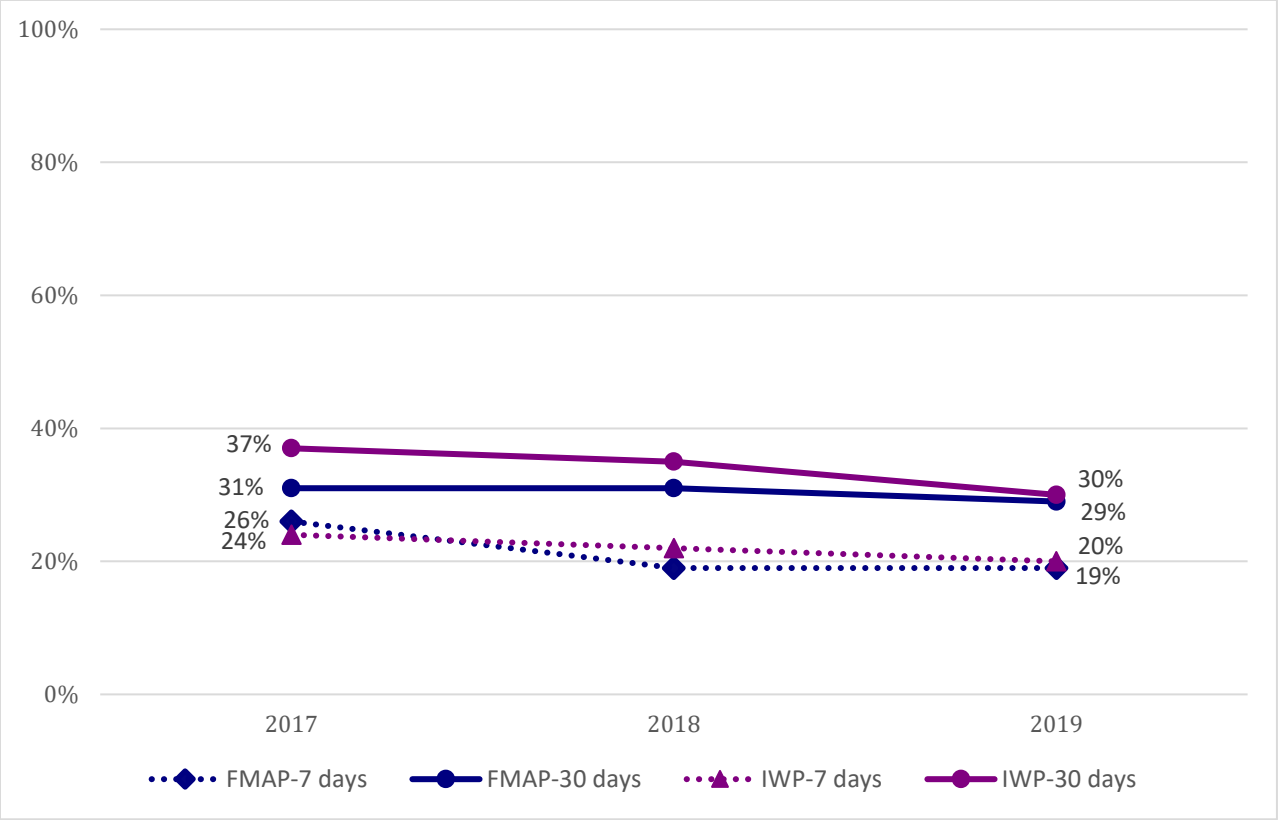


Figure 11. Percentage of individuals who followed up with a dentist 7 and 30 days after emergency department visits for non-traumatic dental conditions



Data labels indicate percentage of individuals who followed up by age and length of time.

Table X. Rates of emergency department visits for non-traumatic dental conditions

	FMAP			IWP			DWP 2.0		
	2017 MSP	2018 DWP 2.0	2019 DWP 2.0	2017 DWP 1.0	2018 DWP 2.0	2019 DWP 2.0	2017 Pre-DWP 2.0	2018 DWP 2.0	2019 DWP 2.0
19-44 years of age									
Eligible months	269,126	302,221	339,215	716,704	824,113	973,835	985,830	1,126,334	1,313,050
Number of visits	583	579	686	1,098	994	1,259	1,681	1,573	1,945
Visits/1000 months	2.17	1.92	2.02	1.53	1.21	1.29	1.71	1.40	1.48
% change		-11.5%	+5.2%		-20.9%	+6.6%		-18.1%	+5.7
45-64 years of age									
Eligible months	39,554	45,330	50,303	458,254	489,731	517,338	497,808	535,061	567,641
Number of visits	35	37	43	298	304	333	333	341	376
Visits/1000 months	0.88	0.82	0.85	0.65	0.62	0.64	0.67	0.64	0.66
% change		-6.8%	+3.7%		-4.6%	+3.2%		-4.5%	+3.1%

Table X. Rates of follow-up dental visits within 7 and 30 days after emergency department visits for non-traumatic dental conditions

	FMAP			IWP			DWP 2.0		
	2017 MSP	2018 DWP 2.0	2019 DWP 2.0	2017 DWP 1.0	2018 DWP 2.0	2019 DWP 2.0	2017 Pre-DWP 2.0	2018 DWP 2.0	2019 DWP 2.0
Eligible months	308,680	347,551	389,518	1,174,958	1,313,844	1,491173	1,483,638	1,661,395	1,880,691
Number of ED visits	618	616	729	1,396	1,298	1,592	2,014	1,914	2,321
ED visits/1000 months	2.00	1.77	1.87	1.19	0.99	1.07	1.36	1.15	1.23
Follow-up within:									
7 days	26%	19%	19%	24%	22%	20%	25%	21%	19%
30 days	39%	31%	29%	37%	35%	30%	38%	34%	29%

Hypothesis 1.3 summary

Utilization of the ED for non-traumatic dental conditions has remained relatively stable since 2017 – the year prior to implementation of DWP 2.0. Adults aged 19-44 utilize the ED at higher rates than older DWP 2.0 members. Rates of follow-up with a dentist showed a continued, slight decrease since implementation of DWP 2.0.

Evaluation Question 2 - What are provider attitudes towards the DWP?

Hypothesis 2.1: The DWP 2.0 benefit structure will not be perceived by dentists as a barrier to providing care.

This hypothesis examines dentists' acceptance of new patients and attitudes towards DWP 2.0 using survey data.

Measure 21: Dentist willingness to accept new patients

Overall, 28.8% of general dentists in private practice were accepting new DWP patients, with 2.6% accepting all new patients, and 26.2% accepting some new patients (Figure 12). This represents a decrease in dentists' self-reported DWP acceptance of new patients from 42% in 2015 and 2016 (Figure 13).

Among dentists who reported only accepting some patients, the most common limits placed on new DWP patient acceptance were:

- Referrals or family members of existing patients (72%)
- Set number of new DWP patients (34%)
- Emergencies (29%)

Figure 12. Level of acceptance of new DWP patients, 2019 Iowa Dentist Survey

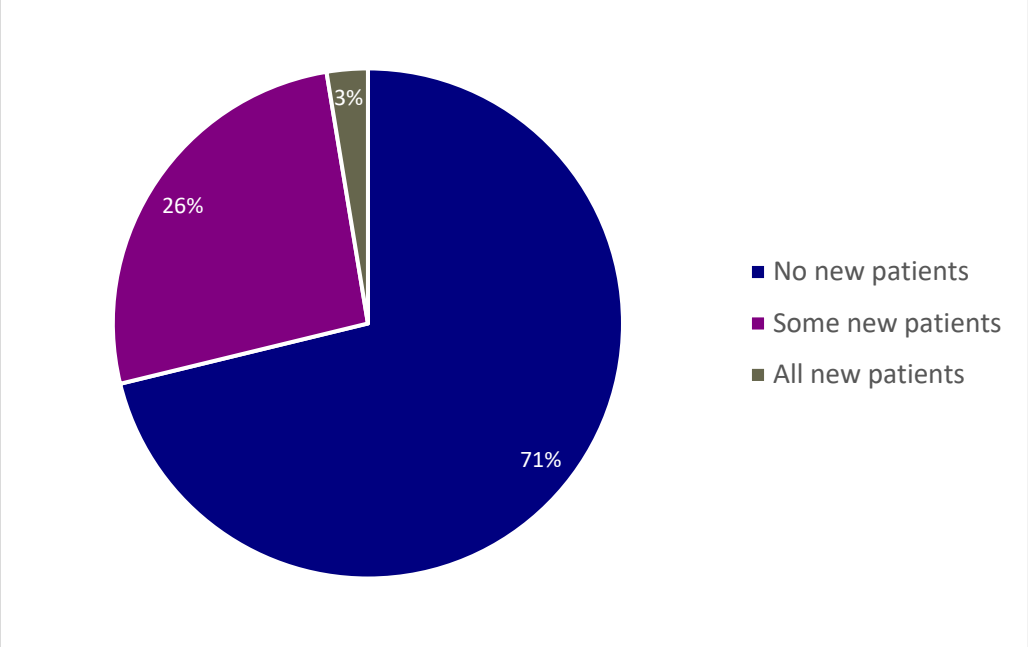
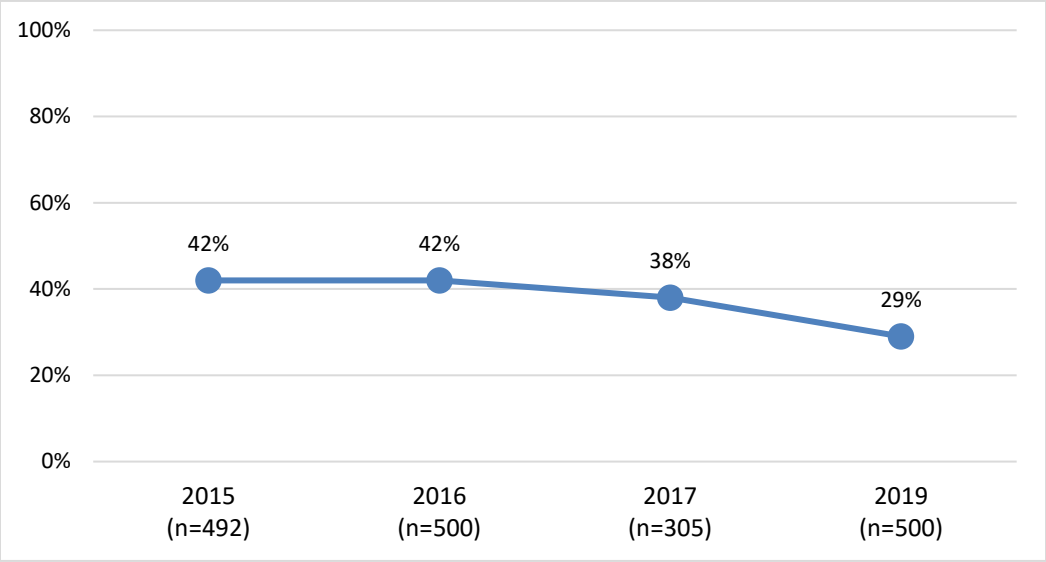


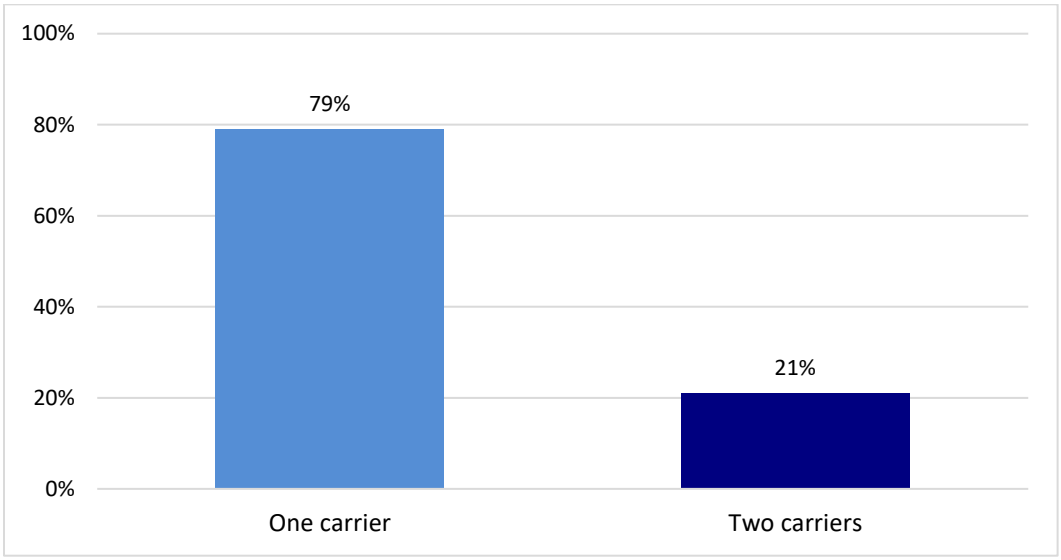
Figure 13. Self-reported acceptance of any new DWP patients over time, general dentists in private practice



Data sources: DWP provider surveys conducted by the PPC in 2015, 2016, 2017, and 2019.

Figure 14 shows the total number of DWP carriers that dentists participate with. Among dentists currently accepting any new DWP patients, 79% only accepted patients from a single DWP carrier (either Delta Dental of Iowa or MCNA), whereas 21% accepted patients from both carriers (Figure 14).

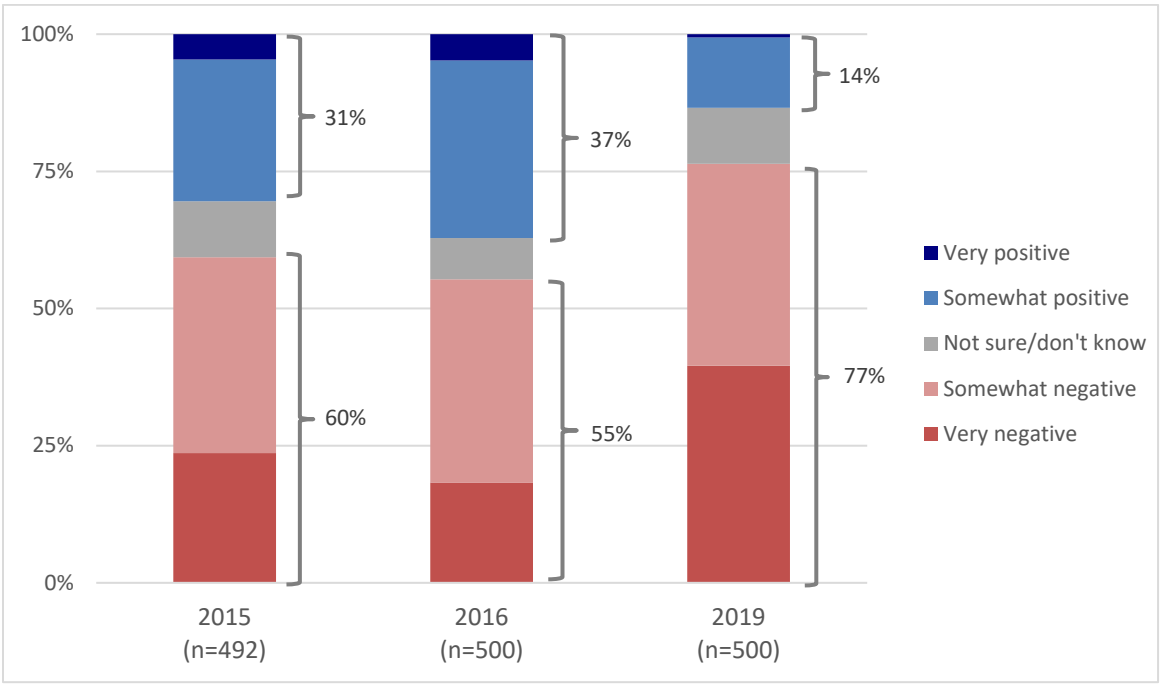
Figure 14. DWP patient acceptance by total number of carriers, general dentists accepting new DWP patients, 2019 Iowa Dentist Survey



Measure 22: Dentist satisfaction with DWP 2.0

As of spring 2019, a majority (77%) of the dentists surveyed reported a negative attitude towards the DWP 2.0 (Figure 15 Figure 15). This represents an increase in negative dentist attitudes toward the DWP since 2015 and 2016.

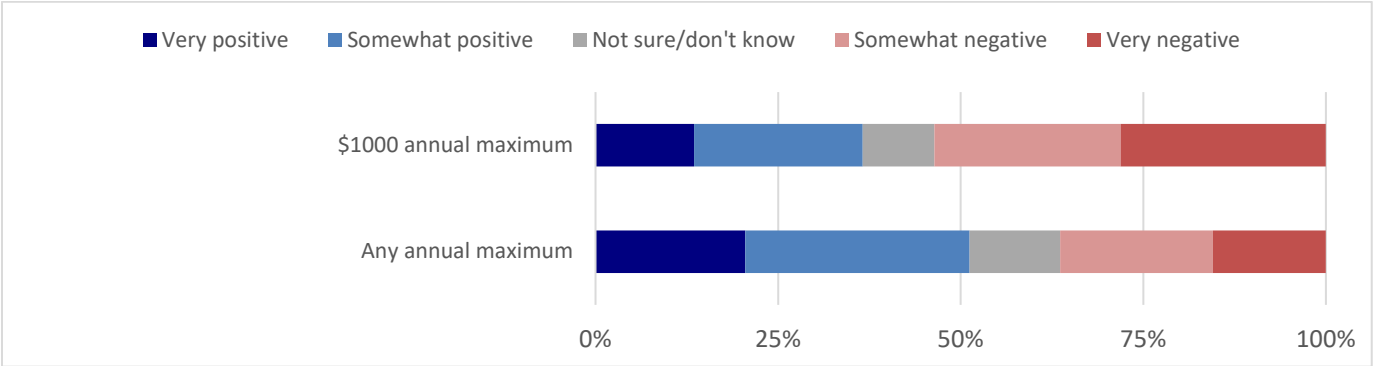
Figure 15. Dentists' overall attitude toward DWP 2.0, general dentists in private practice over time



Data sources: DWP provider surveys conducted by the PPC in 2015, 2016, and 2019.

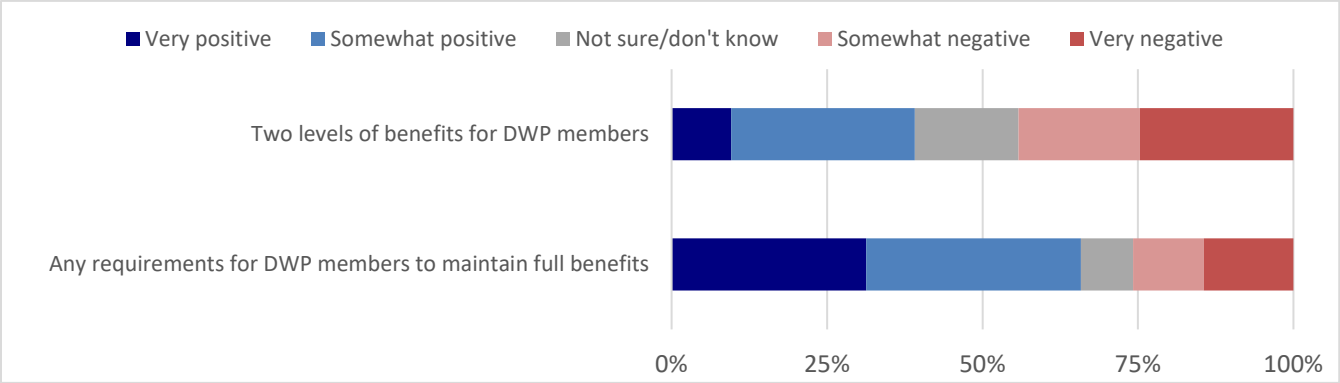
Regarding some of the specific components of the program, a majority of dentists (52%) had positive attitudes toward having *any* annual maximum; however, only 37% had favorable attitudes toward $1000 as the annual limit (Figure 16).

Figure 16. Dentists' attitudes toward the annual benefit maximum, 2019 Dentist survey



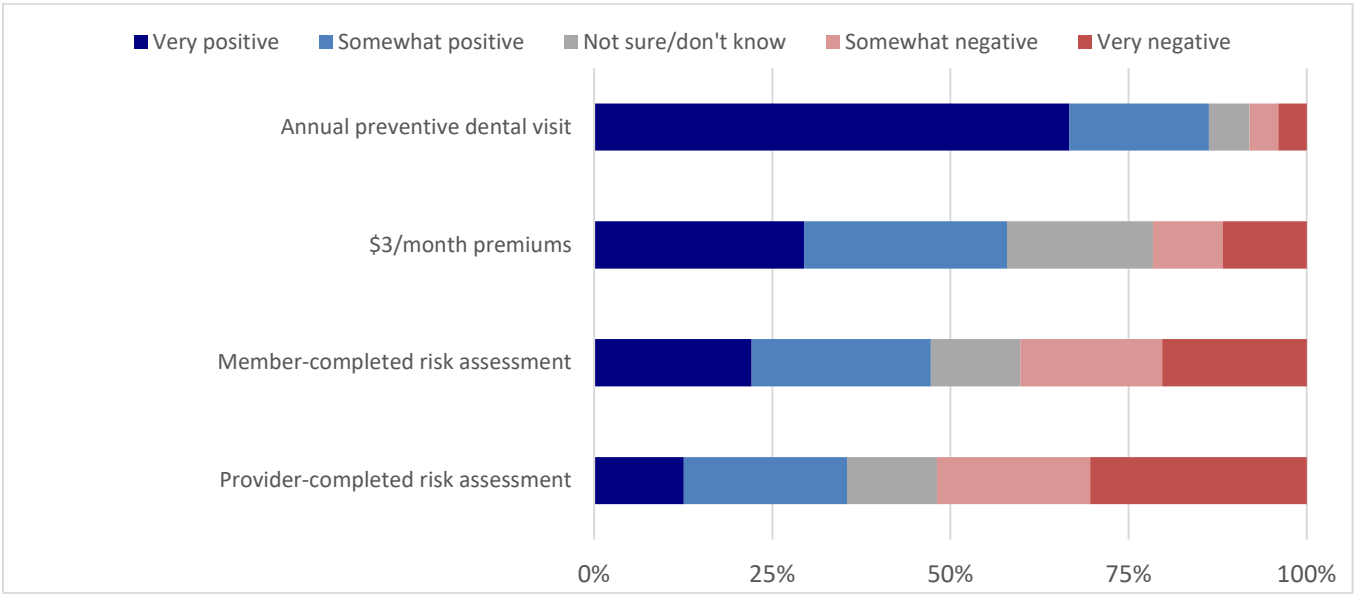
Dentists were generally favorable about having *any* requirements to maintain full benefits in general, however, were mixed about having the existing two benefit levels (Figure 17).

Figure 17. Dentists' attitudes toward aspects of the DWP 2.0 plan structure, 2019 Dentist survey



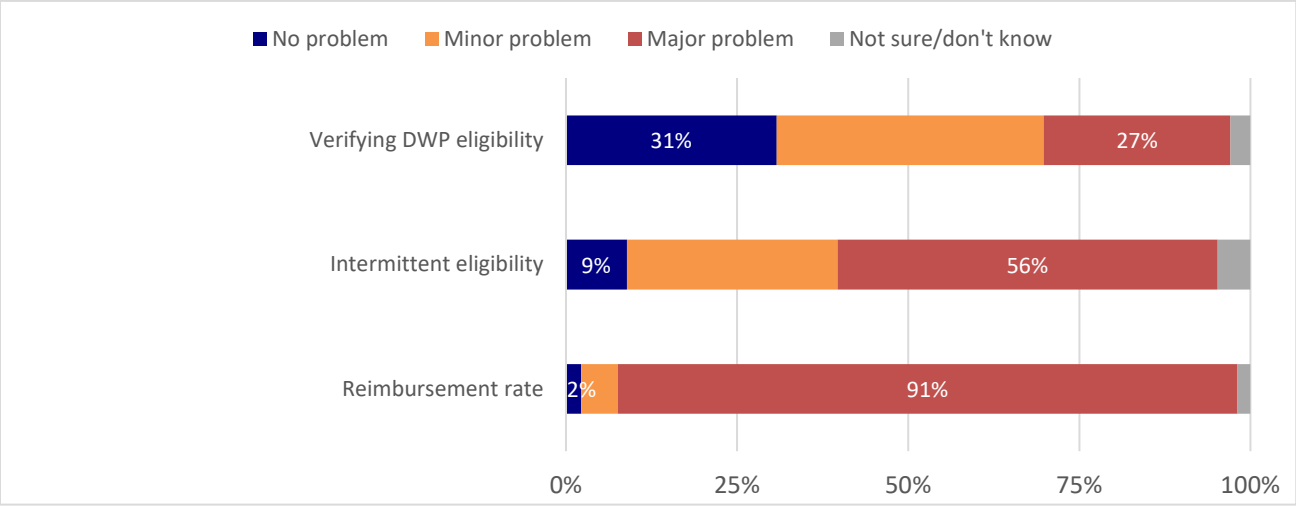
The type of program requirement dentists viewed most favorably was the annual preventive dental visit, whereas the provider-completed risk assessment was viewed least favorably (Figure 18Figure 18).

Figure 18. Dentists' attitudes toward types of requirements to maintain full benefits, 2019 Dentist survey



Among dentists who had participated in DWP 2.0 at some point since August 2017, only 27% viewed verifying DWP eligibility as a major problem, whereas 91% viewed the reimbursement rate as a major problem (Figure 19).

Figure 19. Dentists' attitudes toward administrative aspects of the DWP 2.0 program, 2019 Dentist survey



Summary of open-ended comments from dentists

Dentists were asked to provide comments regarding the following:

- DWP 2.0 benefit structure
- Change in acceptance of DWP patients from DWP 1.0 to DWP 2.0
- Change in acceptance of Medicaid-enrolled children
- Most important change that could be made to improve the DWP

We received a total of 547 comments across the open-ended questions that were asked. The complete list of comments can be found in Appendix B. Since some comments span multiple categories, they are listed in more than one table.

Themes about the benefit structure primarily focused on reimbursement, administrative burden, and healthy behavior requirements. Dentists felt doubly burdened by low reimbursement for services coupled with administrative requirements of tracking eligibility, benefit levels, healthy behaviors, and remaining annual benefits. Many providers felt ambivalent about the healthy behavior requirements and annual maximums, noting that they like the idea of the healthy behavior requirements but it is too burdensome administratively on the provider. Similarly, some providers liked the idea of an annual maximum, but noted that it was difficult to track and that $1000 often does not cover needed services, while others had more negative attitudes toward having an annual maximum as a whole.

There was a broad theme of lack of patient awareness about the benefit structure, including benefit levels, healthy behavior requirements and annual maximum. Dentists commonly noted that patients' lack of awareness of the healthy behavior requirements often resulted in loss of coverage or extra work for the provider to explain the benefit structure or complete the self-assessment.

Among those who had indicated a change in their acceptance of DWP patients from DWP 1.0 to 2.0, they were asked to describe how their acceptance changed. Almost all comments indicated either a reduction or elimination of DWP patient acceptance. When asked why their acceptance changed, the most common reason was reimbursement. Among those who indicated a change in acceptance of Medicaid-enrolled children, the most common type of change was reduced or discontinued acceptance, similarly primarily due to reimbursement.

When asked about the most important change that could be made to improve the program, the most common theme was reimbursement.

Hypothesis 2.1 summary

There has been a steady decline in self-reported private practice dentist participation since 2015, with a concomitant increase in unfavorable attitudes toward the DWP program overall. Among dentists who are accepting new DWP patients, most only accept one carrier. Regarding program structure, dentists viewed the annual preventive visit most favorably and the $1000 annual maximum least favorably. And a large majority of dentists with program experienced viewed reimbursement as a major problem.

Hypothesis 2.2: Over 50% of DWP 2.0 providers will remain in the plan for at least 3 years.

This hypothesis examines access to emergency dental services using administrative data.

Measure 23: Proportion of long term dental providers

In 2019, 1,185 providers provided 1 or more DWP 2.0 patient visits. Providers include dentists and federally qualified health centers (FQHCs). Unique providers per year are provided in Table 5. Approximately 97% of claims in 2017 were submitted by dentists and 3% were submitted by clinics (e.g., Federally Qualified Health Centers), as indicated by the provider type listed on dental claims.

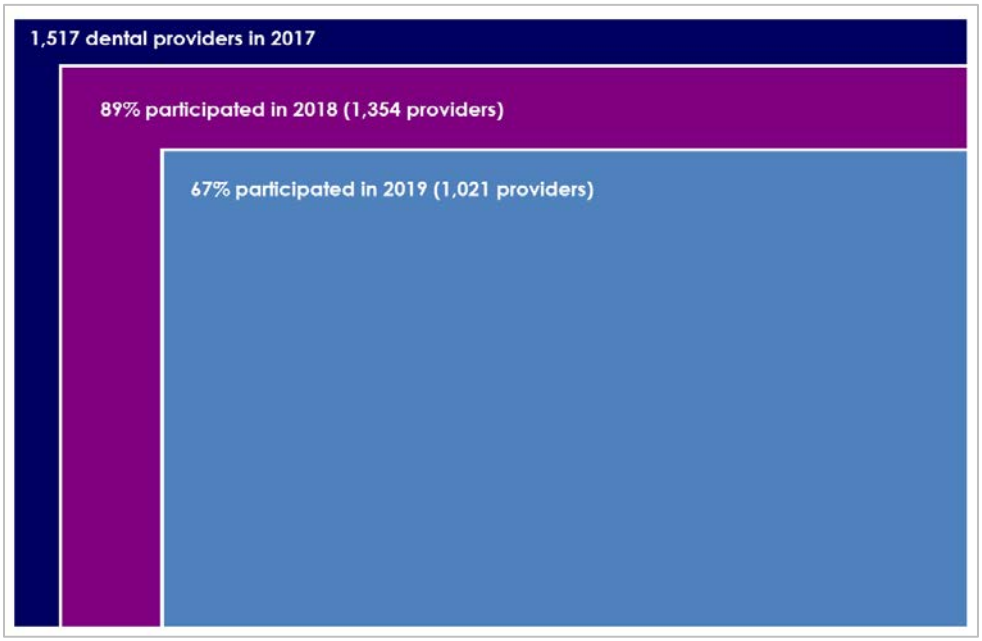
Table 5. Participating providers‡ and number of DWP patient visits* per provider

	DWP 1.0		DWP 2.0			
	2017		2018		2019	
Visits per participating provider	Number of providers	Percent	Number of providers	Percent	Number of providers	Percent
1 visit	69	5%	55	4%	43	9%
2-25 visits	304	20%	339	25%	210	26%
26-100 visits	279	18%	268	20%	244	25%
>100 visits	865	57%	692	51%	688	40%
Total unique dentists	1,517	100%	1,354	100%	1,185	100%

*Visits for DWP 2.0 patients in all eligibility categories with at least 1 month of eligibility (2019 N=320,658)
‡Unique providers identified by NPI. Providers include dentists and Federally Qualified Health Centers.

Among participating providers from 2017 (N=1,517), 89% also participated in 2018, and 67% participated in 2019 (Figure 20). Note: although 1,021 providers from 2017 also participated in 2019, additional dentists provided care in 2019, which brought the total number of providers to 1,185 (Table 5).

Figure 20. Long term dental providers, 2017-2019



Hypothesis 2.2 summary

The number of dental providers participating in DWP 2.0 decreased by 12% from 2018 to 2019. Among the 1,517 dental providers who participated in DWP 1.0 in 2017, 67% remained in 2019.

Evaluation Question 3 - What are the effects of the benefit structure – including healthy behavior requirements, cost sharing, and reduced benefits – on DWP member outcomes?

Hypothesis 3.1: The benefit structure for DWP 2.0 members will increase regular use of recall dental exams over the study period.

This hypothesis examines routine utilization of dental care using administrative data.

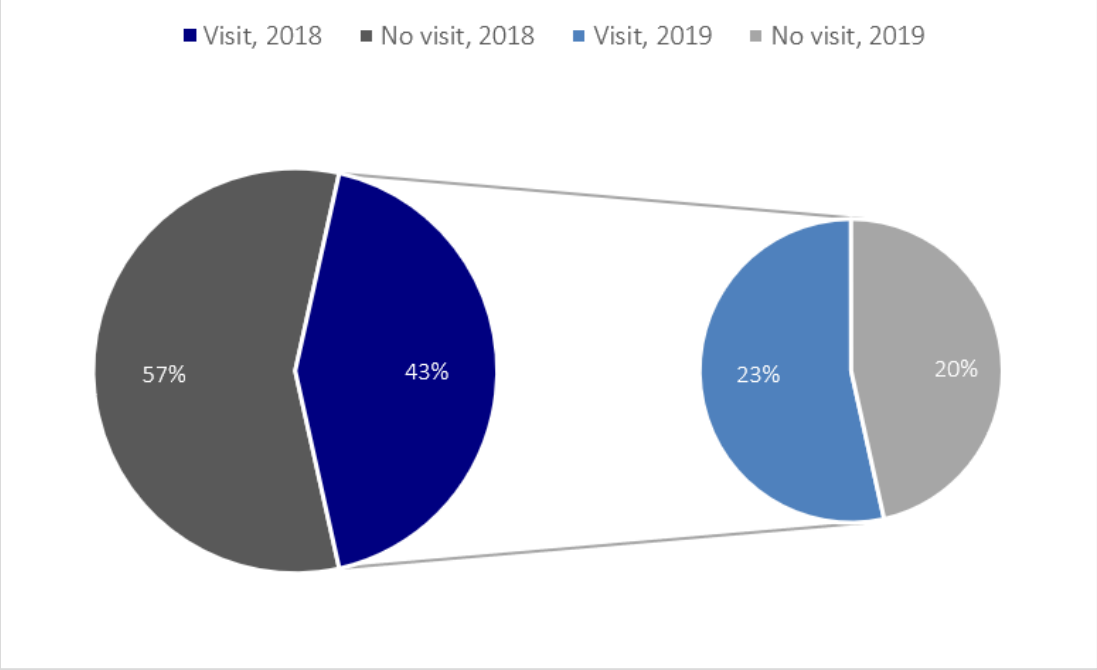
Measure 25: Routine dental examination [See Measure 4]

Measure 26: Dental recall visit

Measure 26 and Measure 34 are equivalent. This measure indicates the proportion of members who had a second preventive dental visit within 4-12 months of their first visit. Preventive dental visits are defined here to correspond to the healthy behavior requirement for an annual preventive dental visit. The study population includes members with 11-12 months of eligibility in 2018 and in 2019 (n=80,783).

Overall, 43% of DWP 2.0 members had a preventive dental visit in Year 1 and 23% had a second preventive dental visit in 2019 (Figure 21). Members who were subject to the healthy behavior requirements in order to avoid monthly premiums were more likely to receive a second dental visit than members who were considered exempt (29% vs. 20%, respectively).

Figure 21. Annual preventive dental visits in first and second years of DWP 2.0 eligibility



Hypothesis 3.1 summary

Measure 1 shows that 31% of all DWP 2.0 members had an annual preventive dental visit in 2019. Measure 4 shows that 27% of individuals who were newly eligible in 2019 had an annual preventive dental visit. Measure 26 shows that 23% of individuals who were newly eligible in 2018 had an annual preventive dental visit in 2018 and 2019.

Hypothesis 3.3: In year 2 of the DWP 2.0 and beyond, use of preventive dental care will be greater than in the first year of the program. This hypothesis will be addressed by measures associated with Hypothesis 3.1.

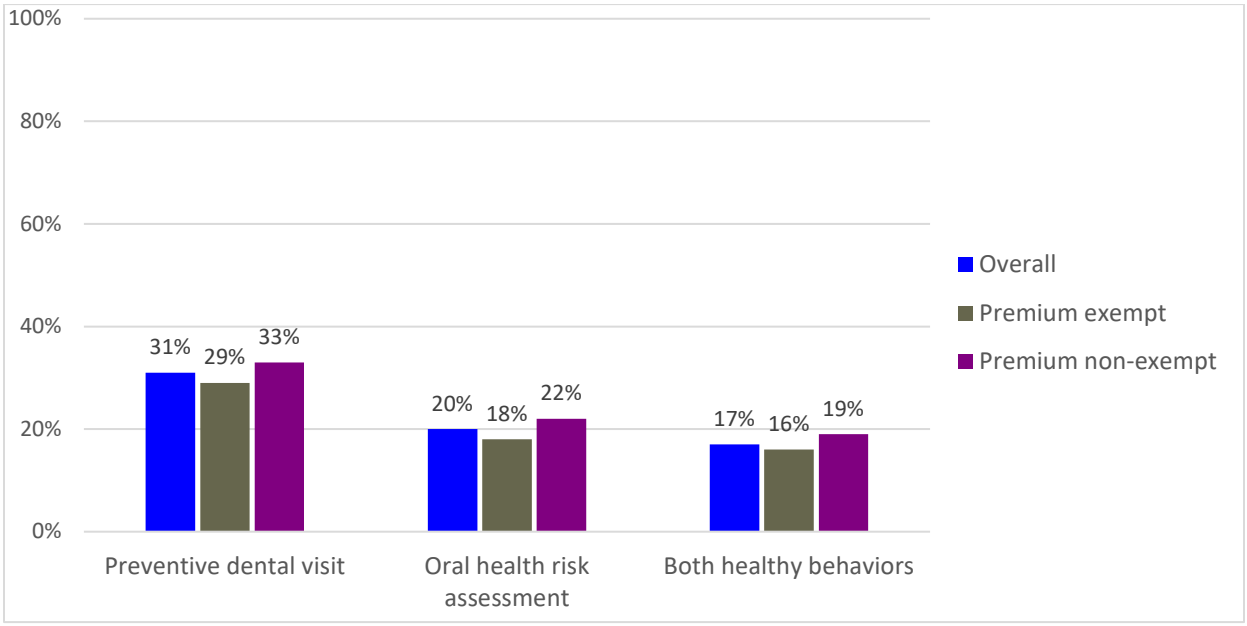
See Measure 4

Hypothesis 3.4: DWP 2.0 policies will promote member compliance with healthy dental behavior requirements.

Measure 28: Member compliance with healthy behavior requirements

Figure 22 depicts members' compliance with healthy dental behaviors in the second year of the DWP 2.0 program (2019). Overall, a greater proportion of members completed the preventive dental visit requirement compared to the oral health self-assessment requirement (31% vs. 20%). A comparison of members who were exempt from the monthly premium requirements versus those who were not shows that premium non-exempt members were more likely to complete both healthy behaviors compared to the premium-exempt group.

Figure 22. Completion of healthy dental behavior requirements



Premium exempt=categorically exempt from monthly premiums
Annual preventive dental visit determined based on claims data.

Hypothesis 3.4 summary

Approximately 1 in 3 DWP 2.0 members completed the requirement for an annual preventive dental visit; 1 in 5 completed the oral health self-assessment.

Evaluation Question 4 - What are the effects of DWP member outreach and referral services?

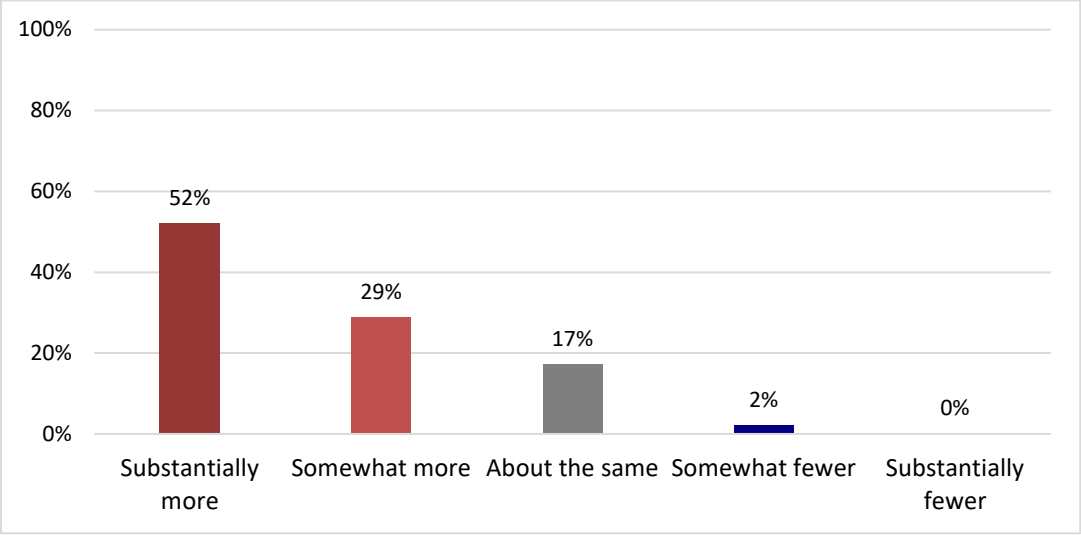
Hypothesis 4.1 DWP 2.0 member outreach services will address dentists' concerns about missed appointments.

This hypothesis uses survey data to examine dentists' concern with missed appointments.

Measure 29: Dentist perceptions of missed appointments

Among dentists who had participated in DWP at some point since August 2017, more than 8 in 10 reported that DWP patients have more broken appointments compared to non-DWP adult patients (Figure 23).

Figure 23. Dentists' perceptions of the frequency of missed appointments among DWP patients compared to non-DWP patients, 2019 Dentist Survey



Hypothesis 4.1 summary

Dentists perceived a substantially higher frequency of broken appointments among DWP members compared to non-DWP patients.

Hypothesis 4.2 DWP 2.0 member referral services will improve access to specialty care for DWP 2.0 members as compared to FMAP members prior to July 1, 2017.

This hypothesis compares self-reported need and access to specialty care for DWP 2.0 members and previously FMAP members.

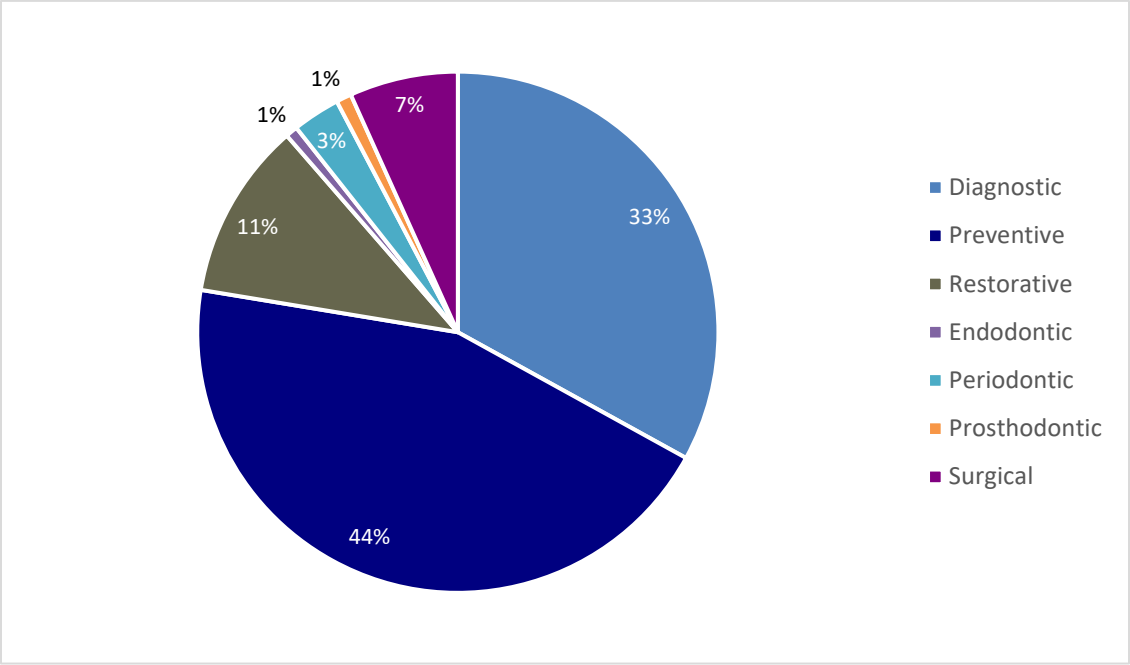
Measure 32: Utilization of specialty dental services

In the 2018 DWP 2.0 Consumer Survey, 36% of respondents reported unmet need for specialty dental care. Approximately half of respondents reported never or sometimes obtaining specialty dental care as soon as wanted. In the 2018 DWP 2.0 Consumer Survey, the most common type of unmet need was for tooth extractions or other oral surgery, followed by root canals or other endodontic treatment.

Figure 24 shows the percentage of services provided to DWP 2.0 members by service category. Although some of the comparisons between the IWP and FMAP comparison groups were different at statistically significant levels, the relative magnitude of differences was not meaningful (i.e. <1% difference). Therefore, results are presented here for the combined DWP 2.0 population.

Over three-quarters of services (77%) provided to the study population were for diagnostic or preventive services. The most frequently provided service was a dental prophylaxis (D1110), which accounted for 15% of all services. The second most frequently provided service was a periodic oral evaluation for an established patient (D0120), accounting for 14% of services.

Figure 24. Percentage of dental services by category provided to DWP 2.0 members, 2019



Services are categorized by Current Dental Terminology classifications.
Includes members with 11-12 months of eligibility in 2019

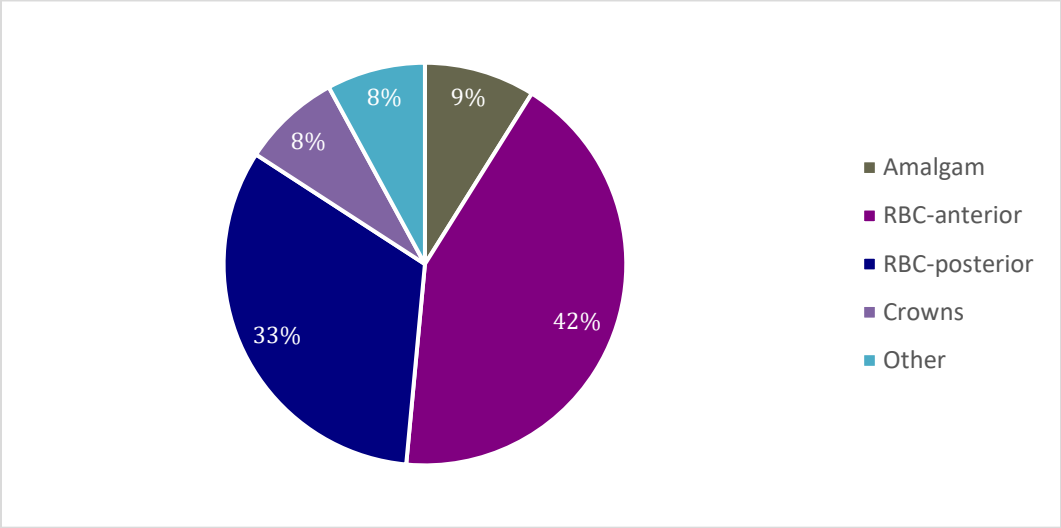
Diagnostic and Preventive Services

Receipt of diagnostic and preventive services are described with Measure 5.

Restorative Services

Figure 25 shows the proportion of restorative services by type of restoration that were provided to DWP 2.0 members in 2019. Anterior resin-based composite (RBC) restorations accounted for 42% of all restorative services, while about 1/3 of all restorations were posterior RBCs . With 5,170 units, crowns (single restorations only) accounted for 8% of restorative services and 1% of all services. Approximately 2% of the study population (n=3,383 members) received 1 or more crowns.

Figure 25. Percentage of restorative services by type provided to DWP 2.0 members, 2019



"Other" category includes inlays, onlays, temporary restorations, core buildups, crown repairs, etc.
RBC=Resin-based composite
Includes members with 11-12 months of eligibility in 2019

Endodontic Services

Endodontic procedures accounted for 1% of services provided in 2019 to the study population. The majority of endodontic services – 82% - were for endodontic therapy, or root canal treatments. Two percent of the study population received any endodontic service in 2019.

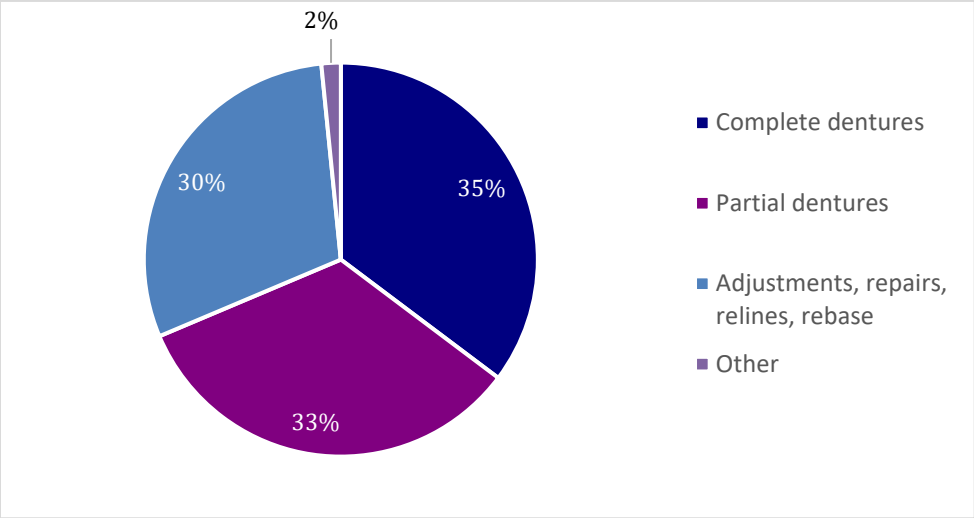
Periodontal Services

Periodontal scaling and root planning (i.e., "deep cleanings"), along with periodontal maintenance, accounted for 95% of periodontal services provided to the study population. Four percent of the study population received any periodontal service in 2019.

Prosthodontic Services

Two percent of the study population received any prosthodontic services. Prosthodontic services largely included complete or partial dentures, or repairs made to existing prostheses (Figure 26).

Figure 26. Percentage of prosthodontic services by type provided to DWP 2.0 members, 2019



"Other" category includes interim prostheses, tissue conditioning, overdentures, etc.

Surgical Services

Surgical procedures accounted for 7% of services provided to the study population (Figure 24). Ninety-six percent of surgical procedures were tooth extractions. Eight percent of members with 11-12 months of eligibility in 2019 received 1 or more extractions. Mean number of extractions per patient was 3 (SD 4), with 25% of patients receiving 4 or more extractions. The most common surgical procedure not involving an extraction was alveoloplasty – a procedure to reshape bone, usually performed in preparation for a prosthesis (e.g., complete or partial dentures).

Hypothesis 4.2 summary

Three in four services provided to the study population were for diagnostic and preventive services. Restorative procedures, including amalgam and composite fillings, were the next most common services. Surgical procedures overwhelmingly were for tooth extractions. Combined, endodontic, periodontal, and prosthodontic services accounted for less than 10% of services provided in 2019. Fewer than 1% of the study population received root canal treatments.

Hypothesis 4.3: DWP 2.0 member outreach will improve DWP 2.0 members' compliance with follow-up visits, including recall exams, as compared to DWP 1.0 and FMAP members.

This hypothesis examines care continuity using administrative data. Figure 27 provides a flow diagram showing the study population and relationships between Measures 26, 34, and 35.

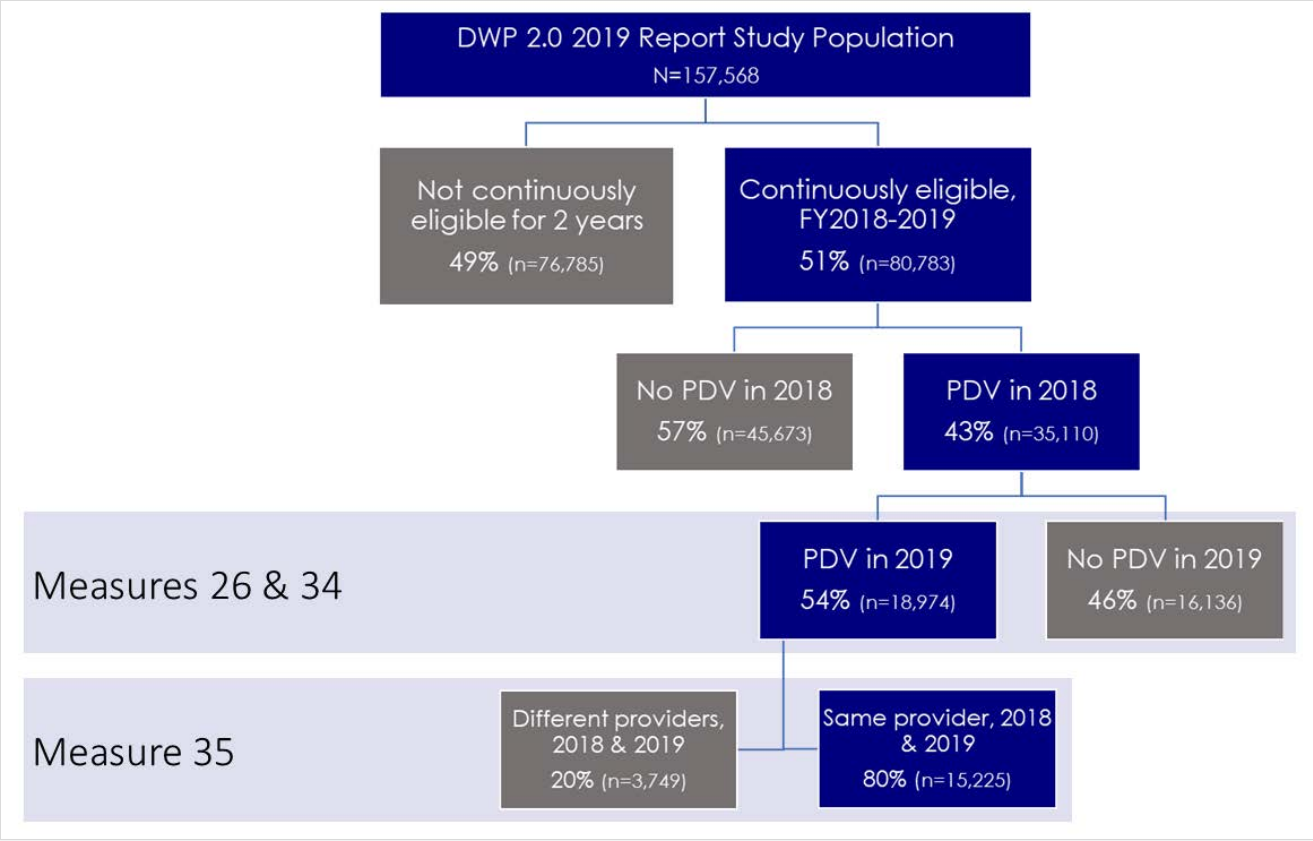
Measure 34: Care continuity – see Measure 26

This measure indicates the proportion of members in DWP 2.0 with at least 2 years of continuous enrollment (2018-2019) who had an annual preventive dental visit in both years. Twenty-three percent of the eligible study population had an annual preventive dental visit in Year 1 and Year 2 of DWP 2.0. Considered another way, 43% had a comprehensive exam in the first year and 54% of those individuals also had an annual dental visit in 2019.

Measure 35: Usual source of dental visits

This measure also examines routine dental care among members with 2 years of eligibility (2018 and 2019), but also considers whether the individual saw the same dentist for both visits. Eighty percent (n=15,225) of individuals with 2 continuous preventive dental visits (Measure 34) saw the same provider for both visits.

Figure 27. Study population and outcomes, Measures 26, 34, and 35



PDV=preventive dental visit

Hypothesis 4.3 summary

Care continuity could not be evaluated previously. In 2019, 54% of continuously enrolled individuals with a visit in 2018 also had an annual preventive dental visit in 2019. Among those members, 80% saw the same provider for both their 2018 and 2019 visits.

Conclusions and Policy Implications

In 2019, the impact of the healthy behavior requirements on dental utilization is unclear for several reasons:

- Over half (57%) of the DWP 2.0 members were exempt from the requirements, including 87% of the FMAP comparison group, (Table 3 & Table 4).
- Among members who were not exempt from the requirements, very few (10%) maintained full benefits by completing the two required healthy behaviors (Figure 22). This resulted in a small proportion of DWP 2.0 members (7%) being moved from full to basic dental benefits in 2019 after failing to complete the two required healthy behaviors or pay monthly premiums (Figure 3).
- Future evaluations should examine whether members are preferentially choosing to pay monthly premiums in lieu of completing the healthy behaviors. Data availability limited our ability to examine this for 2019. Additionally, data about material hardship exemptions were not available to us. Anecdotally, however, IME has indicated that these exemptions are not uncommon.

Findings from this evaluation indicate several areas for potential concern regarding the DWP 2.0 provider network. Several measures indicate that DWP 2.0 members face barriers to receiving care from a dentist:

- Participation among dentists has declined since 2017 (Figure 20), with 29% of 2019 survey respondents indicating that they accept at least some new DWP 2.0 patients, with only 3% accepting all new DWP 2.0 patients (Figure 13).
- The proportion of dentists providing more than 100 visits per year has declined since 2017 (Table 5). In 2019, the majority of participating dentists accepted patients from only one carrier (either Delta Dental or MCNA) (Figure 14).
- Rates of emergency department utilization for non-traumatic dental conditions by DWP 2.0 members appear relatively stable (Figure 8 & Figure 9). However, due to increased numbers of enrollees, this translated into 77 fewer ED visits in FY2019 than would be expected based on FY2018 rates. Rates of follow-up with a dentist after an emergency department visit appear to be decreasing (Figure 11). Combined with the other findings of this evaluation, this may also indicate barriers to finding a dentist.
- Rates of first preventive dental visits for new members (Measure 4) are lower than visits for other members.
- Care continuity between 2018 and 2019 (Measures 26 and 34) shows that many members with a visit in 2018 did not receive a second one in 2019.
- The majority of services that DWP 2.0 patients received in 2019 were for diagnostic or preventive care (Figure 24). In the 2018 survey, DWP 2.0 members indicated the greatest unmet need for surgical and endodontic care. Future evaluations should consider whether a large amount of unmet need for extractions still remains.

Appendix A. 2019 Dentist Survey Instrument with Descriptive Results

Note: References to DWP carriers have been edited as Carrier 1 and Carrier 2. Results provided for general dentists only.

The University of Iowa Public Policy Center

Dentist Survey: Iowa's Adult Medicaid Program

Survey instructions: Answer each question by marking the box to the left of your answer.

You are sometimes told to skip over some questions in this survey. When this happens you will see an arrow with a note that tells you what question to answer next, like this:

☐ Yes
☐ No ➔ If No, Go to #4

If you make a mistake, please cross out the incorrect answer and circle the correct answer. If there is a question that you are uncomfortable answering, feel free to skip to the next question. If you have questions, please call 1-800-710-8891.

If you practice in more than one location, please answer the questions in this survey as they pertain to what you consider your *primary practice location.*

THE DENTAL WELLNESS PLAN (DWP) 2.0 PROGRAM

1. In August 2017, the state implemented DWP 2.0, which joined previous adult Medicaid and DWP 1.0 members into a single program. Which of the following aspects of the current DWP 2.0 program were you aware of prior to this survey? *Select all that apply.*
   - [1] ☐ All DWP 2.0 members are eligible for comprehensive dental coverage their first year in the program 56%
   - [2] ☐ To maintain comprehensive coverage, members must have a preventive visit and complete a self-risk assessment every 12 months, otherwise they will have to pay a $3/month premium 60%
   - [3] ☐ If members do not pay the $3 premium, dental coverage will be reduced to basic benefits (e.g., preventive and emergency services) only 42%
   - [4] ☐ As of September 2018, DWP 2.0 members have an annual benefit maximum of $1000 68%
   - [5] ☐ None; I was not aware of any of these 23%

2. What best describes your overall attitude toward the Dental Wellness Plan 2.0?
   - [1] ☐ Very positive 1%
   - [2] ☐ Somewhat positive 13%
   - [3] ☐ Somewhat negative 37%
   - [4] ☐ Very negative 40%
   - [5] ☐ Not sure/Don't know 10%

3. What best describes your attitude toward having two levels of benefits for DWP members? (i.e. full benefits in the first year, and basic benefits if members do not meet healthy behavior requirements)
   - [1] ☐ Very positive 10%
   - [2] ☐ Somewhat positive 30%
   - [3] ☐ Somewhat negative 20%
   - [4] ☐ Very negative 25%
   - [5] ☐ Not sure/Don't know 17%

4. What best describes your attitude toward having <u>any</u> requirements that DWP members must complete in order to maintain full benefits?
   - [1] ☐ Very positive 31%
   - [2] ☐ Somewhat positive 35%
   - [3] ☐ Somewhat negative 11%
   - [4] ☐ Very negative 14%
   - [5] ☐ Not sure/Don't know 8%

5. What best describes your attitude toward having a $1000 annual benefit maximum for DWP members?
   - [1] ☐ Very positive 14%
   - [2] ☐ Somewhat positive 23%
   - [3] ☐ Somewhat negative 26%
   - [4] ☐ Very negative 28%
   - [5] ☐ Not sure/Don't know 10%

6. What best describes your attitude toward having <u>any</u> annual benefit maximum for DWP members?
   - [1] ☐ Very positive 21%
   - [2] ☐ Somewhat positive 31%
   - [3] ☐ Somewhat negative 21%
   - [4] ☐ Very negative 16%
   - [5] ☐ Not sure/Don't know 12%

7. Please circle the number that best describes your attitude toward each of the following types of requirements for DWP members to maintain full benefits.

	Very positive	*Somewhat positive*	*Somewhat negative*	*Very negative*	*Not sure/ Don't know*
a. Annual preventive dental visit	1 (67%)	2 (20%)	3 (4%)	4 (4%)	NS (6%)
b. Member-completed risk assessment	1 (22%)	2 (25%)	3 (20%)	4 (20%)	NS (13%)
c. Provider-completed risk assessment (used previously in DWP 1.0)	1 (13%)	2 (23%)	3 (22%)	4 (30%)	NS (13%)
d. $3/month premiums	1 (30%)	2 (29%)	3 (10%)	4 (12%)	NS (21%)

8. Do you have any additional comments about the benefit structure of DWP 2.0? (e.g., benefit levels, healthy behavior requirements, annual benefit maximum)

PARTICIPATION IN DWP AND MEDICAID

9. Are you currently accepting <u>new</u> Dental Wellness Plan patients with [<u>Carrier 1</u>]?
   - [1] ☐ Yes, we are accepting <u>all</u> new DWP [Carrier 1] patients 6%
   - [2] ☐ Yes, we are accepting <u>some</u> new DWP [Carrier 1] patients, including: (Select all that apply) 22%
     - [1] ☐ A set number of new DWP [Carrier 1] patients 35%
     - [2] ☐ Referrals or family members of existing patients 72%
     - [3] ☐ Referrals from other dentists/physicians 20%
     - [4] ☐ Emergencies 29%

[5] ☐ Other: 18%_____

[3] ☐ No, we are not accepting any new DWP [Carrier 1] patients 72%

10. Thinking of all the patients you have seen in the past 6 months, approximately how many patients had DWP [Carrier 1]?
    - [1] ☐ 0 30%
    - [2] ☐ 1-10 13%
    - [3] ☐ 11-50 26%
    - [4] ☐ 51-100 15%
    - [5] ☐ More than 100 17%

11. Are you currently accepting new Dental Wellness Plan patients with [Carrier 2]?
    - [1] ☐ Yes, we are accepting all new DWP [Carrier 2] patients 3%
    - [2] ☐ Yes, we are accepting some new DWP [Carrier 2] patients, including: (Select all that apply) 3%
        - [1] ☐ A set number of new DWP [Carrier 2] patients 27%
        - [2] ☐ Referrals or family members of existing patients 67%
        - [3] ☐ Referrals from other dentists/physicians 27%
        - [4] ☐ Emergencies 27%
        - [5] ☐ Other: 20%_____
    - [3] ☐ No, we are not accepting any new DWP [Carrier 2] patients 94%

12. Thinking of all the patients you have seen in the past 6 months, approximately how many patients had DWP [Carrier 2]?
    - [1] ☐ 0 74%
    - [2] ☐ 1-10 13%
    - [3] ☐ 11-50 8%
    - [4] ☐ 51-100 3%
    - [5] ☐ More than 100 3%

13. Has your acceptance of new DWP (either Delta Dental or MCNA Dental) patients changed since DWP 2.0 was implemented in August 2017?
    - [1] ☐ Yes, please describe how it changed: 37%_____
    - [2] ☐ No ➔ Go to #15 63%

14. What are the main reason(s) why your DWP participation changed since DWP 2.0 was implemented in August 2017?

15. Who was *primarily* responsible for making the decision whether your practice would accept DWP patients? *Please select only one.*
    - [1] ☐ I was 48%
    - [2] ☐ The dentists in the practice as a group 24%
    - [3] ☐ The owner of the practice 20%
    - [4] ☐ The clinic management/administration 5%
    - [5] ☐ Other: 2%_____

16. Are you currently accepting new Medicaid-enrolled children as patients (not including Hawk-I)?
    - [1] ☐ Yes, we are accepting all new child Medicaid patients 19%
    - [2] ☐ Yes, we are accepting some new child Medicaid patients, including: (Select all that apply) 30%
        - [1] ☐ A set number of new child Medicaid patients 24%
        - [2] ☐ Referrals or family members of existing patients 80%
        - [3] ☐ Referrals from other dentists/physicians 23%
        - [4] ☐ Emergencies 31%
        - [5] ☐ Other: 9%_____

[3] ☐ No, we are not accepting any new child Medicaid patients 51%

17. Thinking of all the patients you have seen in the past 6 months, approximately how many patients were Medicaid-enrolled children?
    [1] ☐ 0 21%
    [2] ☐ 1-10 16%
    [3] ☐ 11-50 33%
    [4] ☐ 51-100 17%
    [5] ☐ More than 100 14%

18. Has your acceptance of new Medicaid-enrolled children changed since DWP 2.0 was implemented in August 2017?
    [1] ☐ Yes, please describe how it changed: 12%__
    [2] ☐ No ➔ Go to #20 88%

19. What are the main reason(s) why your Medicaid participation changed since DWP 2.0 was implemented in August 2017?

YOUR EXPERIENCES WITH THE DENTAL WELLNESS PLAN

20. Have you participated in the Dental Wellness Plan 2.0 at any time since it was implemented in August 2017?
    [1] ☐ Yes 66%
    [2] ☐ No ➔ Go to #30 34%

For questions 21-29, please answer as they pertain to either your current or past participation in DWP 2.0.

21. Does your office help any of your DWP patients complete their self-risk assessment?
    [1] ☐ Yes, all DWP patients 12%
    [2] ☐ Yes, some DWP patients 26%
    [3] ☐ No 62%

22. In your experience, do your DWP patients have more, the same, or fewer broken appointments compared to non-DWP adult patients?
    [1] ☐ Substantially more 52%
    [2] ☐ Somewhat more 29%
    [3] ☐ About the same 17%
    [4] ☐ Somewhat fewer 2%
    [5] ☐ Substantially fewer 0%

23. Have you had difficulty referring your DWP patients to any dental specialists?
    [1] ☐ Yes 95%
    [2] ☐ No ➔ Go to #25 5%
    [3] ☐ N/A – I am a specialist ➔ Go to #26 0%

24. Which types of dental specialists have you had difficulty referring your DWP patients to?
    Select all that apply.
    [1] ☐ Oral surgeon 88%
    [2] ☐ Periodontist 67%
    [3] ☐ Endodontist 91%
    [4] ☐ Prosthodontist 41%
    [5] ☐ Other: 10%_____

25. Given the differences between public and private insurance, we are interested in the types of services offered to DWP patients compared to privately insured patients. Please select the types of services you typically provide(d) to patients with DWP and with private insurance.

Types of services provided	*DWP patients*	*Private insurance patients*
a. Operative/restorative	☐ 100%	☐ 98%
b. Endodontic (any)	☐ 72%	☐ 79%
c. Scaling and root planing	☐ 85%	☐ 95%
d. Routine extractions	☐ 84%	☐ 87%
e. Crown/bridge	☐ 83%	☐ 97%
f. Removable partial dentures	☐ 78%	☐ 96%
g. Complete dentures	☐ 74%	☐ 92%

26. Among the DWP patients that you have seen since the annual benefit maximum went into effect in September 2018, how many patients were aware of the new $1000 annual maximum?

1☐ All 1%
2☐ Most 7%
3☐ Some 21%
4☐ Few 32%
5☐ None 15%

6☐ Don't know/Not sure 20%
7☐ I haven't seen any DWP patients since September 2018 4%

27. Would you recommend DWP participation to other Iowa dentists?

1☐ Definitely yes 3%
2☐ Probably yes 15%
3☐ Probably no 40%
4☐ Definitely no 41%

28. The following question shows some issues that dentists may have with the DWP. Please circle the number to indicate how much you think that issue is a problem with each carrier in the Dental Wellness Plan.

	Carrier 1				Carrier 2			
	No problem	Minor problem	Major problem	Not sure/ Don't know	No problem	Minor problem	Major problem	Not sure/ Don't know
a. Denial of payment	1 (10%)	2 (47%)	3 (39%)	NS (4%)	1 (3%)	2 (9%)	3 (23%)	NS (65%)
b. Slow payment	1 (51%)	2 (27%)	3 (15%)	NS (7%)	1 (7%)	2 (9%)	3 (17%)	NS (67%)
c. Verifying benefit level (full or basic)	1 (37%)	2 (36%)	3 (22%)	NS (5%)	1 (10%)	2 (8%)	3 (13%)	NS (69%)
d. Verifying risk assessment completion	1 (24%)	2 (34%)	3 (25%)	NS (18%)	1 (6%)	2 (9%)	3 (12%)	NS (73%)
e. Verifying remaining benefit amount toward $1000 annual max	1 (31%)	2 (36%)	3 (29%)	NS (5%)	1 (5%)	2 (12%)	3 (14%)	NS (70%)
f. Overall administrative burden	1 (9%)	2 (29%)	3 (60%)	NS (3%)	1 (2%)	2 (4%)	3 (28%)	NS (66%)

29. How much of a problem are the following administrative aspects of the DWP 2.0 program overall?

	DWP 2.0 Overall			
	No problem	Minor problem	Major problem	Not sure/ Don't know
a. Intermittent eligibility	1 (9%)	2 (31%)	3 (56%)	NS (5%)
b. Verifying DWP eligibility	1 (31%)	2 (39%)	3 (27%)	NS (3%)
c. Reimbursement rate	1 (2%)	2 (5%)	3 (91%)	NS (2%)

PRACTICE SETTING

Finally, we would like to ask some questions about your practice setting to identify how different practice characteristics relate to Iowa dentists' impressions of the Dental Wellness Plan.

30. How would you best describe your practice during the past 12 months?
1☐ Too busy to treat all requesting appointments 14%
2☐ Provided care to all requesting it, but felt overworked 27%
3☐ Provided care to all requesting it, but did not feel overworked 52%
4☐ Not busy enough, would have like more patients 7%

31. In your practice, do you usually work 32 hours or more per week?

1☐ Yes 87%
2☐ No 13%

32. In your primary practice, do you use an electronic health record system for patient records?

1☐ Yes 81%
2☐ No 19%

33. How would you describe your role in your primary practice?

1☐ Solo practice owner 52%
2☐ Partner 23%
3☐ Associate buying into the practice 4%
4☐ Associate not buying into the practice 10%
5☐ Employee in a corporate owned practice (e.g., Aspen, Ocean Dental, Applewhite Dental) 5%
6☐ Other: 6%_____

34. What is the most important change that could be made to improve the Dental Wellness Plan?

35. We are interested in any other comments you may have about the Dental Wellness Plan.

Appendix B. 2019 Dentist Survey Open-ended Comments

Do you have any additional comments about the benefits structure of DWP 2.0? (e.g., benefits levels, healthy behavior requirements, annual benefit maximum)?

All survey respondents

Reimbursement
1. Adds to completing of a program which pays below my breakeven point.
2. If the reimbursement were better we would participate. Too low. Lose money.
3. Numerous times we completed work then find out they have basic. Costs us way too many hours of tracking down claims to be paid 40 cents on the dollar.
4. I like having the patients take initiative, but they do not and cause admin burden. It is not our job to hold their hand when we get 35 cents on the dollar. I have drastically reduced my DWP participation after evaluating risk versus reward.
5. When a member is on basic benefits they do not qualify for fluoride. Fluoride helps prevent further decay, low reimbursement. It would seem appropriate to allow this under basic. Also, full mouth scaling should be covered.
6. Since the providers are being compensated at such a reduced level, why are we then paying tax on what we collected.
7. Horrible reimbursements. Costs for lab are not covered by current level of reimbursement. I didn't think that IME could be made worse by Delta.
8. I think the way this was brought in was very dishonest. Paying dentist, giving much better reimbursement and then taking it all away and basically making it Title XIX pay again, can't run business with these payments.
9. Too much administrative monitoring with too low of reimbursements to be viable.
10. Overhead for providers don't meet with the payback. We are losing money seeing this insurance.
11. The benefit maximum is way too low to stabilize the average patient. The reimbursement rate is obscenely low, preventing the provider to even cover overhead/lab bills.
12. Except for the fee structure everything else is good. This group of people don't show up for their appointments for some reason.
13. We agree the member should be responsible for their dental health. Not monetary. Maximum is too low reimbursement too low, so few offices participate. We are no longer accepting new comprehensive patients. Emergencies only. The bonus for offices was a great idea.
14. Reimbursement is poor, we are almost paying for the patients to be seen.
15. I do participate in this program. I like the idea of the required preventive visits and an annual maximum. But the reimbursements are almost at embarrassing levels. Increase the levels and more dentists will participate, it's really that simple. We don't expect reimbursements to match our fees, but 50% would do wonders.
16. The benefit levels are disgraceful, expecting private practitioners to provide care for reimbursement that does not cover the expense of business overheard.
17. Most provider reimbursement amounts continue to decrease while lab fees and material cost continue to increase.
18. Until the reimbursement rates get much better, this program will fair because of lack of participation by dentists. We cannot see patients and lose money.
19. Benefit levels are atrocious, every patient I see that has DWP, the practice loses money. Therefore, I have to raise my prices which affects the cash and insurance paying patients. I work in a very blue-collar area, which means the majority of my patients have DWP. This will put us out of business if it continuous with the current reimbursement rates.
20. Keeping track of each DWP patient's benefit level, healthy behaviors, and maximum has been tough. When we get reimbursed close to nothing it's very discouraging to continue to care for those patients.
21. If you are going to cap at $1000 per year why not actually reimburse those of us seeing them more to cover our expenses.
22. The annual maximums are too high when considering reimbursement fees. The required preventative visit always turns into extremely extensive Tx plans and is a way for them to get in the door, we've had several patients w/full dentures needing a cleaning apt but don't disclose their dentures. Then they want new dentures and that reimbursement fee is a joke.
23. DWP 2.0 is placing a huge administrative burden on my small business. Not only is the reimbursement low, now I must concern myself as to if the treatment is covered!
24. DWP needs to reimburse more for lab needs barley covers my lab bill for crowns/RPD/dentures.
25. Too much checking status on computer. Compensation 1/3 of what I normally charge. Missed appts/cancel within 24 hours (knows to say family emergency, sick, sick kid, etc.).
26. 1) Yes, get these people healthy, yearly maximums are stupid! More government control; 2) Fee increases, existing fees don't allow lab fees to be paid; 3) No profitability in this model.
27. Reimbursement does not cover costs. Consider all DWP care a donation. Total loss to practice. Pain in the neck to try to monitor max, etc.
28. Negative toward 2.0 because payment for services went down from 1.0 to 2.0 and I also believe they should have to pay a co-pay of $3-$5 at each visit.
29. Instead of worrying about benefit levels and maximums, you should focus on having a higher reimbursement amount for procedures done. Eliminate certain procedures from coverage that are not in basic coverage (ex: crowns, ortho). Providers cannot afford to work on these patients when reimbursement is so low.
30. Benefit levels too low although with fee structure it should carry the patients further.
31. I liked the graduated benefits of the original plan and the reimbursement of the original DWP. Providers were misled into signing onto the plan, then rates decreased with the combining DWP and Medicaid.
32. Original plan had graduated benefits that were earned by going to preventive appointments. Why was that eliminated? Instead they put in this self-risk assessment and then ask providers who are barely being compensated to help them fill these out!? Then it's not really a self-assessment.
33. I liked the graduated benefits of the original plan. I also liked the reimbursement rate of the original DWP. Providers were misled into signing up, and then the reimbursement rates plummeted with combining DWP and Medicaid. Also, we have many patients who struggle mentally, so the self-risk assessment is ridiculous. We are taking (or reducing) benefits on the wrong people! And having staff fill them out is equally ridiculous.
34. We no longer take patients with this insurance as it was way too time consuming, reimbursement was horrible, and requirements change all of the time.

35. As more and more individuals will move to this coverage (undoubtedly) I wonder how dental practices will be able to offer services for patients at these reimbursement levels.
36. Benefit structure no but reimbursement. I do, very poor.
37. DWP should only cover extractions and dentures for adults. Having a $1000 cap means there is no point in private practice accepting DWP as it takes away any possibility of running profit. A better DWP would pay 100% of UCR.
38. Would like to know fee schedule. I have a problem with an insurance company managing a system that can be done by our state.
39. This program is complete garbage. The fee reimbursement is a complete joke and is quite insulting. It's amazing how grocery stores get a dollar for a food stamp, but the dentists and other doctors get 30%.
40. Reimbursement is low, so dentists contribute more than the insurance company does toward the care. These patients have much more dental need than general population. To get them healthy/address their dental needs the $1,000 just isn't enough for patients who have a lot of need.
41. Fee for service doesn't work. I commend the effort in creating this program to provide dental care to the underserved. Expanding facilities i.e. Broadlawns, Davenport Community Health, etc. Paying dentists per diem rate to teach students/monitor them. Providing acute care and continuing the program (preventative, minor restorative) is perfectly fair and paying providers at current rates will not create an increase in participants.
42. Terrible reimbursement.
43. As practices that are busy anything that keeps processing more efficient and increases the reimbursement would help. You are addressing the accountability of the patients, but I hear from other offices that the failure rates of appointments are very high.
44. The annual max is only part of the issue. Bigger problem is the pathetically low reimbursement rate to providers!
45. At first you might think that a dentist would be very positive about healthy behavior requirements as incentives to get the patients there, and keep appointments, etc. but many of these patients will miss appointments (dentist loses) any way, but once you have started treating them, the dentist will be expected (or want) to keep treating them any way (emergencies, etc.) and the dentist still loses. Even if the dentist gets paid, he loses as the reimbursements don't even cover his expenses.
46. Yes, the benefits are great, the reimbursement rate is the problem.
47. Maximize reimbursement with minimal extra paperwork/regulations.
48. It is a restrictive program for dentist who should make treatment decisions, not the government. It has too much paperwork/staff time associated with it for the reimbursement paid.
49. It all boils down to reimbursement. Patient compliance is also an issue to review.
50. The $1000 max wouldn't be so bad if the reimbursement percentage to the dentist was higher. Many procedures are reimbursed at 20% of the fee. There is no way we can afford to see these patients when our overhead is 60-70 %. Try paying a grocery store 20% with food stamps and see if they can make it.
51. This is a nightmare to manage. We do not have a problem with a yearly maximum, but when you start saying some services are not counted toward yearly max, you are setting us all up to fail. Not only does the doctor's reimbursement incredibly low and lower each year, then they are faced with the possibility that we may miss what the patient is entitled to for services. Did they do their risk assessment? Did they pay their premium (Do you really think $3/mo is worth the risk the doctor may take?) We feel we should just take our disability patients with no reimbursement and quit the program. Way too many stipulations. The loser will be the provider. Work will be completed and reimbursement will be denied. We spend more time on IWP patients checking eligibility, remaining benefits, etc. And have had issues that Delta's website is incorrect. Why should we participate in such a program? It is only going to get worse managing our IWP after June 30th.
52. Benefit level is very low. I would like to help with the low income population. I feel these patients need to have more personal resources invested in their dental care. This would make them value their services much more than they do now. It would also help with reimbursement levels.
53. The majority of all DWP have not been seen by a dentist for many, many years due to lack of finances. The majority require ScRP, multiple extractions, removable prosthesis etc. A $1000 max doesn't come close to covering this, even with horrible rates considered fair by DWP. Typical state-aided patients feel entitled and make no attempt to help the benefit max situation.
54. The reimbursements are so poor, my office has stopped taking patients with this insurance. It is not worth me getting out of bed to come in and see patients who have this insurance. If reimbursements would be somewhat normal, then access to care would be changed for the better.
55. Reimbursement needs to be higher. Modern offices cannot afford to treat DWP for the low fees they pay.
56. It is a good idea, but you still lose money for every procedure. I ended up dropping it and seeing a few existing patients and not charging them anything. The time it takes to jump through the hoops for authorization was a waste too. The fiasco of them changing what was allowed, even when a procedure had been pre-authorized, that was the last straw for our office.
57. I am not pleased with any of the changes made to DWP; it was a bait and switch to the dentist. Fees moved to Medicaid level and rescission of the bonus plan.
58. Make members more responsible for their health care and improve the reimbursement for practitioners.
59. Reimbursement does not allow for quality/quantity treatment of these pts as it does not cover overhead of office. Would not be able to stay in business with high volume of pts w/this coverage.
60. Go back to DWP 1.0 with a $2000 maximum. Please increase the reimbursement rates to previous levels under DWP 1.0. The public health clinics are not sustainable at these rates. We need to at least be able to break even. I work at the Story County Dental Clinic.
61. Am very disappointed with the entire program especially reimbursement.

Annual maximum issues
Total dollar amount and services covered under annual max insufficient.

1. I don't believe that the members take the time to do the assessment. $1000 - max is the same max that was used for many ins companies back when I started working 35 years ago.
2. It's great for some, but those who truly need the help and are good pts who can't get all their work done because their annual max has been reached is hard. They need the treatment and can't afford it so they pull their teeth.
3. DWP patients are not a responsible population, getting all treatment done with $1000 is unrealistic because of the amount of work and neglect we see. Changing the program requirements of yr. or of other year for us as providers is insane!

4. $1000 max lets me start to stabilize patients but often times there is so much dental decay that you can't finish and end up waiting a year and waste all the work you've done. Benefit levels can change in the middle of care leaving the provider holding the bag. Patients receiving procedures often receive authorization for a pre-determined benefit only to find the benefit received by the time treatment is finished.
5. $3 premiums should be higher. Maximum hardly covers the work they need, they should see the value of benefit. I like the idea of requirements the DWP member must complete to make them have some responsibility.
6. #3 - 2 programs complicate the system. #4 - Members do not take the responsibility to complete the forms. #5,6 - They get everything for free so why cap the $1000; they never get to see the value of service they receive paying $0. #7 - They can pay more than $3; they always come in with designer purses, fancy nails, tan, hair dyed and designer jeans. Also post on FB all their vacations and excursions that they have $ for.
7. $1000 goes nowhere. Having such a low annual benefit encourages patch work treatment rather than comprehensive care. We aren't focusing on improving dental health, merely getting by.
8. Personally, I like a maximum. Extractions should not be included in max benefits. Make program easier for dentists, so people are either covered or not. Too much messing around with people who are on basic. Calendar year.
9. Benefit levels are too much work to track as a provider. We don't do this with any other insurance company. We would prefer to know that they either have benefits or they don't. The concept of healthy behaviors is beneficial. However, none of our patients were aware that they needed to do it or that it affected their coverage. We like the idea of a max to help teach patients understand how benefits work. That being said, we thought it should apply to all services not just select benefits. Overall, we felt the idea was good but a lot of the responsibility to inform and educate fell on the provider at the consequence of providing services and potentially not being compensated.
10. I like the $1000 annual benefit maximum but sometimes feel extractions shouldn't count towards it. Patients who need full mouth extractions go over this limit so we are forced to leave some teeth behind and then the patient must return for emergency extractions as they occur. This prolongs the patient's condition and takes up extra chair time for us.
11. The benefit maximum is way too low to stabilize the average patient. The reimbursement rate is obscenely low preventing the provider to even cover overhead/lab bills.
12. We agree the member should be responsible for their dental health. Not monetary. Maximum is too low, reimbursement too low so few offices participate. We are no longer accepting new comprehensive patients. Emergencies only. The bonus for offices was a great idea.
13. Difficult to know when the pt. has maximized their annual benefit.
14. The benefit maximum does not allow for appropriate treatment of dental pain. Often patients need more extractions than permitted by the $1,000.
15. We don't mind the assessment but patients don't know about so my office staff has to go over it with them on our time. The $1000 max is outrageous and reimbursement rates are pathetically low.
16. I do not think a benefit max of $1000 would allow much dental treatment.
17. Patients seem to be uninformed how their benefits work so the responsibility to track their benefits and maximums falls upon the provider and it is too time consuming and complex to track.
18. I find myself having to constantly assess what can be done and putting off needed treatment until benefits renew. I have patients with completed pulp debridements who cannot have therapy completed b/c they have met annual max.
19. Even people with dental benefits through their job have an annual max benefit.
20. Should have no annual max!
21. Having the $1000 annual maximum makes comprehensive care non-existent for many of my patients. By the time they save their worst couple teeth, they have a mouth full of basic restorative work that cannot be completed. It's a huge barrier to care and then those teeth end up needing more extensive treatment.
22. We've had patients lose level of benefits for not paying 3.00 or completing risk assessment. These patients have abscessed teeth, caries, gum disease, pain and discomfort and our hands are tied because they go back to basic benefits. This is unconscionable for our profession and I'm embarrassed for dentistry and the State of Iowa. Can you imagine our medical colleagues denying care to diseased patients because of 3.00 or not filling out a risk assessment? Are these statistics and data that is mined from our underserved more important than delivering the best care we are sworn to provide? I can understand the $1,000 yearly maximum as it relates to budget concerns, but I'd be willing to bet that untreated dental disease will be showing up in ER's and medical offices that are a lot more expensive than the $ they saved at dentists.
23. The $1,000/year is not fair for this population, many just did not have the option of going to a dentist as do people who have $1000 max for their work. Workers also have to pay a percentage of their work, i.e. 50% of the cost of a crown!
24. $1000 isn't enough $ to do much. Far too much write off. Embarrassing for staff and member when no benefits.
25. If you are going to cap at $1000 per year why not actually reimburse those of us seeing them more to cover our expenses?
26. The annual maximums are too high when considering reimbursement fees. The required preventative visit always turns into extremely extensive Tx plans and is a way for them to get in the door, we've had several patients with full dentures needing a cleaning apt but don't disclose their dentures. Then they want new dentures and that reimbursement fee is a joke.
27. Maximum is too low and confusing since some things are included and others are not. These patients seek care sporadically and typically need a lot of care when they do present and often they cannot pay anything at all (unlike other patients with conventional insurance).
28. Annual benefit max is helpful.
29. Having benefit caps makes getting required treatment done difficult and pre-authorization takes too long for most procedures.
30. Even though patients are capped at $1000 yearly maximum, they'd still have to get a lot of work done to even come close to that max with how little this plan reimburses. For example, we treatment planned $3300 of work for a patient and he was only at $800/$1000 max. That's less than 30% reimbursement, which is pretty good.
31. 1) Yes, get these people healthy, yearly maximums are stupid! More government control. 2) Fee increases, existing fees don't allow lab fees to be paid. 3) No profitability in this model.
32. $1000 maximum is too low, if they have 1 tooth needing root canal and crown that uses nearly the full yearly maximum.
33. I like the benefit maximum, though some full mouth extractions exceed the limit.
34. The DWP patients we typically see have dental needs far beyond the $1,000 annual maximum.
35. Benefit levels too low although with fee structure it should carry the patients further.
36. I'm not a fan of the $1000 max. A lot of patients on DWP have lots of dental needs and it's hard to find a provider. Why are they making it even more difficult?
37. Benefit level of $1000 is too low. Risk assessment is waste of everyone's time and only benefits insurance companies.
38. I would prefer 1st year without maximum.

39. Annual maximum should be at least $1,500 if not $2,000. I do think a maximum is required. I feel that the services provided should be maintained as basic services. No fixed pros, no posterior Endo.
40. Needs variable maximum yearly benefit depending on individual patient's needs, could be done with proper pre-estimates of need/care.
41. 1) Annual benefit is limiting, often patients have complex needs. It would take 2 years for FMTE and dentures. 3) Tiered benefits put providers in awkward position of relating to pts the limitations.
42. DWP should only cover extractions and dentures for adults. Having a $1000 cap means there is no point in private practice accepting DWP as it takes away any possibility of running profit. A better DWP would pay 100% of UCR.
43. Reimbursement is low, so dentists contribute more than the insurance company does toward the care. These patients have much more dental need than general population. To get them healthy/address their dental needs the $1,000 just isn't enough for patients who have a lot of need.
44. The annual benefit maximum for some patients greatly constrains their treatment plan and oral health. Tracking the benefits used to date is also a concern for the front desk when giving patients estimates for treatment.
45. The annual max is only part of the issue. Bigger problem is the pathetically low reimbursement rate to providers!
46. Annual benefit maximum is low. Questionable ease in tracking which patient is full vs. basic benefits.
47. With inflation the annual benefit max continues to shrink just like any other provider.
48. I feel healthy benefit requirements are an excellent idea, but not easily tracked and difficult for providers to ensure patient maintains without constantly communicating with insurance company. I feel there should be an annual maximum but as w/most insurances $1000 doesn't cut it anymore.
49. Benefit maximum should be $1500 to allow 2 checkups and a crown, root canal, or restorations per year.
50. Go back to the fee schedule DWP, was originally started with drop to annual benefit maximum.
51. The requirements in theory are good however given the patient population, the expectations need to be very low. The current final result is that it just makes it more difficult for the provider to provide care. Every time I have to sit in my office after a new DWP patient presents and try to determine how best to utilize the limited max for a $24 exam fee it's very hard to justify my time.
52. This is a nightmare to manage. We do not have a problem with a yearly maximum, but when you start saying some services are not counted toward yearly max, you are setting us all up to fail. Not only does the doctor's reimbursement incredibly low and lower each year, then they are faced with the possibility that we may miss what the patient is entitled to for services. Did they do their risk assessment? Did they pay their premium (Do you really think $3/mo is worth the risk the doctor may take?) We feel we should just take our disability patients with no reimbursement and quit the program. Way too many stipulations. The loser will be the provider. Work will be completed and reimbursement will be denied. We spend more time on IWP patients checking eligibility, remaining benefits, etc. And have had issues that Delta's website is incorrect. Why should we participate in such a program? It is only going to get worse managing our IWP after June 30th.
53. The majority of all DWP have not been seen by a dentist for many, many years due to lack of finances. The majority require ScRP, multiple extractions, removable prosthesis etc. A $1000 max doesn't come close to covering this, even with horrible rates considered fair by DWP. Typical state-aided patients feel entitled and make no attempt to help the benefit max situation.
54. The annual benefit maximum frequently leads to compromises in high-quality care because patients do not have the ability to cover expenses above the maximum benefit. This leads to the provider taking educated guesses as to what treatment can be reasonably postponed- and this in a population that is often receiving their first dental care in decades. The most disruptive element is that new changes are rolled out with little time for patients and providers to adjust to new requirements. Many DWP members are poorly educated and functionally illiterate. They often, therefore, do not understand the requirements that are imposed and get confused with previous requirements.
55. For a sizable portion of patients, $1000 max will not allow disease control. It could get restorative needs met, or perio needs met, but having both completed under $1000 is difficult. The treatment plan needs to be more aggressive in extractions at that point, or the patient has to have uncontrolled disease for another year until their benefit replenishes.
56. Every year this plan changes and is more complicated than the previous year. We have to deny patient treatment because they max out, and can't afford treatment with this annual max that was implemented. We have patients crying in our office that they can't have services. Patients max out after one root canal and crown. Now this Basic downgrade coverage surprised the office. In our opinion if you are going to limit a patient treatment, change their eligibility to a different color than green. It is very small print on the portal that they are Basic. The other thing is the plan is already reduced the amount of benefits, and now we are punishing the patient for a caries risk assessment that is not turned in. We did not realize what basic meant until our services were not being paid, and we had to collect from patients the amount unpaid by the plan. When the patients do fill out the caries risk form, we are told their benefits do not renew until their next enrollment date which could be a year from now. IL Medicaid does not have these limitation and rules for their patients. It is confusing as a provider and tedious to check all these additional rules, and patients eligibility coverage, this is not like the commercial plan that the reps keeping informing me it is supposed to be like. Commercial PPO don't downgrade coverage for forms not turned in. The other thing is the provider office is getting the backlash from patients when we tell them they are basic, and not the insurance company.
57. Maximum needs to be higher for some patients.
58. The process for removing limits on disabled patients is too cumbersome and I would argue is in direct violation of the Americans with disability act because of plan limitations with prior authorizations for the almost everything, it makes it nearly impossible to give timely care to Iowans with disabilities, authority to remove caps should rest entirely with delta, the state Medicaid system takes way too long and again is likely violating Americans with disabilities act statues. reimbursement rates are way too low. There should be no caps for oral surgery if treatment is leading to a set of complete dentures, this makes it impossible for patient that need full mouth extraction to actually be able to afford it and when you code surgical extractions after they hit their maximum it defaults to simple extractions which is hell on use providers. no wonder there are no oral surgeons in network.
59. The annual benefit maximum of $1,000 is absolutely, completely, 100%, insufficient. This amount barely covers the cost of the patient's exams and preventative treatment for one year. If the patient requires any sort of restorative or surgical procedures, they will exceed this maximum almost immediately. This $1,000 annual maximum has been in place, unchanged, for decades. This makes absolutely no sense that it would not, at the very least, be adjusted for inflation over the years.
60. I am an oral surgeon and many patients require multiple extractions. $1000 does not cover the problem and you know who is left holding the bags. The provider, that is wrong.
61. Annual benefit maximum of 1,000 has adversely affected my practice. My procedures (full mouth extractions) usually go over the 1000 max. The patient is then required to cover the difference. They rarely do this. They will schedule and then no-show b/c they owe money. We will be dropping the Wellness Program soon.

62. I believe that newly enrolled members, some of whom are an absolute disaster with years of dental neglect, should be given unlimited benefits for 6 months (Title 19 rules) to allow the massive initial effort to eliminate disease and provide function. A one-month enrollment in Title 19 (with no 1000 cap) would allow the extraction of all teeth only if the patient can find a DDS, get an appointment, and complete treatment in that time frame. As it is, the patient gets clean up after DWP, leaving no $ for restorative, thus influencing the decision to extract rather than repair.
63. Many DWP patient we see (I'm an oral surgeon) need multiple teeth extracted and/or dentures, must patients can't afford that treatment with the benefit maximum so it hinders our ability to adequately treat our patients.
64. Annual benefit maximum is appropriate and needed.
65. For our office the $1000 max has killed the DWP program. Many patients need all their teeth out. They come in with swelling and we address their acute problem, but can't take care of their other needs. They then show up with swelling again. The $1000 max hurts pts.
66. The annual benefit is way too low.
67. Prefer patients to have biannual preventive visits to maintain full benefits. Can help catch small issues instead of patients showing up with catastrophic mouths that I can't fix with $1000.

Healthy Behavior requirements

Lack of awareness leads to low-compliance especially with oral risk assessments; burdensome for patients; responsibility falls on providers to educate the patients.

1. Many unable to do self-assessment and some unaware of premiums so lost coverage.
2. I find it is difficult for special needs patients to navigate the self-assessment. I also find it difficult for special needs patients to navigate between the (carrier) and the (carrier) plans, as I am only a provider for (carrier) this has been a problem.
3. Benefit levels are too much work to track as a provider. We don't do this with any other insurance company. We would prefer to know that they either have benefits or they don't. The concept of healthy behaviors is beneficial. However, none of our patients were aware that they needed to do it or that it affected their coverage. We like the idea of a max to help teach patients understand how benefits work. That being said, we thought it should apply to all services not just select benefits. Overall, we felt the idea was good but a lot of the responsibility to inform and educate fell on the provider at the consequence of providing services and potentially not being compensated.
4. The assessment requirement hurts patients who are unable to complete/understand the requirement. The limit hurts patients. The purpose of the restrictions is to save money. Their restrictions also hurt/are a disincentive to participating dental practices.
5. Healthy behaviors not completed such as, assessment prohibit us from completing needed dental treatment, patient status reduced to basic. No funds available for the patient to pay. These patients do not have the means to complete the assessment nor do they understand some of the questions asked.
6. We don't mind the assessment, but patients don't know about, so my office staff has to go over it with them on our time. The $1000 max is outrageous and reimbursement rates are pathetically low.
7. Patients seem to be uninformed how their benefits work so the responsibility to track their benefits and maximums falls upon the provider and it is too time consuming and complex to track.
8. Patients seem to have no idea about any of these requirements. They never have the oral health assessment filled out or understand their levels.
9. Too much work to help patients navigate their benefits; many unable to do self-assessment and some unaware of premiums so lost coverage.
10. #3 - 2 programs complicate the system. #4 - Members do not take the responsibility to complete the forms. #5,6 - They get everything for free so why cap the $1000; they never get to see the value of service they receive paying $0. #7 - They can pay more than $3; they always come in with designer purses, fancy nails, tan, hair dyed and designer jeans. Also post on FB all their vacations and excursions that they have money for.
11. Benefit levels are too low, asking them to complete an oral risk assessment is wishful thinking. I do feel they should be required to pay a small portion of their insurance/treatment to make the more accountable.
12. People's coverage is unpredictable. You can do Tx then find out later it wasn't covered because they didn't qualify. Pt's don't follow the healthy behavior.
13. In theory the risk assessment is a good idea but when they don't comply it's the dentist that is penalized.
14. People were more motivated if they knew they had to be seen in 12 months and not fail any appts. I don't think many people will do their own assessments.
15. The patients do not see the benefit to doing the risk assessment on-line and as an office we should not have to track this for treatment to be paid on.
16. It is very challenging to keep tabs on what level a patient has and if they had filled out their healthy behavior requirements because the requirements were not well explained. Also, changing requirements yearly (as has been the case) makes it difficult for my front office to track and keep up to date.
17. A lot of DWP members are on DWP for a reason. They don't function well in society for a number of reasons. To expect them to do member-completed risk assessment is well, not to be expected. I realize there is a need for cost containment but there are better ideas out there.
18. For those who don't meet the annual requirements, having the reduced benefit level increases the burden on dentists further, because allowing only preventive Tx and emergency Tx just further increases emergency visits, which often require weekend visits, which are still reimbursed at the same very low rates. I think if they don't meet the requirements or pay their $3 premium, they should not be granted coverage.
19. I don't believe that the members take the time to do the assessment. $1000 - max is the same max that was used for many ins companies back when I started working 35 years ago.
20. I find it is difficult for special needs patients to navigate the self-assessment. I also find it difficult for special needs patients to navigate between the (carrier) and the (carrier) plans, as I am only a provider for (carrier) this has been a problem.
21. Too much work to help patients navigate their benefits; many unable to do self-assessment and some unaware of premiums so lost coverage.
22. Benefit levels are too much work to track as a provider. We don't do this with any other insurance company. We would prefer to know that they either have benefits or they don't. The concept of healthy behaviors is beneficial. However, none of our patients were aware that they needed to do it or that it affected their coverage. We like the idea of a max to help teach patients understand how benefits work.

That being said, we thought it should apply to all services not just select benefits. Overall, we felt the idea was good but a lot of the responsibility to inform and educate fell on the provider at the consequence of providing services and potentially not being compensated.

23. In theory the risk assessment is a good idea but when they don't comply it's the dentist that is penalized.
24. The assessment requirement hurts patients who are unable to complete/understand the requirement. The limit hurts patients. The purpose of the restrictions is to save money. Their restrictions also hurt/are a disincentive to participating dental practices.
25. People were more motivated if they knew they had to be seen in 12 months and not fail any appts. I don't think many people will do their own assessments.
26. The patients do not see the benefit to doing the risk assessment on-line and as an office we should not have to track this for treatment to be paid on.
27. It is very challenging to keep tabs on what level a patient has and if they had filled out their healthy behavior requirements because the requirements were not well explained. Also, changing requirements yearly (as has been the case) makes it difficult for my front office to track and keep up to date.
28. We don't mind the assessment, but patients don't know about, so my office staff has to go over it with them on our time. The $1000 max is outrageous and reimbursement rates are pathetically low.
29. Benefit levels do not pay for overhead, requirement for annual preventive to keep benefits is fine. Paperwork and rule changing was inconsistent and difficult.
30. Patients seem to be uninformed how their benefits work so the responsibility to track their benefits and maximums falls upon the provider and it is too time consuming and complex to track.
31. Keeping track of each DWP patient's benefit level, healthy behaviors, and maximum has been tough. When we get reimbursed close to nothing it's very discouraging to continue to care for those patients.
32. We've had patients lose level of benefits for not paying 3.00 or completing risk assessment. These patients have abscessed teeth, caries, gum disease, pain and discomfort and our hands are tied because they go back to basic benefits. This is unconscionable for our profession and I'm embarrassed for dentistry and the State of Iowa. Can you imagine our medical colleagues denying care to diseased patients because of 3.00 or not filling out a risk assessment? Are these statistics and data that is mined from our underserved more important than delivering the best care we are sworn to provide? I can understand the $1,000 yearly maximum as it relates to budget concerns, but I'd be willing to bet that untreated dental disease will be showing up in ER's and medical offices that are a lot more expensive than the $ they saved at dentists.
33. I believe the requirement that members or doctors complete a risk assessment is solely Delta's attempt to decrease their payments.
34. Healthy behavior requirements are a great idea, but many patients seem to be unaware these requirements exist, and furthermore don't seem to care. The penalty for not completing the requirement is not significant enough for them to care about reduced benefits.
35. Co-pays were a hassle. Patients weren't aware or failed to pay.
36. We think, just like our other patients, that DWP patients who are regular prophy's should come twice per calendar year for preventive. They should also have a max of benefits as many require a great amount of treatment. They should finish the survey to keep up with benefits.
37. For those who don't meet the annual requirements, having the reduced benefit level increases the burden on dentists further, because allowing only preventive Tx and emergency Tx just further increases emergency visits, which often require weekend visits, which are still reimbursed at the same very low rates. I think if they don't meet the requirements or pay their $3 premium, they should not be granted coverage.
38. Patients seem to have no idea about any of these requirements. They never have the oral health assessment filled out, or understand their levels.
39. Benefit level of $1000 is too low. Risk assessment is waste of everyone's time and only benefits insurance companies.
40. Benefits are inadequate, and people should not have to jump through hoops (and be penalized if they don't) for access to basic health and dental insurance.
41. 1) Questions 3-6 were unclear for me, so trying to say: patients need to be responsible for healthy behaviors. 2) $1000 annual benefit, are patients responsible for services beyond that? 3) Benefit levels, once again are patients responsible for services beyond? Hopefully, this explains why my responses are all over the map.
42. We recently have had issues with DWP switching our patients to basic although they had completed all requirements because they didn't call us to report they completed their requirements per (carrier). Many of these patients can't take care of themselves let alone calling to tell someone they went to the DDS and filled out their survey.
43. Benefits should be higher; the premium should be much higher - $30. Healthy behavior requirements are excellent. This helps Wellness people rise and improve and discourages failure to use services.
44. Healthy behavior assessment is a good idea, but it is unrealistic to think that very many would actually fill out any paperwork.
45. Too many rules and hoops to jump through. I like the idea of making people be accountable/responsible for their own health and care, but I don't know that many of the people on it can function at that level. I don't like that any of that falls on me.
46. I feel healthy benefit requirements are an excellent idea, but not easily tracked and difficult for providers to ensure patient maintains without constantly communicating w/ins co. I feel there should be an annual maximum but as with most insurances $1000 doesn't cut it anymore.
47. I dislike the judgement being placed on members based on the healthy behavior requirements. This is a slippery slope for insurance companies to get involved in. As a paying member of an insurance plan, I would expect to get the same benefits as any other paying member, regardless of my behavior/lifestyle. Only God can judge me for that.
48. I feel that having 2 levels may become complicated as benefits may change from the time of Tx/Tx planning until Tx is completed. Also, I don't feel a patient assessment can be reliable as an assessment tool to determine benefit levels.
49. Yes, the problem is when they lose benefits level then we get no shows for the work we scheduled that they are not eligible to complete.
50. Any ways that make the patient more responsible for understanding their coverage instead of expecting the provider to do it all for them.
51. The requirements in theory are good however given the patient population, the expectations need to be very low. The current final result is that it just makes it more difficult for the provider to provide care. Every time I have to sit in my office after a new DWP patient presents and try to determine how best to utilize the limited max for a 24.00 exam fee its very hard to justify my time.
52. This is a nightmare to manage. We do not have a problem with a yearly maximum, but when you start saying some services are not counted toward yearly max, you are setting us all up to fail. Not only does the doctor's reimbursement incredibly low and lower each year, then they are faced with the possibility that we may miss what the patient is entitled to for services. Did they do their risk assessment? Did they pay their premium (Do you really think $3/mo is worth the risk the doctor may take?) We feel we should just take our disability patients with no reimbursement and quit the program. Way too many stipulations. The loser will be the provider. Work will be completed, and reimbursement will be denied. We spend more time on IWP patients checking eligibility, remaining benefits, etc.

And have had issues that Delta's website is incorrect. Why should we participate in such a program? It is only going to get worse managing our IWP after June 30th.

53. For our patients this has been the hardest style of DWP to get patients to commit to. They have trouble finishing the surveys, we try to remind them to complete them, we try to assist while they are at our office, but it has proven lots more difficult than we anticipated.
54. The member completed risk assessment puts too much administrative burden on dental offices. Members do not seem to be aware of this requirement and the dental office (if they want to get paid) is forced to educate the patient about their insurance and practically do the assessment for them. Then after the assessment is completed, wait and unknown amount of time until the member reaches full benefits again.
55. I like the concept of the healthy behaviors requirements and putting more on the patient to keep them engaged in their oral health. The major downside is that it creates a lot of work for the office to make sure the patient qualifies for the treatment they will be receiving.
56. The patients seem unaware of their requirement to complete their oral health assessment. We can be in the middle of making dentures, their benefit level changes and then we cannot complete the dentures until they have met the requirements. Could there be some type of grace period?
57. The annual benefit maximum frequently leads to compromises in high-quality care because patients do not have the ability to cover expenses above the maximum benefit. This leads to the provider taking educated guesses as to what treatment can be reasonably postponed - and this in a population that is often receiving their first dental care in decades. The most disruptive element is that new changes are rolled out with little time for patients and providers to adjust to new requirements. Many DWP members are poorly educated and functionally illiterate. They often, therefore, do not understand the requirements that are imposed and get confused with previous requirements.
58. Every year this plan changes and is more complicated than the previous year. We have to deny patient treatment because they max out, and can't afford treatment with this annual max that was implemented. We have patients crying in our office that they can't have services. Patients max out after one root canal and crown. Now this Basic downgrade coverage surprised the office. In our opinion if you are going to limit a patient treatment, change their eligibility to a different color than green. It is very small print on the portal that they are Basic. The other thing is the plan is already reduced the amount of benefits, and now we are punishing the patient for a caries risk assessment that is not turned in. We did not realize what basic meant until our services were not being paid, and we had to collect from patients the amount unpaid by the plan. When the patient do fill out the caries risk form, we are told their benefits do not renew until their next enrollment date which could be a year from now. IL Medicaid does not have these limitation and rules for their patients. It is confusing as a provider and tedious to check all these additional rules, and patients' eligibility coverage, this is not like the commercial plan that the reps keeping informing me it is supposed to be like. Commercial PPO don't downgrade coverage for forms not turned in. The other thing is the provider office is getting the backlash from patients when we tell them they are basic, and not the insurance company.
59. I think it's good to have the member be held accountable for their own benefit. I also think that the $3 could be raised to at least $10, this would at least have some more accountability, and would cover the cost of the mailings that are sent out to communicate with the client Prefer patient's to have biannual preventive visits to maintain full benefits. Can help catch small issues instead of patients showing up with catastrophic mouths that I can't fix with $1000.
60. The Wellness patient do not have the desire to do the risk assessment and they don't care about the benefit maximum. They just want their work done. They are not willing to pay so when we reach the maximum they don't return. This is not working!

Administrative burdens
Tracking patient eligibility/benefits levels/annual maximum and Healthy Behaviors requirement

1. Patients get upset with us with changes. It's difficult to track maximums. The structure of XIX and DWP 2.0 creates a paper pusher insurance admin nightmare for offices. Instead of common-sense requirements the 2.0 structure causes harm, misinformation, challenges to patient and provider. Patients should have skin in the game, State aid should advocate for patients and not profits, and providers should be able to see 2.0 patients without the need to hire more admin help to play by the rules of the State. In the end the patient loses.
2. Numerous times we completed work then find out they have basic. Costs us way too many hours of tracking down claims to be paid 40 cents on the dollar.
3. I like having the patients take initiative, but they do not and cause admin burden. It is not our job to hold their hand when we get 35 cents on the dollar. I have drastically reduced my DWP participation after evaluating risk versus reward.
4. There is too much for the provider to keep track of.
5. This has made our patient tracking very tedious and we are seriously dropping the program.
6. Too much work to help patients navigate their benefits; many unable to do self-assessment and some unaware of premiums so lost coverage.
7. No easy place to see benefits used us benefits remaining.
8. A lot of extra leg work to figure out, what does patients qualify for? Does that fall under their benefit max? What happens if emergency and have to go over?
9. Personally, I like a maximum. Extractions should not be included in max benefits. Make program easier for dentists, so people are either covered or not. Too much messing around with people who are on basic. Calendar year.
10. Benefit levels are too much work to track as a provider. We don't do this with any other insurance company. We would prefer to know that they either have benefits or they don't. The concept of healthy behaviors is beneficial. However, none of our patients were aware that they needed to do it or that it affected their coverage. We like the idea of a max to help teach patients understand how benefits work. That being said, we thought it should apply to all services not just select benefits. Overall, we felt the idea was good but a lot of the responsibility to inform and educate fell on the provider at the consequence of providing services and potentially not being compensated.
11. People's coverage is unpredictable. You can do Tx then find out later it wasn't covered because they didn't qualify. Patients don't follow the healthy behavior.
12. The fact that it is provider's responsibility to track the remaining benefits puts extra burden on the providers.
13. The patients do not see the benefit to doing the risk assessment on-line and as an office we should not have to track this for treatment to be paid on.
14. It is very challenging to keep tabs on what level a patient has and if they had filled out their healthy behavior requirements because the requirements were not well explained. Also, changing requirements yearly (as has been the case) makes it difficult for my front office to track and keep up to date.

15. I wish they were all on one plan. More staff hours needed to determine benefits.
16. The website is not clear on who has completed risk assessments. Sometimes it will say no but patient has completed and vice versa.
17. Difficult to know when the pt. has maximized their annual benefit.
18. Benefit levels do not pay for overhead, requirement for annual preventive to keep benefits is fine. Paperwork and rule changing was inconsistent and difficult.
19. Patients seem to be uninformed how their benefits work so the responsibility to track their benefits and maximums falls upon the provider and it is too time consuming and complex to track.
20. Keeping track of each DWP patient's benefit level, healthy behaviors, and maximum has been tough. When we get reimbursed close to nothing it's very discouraging to continue to care for those patients.
21. DWP 2.0 is placing a huge administrative burden on my small business. Not only is the reimbursement low, now I must concern myself as to if the treatment is covered!
22. The benefit max is a real problem for patients who have extreme dental needs. Often these patients have not had care for many years. As a provider we spend a lot of staff time determining remaining benefits and coverage level.
23. Too much checking status on computer. Compensation 1/3 of what I normally charge. Missed appts/cancel w/in 24 hrs. (knows to say family emergency, sick, sick kid, etc.).
24. It gets more difficult each year. We want to help these pts but almost isn't worth all the trouble.
25. Reimbursement does not cover costs. Consider all DWP care a donation. Total loss to practice. Pain in the neck to try to monitor max, etc.
26. 1) Better ways to monitor levels/requirements; 2) Better understanding of when maximum is reached. How to proceed with Tx and costs.
27. Very hard to manage as an office.
28. We no longer take patients with this insurance as it was way too time consuming, reimbursement was horrible and requirements change all of the time.
29. The annual benefit maximum for some patients greatly constrains their treatment plan and oral health. Tracking the benefits used to date is also a concern for the front desk when giving patients estimates for treatment.
30. Annual benefit maximum is low. Questionable ease in tracking which patient is full vs basic benefits.
31. Way too complex for the insured and way too much trouble for provider.
32. Too many rules and hoops to jump through. I like the idea of making people be accountable/responsible for their own health and care, but I don't know that many of the people on it can function at that level. I don't like that any of that falls on me.
33. I feel healthy benefit requirements are an excellent idea, but not easily tracked and difficult for providers to ensure pt. maintains without constantly communicating with insurance company. I feel there should be an annual maximum but as w/most insurances $1000 doesn't cut it anymore.
34. Maximize reimbursement with minimal extra paperwork/regulations.
35. It is a restrictive program for dentist who should make treatment decisions, not the government. It has too much paperwork/staff time associated with it for the reimbursement paid.
36. As a provider ii find it hard to keep tract of patient benefit levels, oral health assessments, pt. copayments are paid. There is a lot of things to do to see if the patients meet eligibility to see the patient. I have hired extra staff to handle this insurance with little pay out. We are losing money seeing this insurance.
37. Keeping track of their benefit level falls upon the dental office completely and it is the dental office that loses if it's not kept track of.
38. This is a nightmare to manage. We do not have a problem with a yearly maximum, but when you start saying some services are not counted toward yearly max, you are setting us all up to fail. Not only does the doctor's reimbursement incredibly low and lower each year, then they are faced with the possibility that we may miss what the patient is entitled to for services. Did they do their risk assessment? Did they pay their premium (Do you really think $3/mo is worth the risk the doctor may take?) We feel we should just take our disability patients with no reimbursement and quit the program. Way too many stipulations. The loser will be the provider. Work will be completed, and reimbursement will be denied. We spend more time on IWP patients checking eligibility, remaining benefits, etc. And have had issues that Delta's website is incorrect. Why should we participate in such a program? It is only going to get worse managing our IWP after June 30th.
39. The member completed risk assessment puts too much administrative burden on dental offices. Members do not seem to be aware of this requirement and the dental office (if they want to get paid) is forced to educate the patient about their insurance and practically do the assessment for them. Then after the assessment is completed, wait and unknown amount of time until the member reaches full benefits again.
40. I like the concept of the healthy behaviors requirements and putting more on the patient to keep them engaged in their oral health. The major downside is that it creates a lot of work for the office to make sure the patient qualifies for the treatment they will be receiving.
41. Every year this plan changes and is more complicated than the previous year. We have to deny patient treatment because they max out and can't afford treatment with this annual max that was implemented. We have patients crying in our office that they can't have services. Patients max out after one root canal and crown. Now this Basic downgrade coverage surprised the office. In our opinion if you are going to limit a patient treatment, change their eligibility to a different color than green. It is very small print on the portal that they are Basic. The other thing is the plan is already reduced the amount of benefits, and now we are punishing the patient for a caries risk assessment that is not turned in. We did not realize what basic meant until our services were not being paid, and we had to collect from patients the amount unpaid by the plan. When the patient do fill out the caries risk form, we are told their benefits do not renew until their next enrollment date which could be a year from now. IL Medicaid does not have these limitation and rules for their patients. It is confusing as a provider and tedious to check all these additional rules, and patients eligibility coverage, this is not like the commercial plan that the reps keeping informing me it is supposed to be like. Commercial PPO don't downgrade coverage for forms not turned in. The other thing is the provider office is getting the backlash from patients when we tell them they are basic, and not the insurance company.
42. The burden on the dental provider to track these benefit levels deterred me from continuing to be a DWP provider. I cut ties after the program change.
43. Too much administrative monitoring with too low of reimbursements to be viable.
44. Changing the program requirements of yr. or of other year for us as providers is insane!

Cost to patients- premiums and copays
1. $3 premiums should be higher. Maximum hardly covers the work they need, they should see the value of benefit. I like the idea of requirements the DWP member must complete to make them have some responsibility.

2. Benefit levels are too low, asking them to complete an oral risk assessment is wishful thinking. I do feel they should be required to pay a small portion of their insurance/treatment to make the more accountable.
3. We agree the member should be responsible for their dental health. Not monetary. Maximum is too low, reimbursement too low so few offices participate. We are no longer accepting new comprehensive patients. Emergencies only. The bonus for offices was a great idea.
4. Who collects premium? If dental office, then I see this as a problem.
5. Put $3 copay on card.
6. Co-pays were a hassle. Patients weren't aware or failed to pay.
7. Neg toward 2.0 because payment for services went down from 1.0 to 2.0 and I also believe they should have to pay a co-pay of $3-$5 at each visit.
8. We feel the patients should pay something for a premium just like any other patient. For the amount of work that typically needs to be completed for them, the time we put in for benefits/pre-authorizations, etc., and the amount we have to adjust off/get paid for, it does not even out for our practice.
9. Benefits should be higher, the premium should be much higher - $30. Healthy behavior requirements are excellent. This helps Wellness people rise and improve and discourages failure to use services.
10. I think they need to have a higher premium payout to make them feel that this is their responsibility and not just another handout. I think with higher premium they take more responsibility.
11. $3 is so minimal, it is practically nonexistent. I think the premium should be much higher if they want to maintain benefits.
12. The $3/month premium is a joke. Especially since we were informed that if a patient calls Delta they have been told by representatives there they can simply select "hardship" and be exempt from the premiums regardless of if they have hardships or not.
13. I think it's good to have the member be held accountable for their own benefit. I also think that the $3 could be raised to at least $10, this would at least have some more accountability, and would cover the cost of the mailings that are sent out to communicate with the client
14. The $3/mo. premium is a joke. Most of my patients are DWP and most of them smoke. They spend $3 to $7 per day on cigarettes. I am not pleased with any of the changes made to DWP; it was a bait and switch to the dentist. Fees moved to Medicaid level and rescission of the bonus plan.
15. The patient should have some responsibility toward payment. Unlimited benefit and unsustainable.
16. Patients should have skin in the game, State aid should advocate for patients and not profits, and providers should be able to see 2.0 patients without the need to hire more admin help to play by the rules of the State. In the end the patient loses.
17. DWP patients are not a responsible population, getting all treatment done with $1000 is unrealistic b/c of the amount of work and neglect we see. Changing the program requirements of yr. or of other year for us as providers is insane!
18. Benefit levels are too low, asking them to complete an oral risk assessment is wishful thinking. I do feel they should be required to pay a small portion of their insurance/treatment to make the more accountable.
19. 1) Require patients to pay if they miss appointments. 2) Who does the premium go to? Doctor or DWP? Should have patients pay to receive service. Nothing is free!
20. Too much checking status on computer. Compensation 1/3 of what I normally charge. Missed appts/cancel within 24 hours (knows to say family emergency, sick, sick kid, etc.).
21. I think it's important that DWP members take some responsibility for their homecare.
22. Healthy behavior requirements are a great idea, but many patients seem to be unaware these requirements exist, and furthermore don't seem to care. The penalty for not completing the requirement is not significant enough for them to care about reduced benefits.
23. As practices that are busy anything that keeps processing more efficient and increases the reimbursement would help. You are addressing the accountability of the patients, but I hear from other offices that the failure rates of appointments are very high.
24. At first you might think that a dentist would be very positive about healthy behavior requirements as incentives to get the patients there, and keep appointments, etc. but many of these patients will miss appointments (dentist loses) any way, but once you have started treating them, the dentist will be expected (or want) to keep treating them any way (emergencies, etc.) and the dentist still loses. Even if the dentist gets paid, he loses as the reimbursements don't even cover his expenses. Bad behavior by the patients maybe should be kicked out of the program completely, or make them pay for missed appointments or bad behavior.
25. There should be penalty for patients breaking their appointments once they are made.
26. Yes, the problem is when they lose benefits level then we get no shows for the work we scheduled that they are not eligible to complete.
27. Are appointment failures being addressed?
28. It all boils down to reimbursement. Patient compliance is also an issue to review.
29. Benefit level is very low. I would like to help with the low-income population. I feel these patients need to have more personal resources invested in their dental care. This would make them value their services much more than they do now. It would also help with reimbursement levels.
30. Annual benefit maximum of 1,000 has adversely affected my practice. My procedures (full mouth extractions) usually go over the 1000 max. The patient is then required to cover the difference; they rarely do this. They will schedule and then no-show b/c they owe money. We will be dropping the Wellness Program soon.
31. Make members more responsible for their health care and improve the reimbursement for practitioners.
32. I like the benefit levels tied to behavior requirement because these patients should be responsible for something in order to get these dental benefits.

Attitudes about DWP patients- high treatment needs
1. $1000 max lets me start to stabilize patients but often times there is so much dental decay that you can't finish and end up waiting a year and waste all the work you've done. Benefit levels can change in the middle of care leaving the provider holding the bag. Patients receiving procedures often receive authorization for a pre-determined benefit only to find the benefit received by the time treatment is finished.
2. 1) Positive-annual max. 2) Positive-start with core benefits-then earn more benefits. 3) Negative-large percentage are emergency and need stabilization treatment.
3. DWP patients are not a responsible population, getting all treatment done with $1000 is unrealistic b/c of the amount of work and neglect we see. Changing the program requirements of yr. or of other year for us as providers is insane!
4. Maximum is too low and confusing since some things are included and others are not. These patients seek care sporadically and typically need a lot of care when they do present and often they cannot pay anything at all (unlike other patients with conventional insurance).

5. The benefit max is a real problem for patients who have extreme dental needs. Often these patients have not had care for many years. As a provider we spend a lot of staff time determining remaining benefits and coverage level.
6. The DWP patients we typically see have dental needs far beyond the $1,000 annual maximum.
7. I'm not a fan of the $1000 max. A lot of patients on DWP have lots of dental needs and it's hard to find a provider. Why are they making it even more difficult?
8. 1) Annual benefit is limiting, often pt. have complex needs. It would take 2 years for FMTE and dentures. 3) Tiered benefits put providers in awkward position of relating to pts the limitations.
9. Reimbursement is low, so dentists contribute more than the insurance company does toward the care. These patients have much more dental need than general population. To get them healthy/address their dental needs the $1,000 just isn't enough for patients who have a lot of need.
10. A large portion of our adult Medicaid patients only come in when they need major treatment like edentulation and dentures. A yearly maximum is incompatible.
11. The majority of all DWP have not been seen by a dentist for many, many years due to lack of finances. The majority require ScRP, multiple extractions, removable prosthesis etc. A $1000 max doesn't come close to covering this, even with horrible rates considered fair by DWP. Typical state-aided patients feel entitled and make no attempt to help the benefit max situation.
12. I think it's good to have the member be held accountable for their own benefit. I also think that the $3 could be raised to at least $10, this would at least have some more accountability, and would cover the cost of the mailings that are sent out to communicate with the client.
13. I believe that newly enrolled members, some of whom are an absolute disaster with years of dental neglect, should be given unlimited benefits for 6 months (Title 19 rules) to allow the massive initial effort to eliminate disease and provide function. A one-month enrollment in Title 19 (with no 1000 cap) would allow the extraction of all teeth only if the patient can find a DDS, get an appointment, and complete treatment in that time frame. As it is, the patient gets clean up after DWP, leaving no $ for restorative, thus influencing the decision to extract rather than repair.
14. For our office the $1000 max has killed the DWP program. Many patients need all their teeth out. They come in with swelling and we address their acute problem, but can't take care of their other needs. They then show up with swelling again. The $1000 max hurts patients.
15. Reimbursement does not allow for quality/quantity treatment of these pts as it does not cover overhead of office. Would not be able to stay in business with high volume of pts w/this coverage.

Benefit levels and covered services

1. $1000 max lets me start to stabilize patients but often times there is so much dental decay that you can't finish and end up waiting a year and waste all the work you've done. Benefit levels can change in the middle of care leaving the provider holding the bag. Patients receiving procedures often receive authorization for a pre-determined benefit only to find the benefit received by the time treatment is finished.
2. Benefit levels are too low, asking them to complete an oral risk assessment is wishful thinking. I do feel they should be required to pay a small portion of their insurance/treatment to make the more accountable.
3. I personally advocated and think it works better for the budget to have the phase I, II, III in the 2014 plan. No annual, earned over time are the key things. Now with the annual max, it was necessary because everyone was eligible day one, costs too much! The Previsor is excellent and can be used to really care for our patients. I miss the fee paid for OHI in 2014.
4. Unlimited benefit allows patients comprehensive care, example: full mouth extractions, dentures.
5. We think, just like our other patients, that DWP patients who are regular prophy's should come twice per calendar year for preventive. They should also have a max of benefits as many require a great amount of treatment. They should finish the survey to keep up with benefits.
6. Annual maximum should be at least $1,500 if not $2,000. I do think a maximum is required. I feel that the services provided should be maintained as basic services. No fixed pros, no posterior Endo.
7. Benefit structure no but reimbursement. I do, very poor.
8. 1) Annual benefit is limiting, often pt. have complex needs. It would take 2 years for FMTE and dentures. 3) Tiered benefits put providers in awkward position of relating to patients the limitations.
9. The patient should have some responsibility toward payment. Unlimited benefit and unsustainable.
10. I feel that having 2 levels may become complicated as benefits may change from the time of Tx/Tx planning until Tx is completed. Also, I don't feel a patient assessment can be reliable as an assessment tool to determine benefit levels.
11. Every year this plan changes and is more complicated than the previous year. We have to deny patient treatment because they max out and can't afford treatment with this annual max that was implemented. We have patients crying in our office that they can't have services. Patients max out after one root canal and crown. Now this Basic downgrade coverage surprised the office. In our opinion if you are going to limit a patient treatment, change their eligibility to a different color than green. It is very small print on the portal that they are Basic. The other thing is the plan is already reduced the amount of benefits, and now we are punishing the patient for a caries risk assessment that is not turned in. We did not realize what basic meant until our services were not being paid, and we had to collect from patients the amount unpaid by the plan. When the patient do fill out the caries risk form, we are told their benefits do not renew until their next enrollment date which could be a year from now. IL Medicaid does not have these limitation and rules for their patients. It is confusing as a provider and tedious to check all these additional rules, and patients eligibility coverage, this is not like the commercial plan that the reps keeping informing me it is supposed to be like. Commercial PPO don't downgrade coverage for forms not turned in. The other thing is the provider office is getting the backlash from patients when we tell them they are basic, and not the insurance company.
12. I believe that newly enrolled members, some of whom are an absolute disaster with years of dental neglect, should be given unlimited benefits for 6 months (Title 19 rules) to allow the massive initial effort to eliminate disease and provide function. A one-month enrollment in Title 19 (with no 1000 cap) would allow the extraction of all teeth only if the patient can find a DDS, get an appointment, and complete treatment in that time frame. As it is, the patient gets clean up after DWP, leaving no $ for restorative, thus influencing the decision to extract rather than repair.
13. Other than children, the plan should cover emergency treatment and fillings/extractions for adults only.

Other Comments
1. The designer of the program has little or no experience treating dental patients.
2. I am worried that (carrier) is gathering information from these risk assessments to apply them to their other insurance plans in order to rationalize limiting coverage or reimbursement.
3. The benefits and max are better than patients who get insurance through a private company at their work. This is not encouraging - working, paying some for their insurance and getting less benefit.
4. 1) Yes, get these people healthy, yearly maximums are stupid! More government control. 2) Fee increases, existing fees don't allow lab fees to be paid. 3) No profitability in this model.
5. Would like to know fee schedule. I have a problem with an insurance company managing a system that can be done by our state.
6. I personally advocated and think it works better for the budget to have the phase I, II, III in the 2014 plan. No annual, earned over time are the key things. Now with the annual max, it was necessary because everyone was eligible day one, costs too much! The Previsor is excellent and can be used to really care for our patients. I miss the fee paid for OHI in 2014.
7. We agree the member should be responsible for their dental health. Not monetary. Maximum is too low, reimbursement too low so few offices participate. We are no longer accepting new comprehensive patients. Emergencies only. The bonus for offices was a great idea.
8. The tiered (earned benefit) approach was the most appealing version of DWP due to increased reimbursement and patient accountability.
9. This plan seems designed to eliminate dental coverage for the most needy. Where the original DWP plan encouraged patient participation, this plan only punishes the neediest.
10. You have destroyed and ruined every part of dental care with this plan.
11. When it switched from 1.0 to 2.0 I was no longer a provider.
12. This program is complete garbage. The fee reimbursement is a complete joke and is quite insulting. It's amazing how grocery stores get a dollar for a food stamp, but the dentists and other doctors get 30%.
13. We were very positive with the DWP 1.0 but when it changed things became very negative towards it. We are debating rather to drop the program and not take patients with it. We currently are not taking any new patients with DWP or Medicaid because of the coverages.
14. all the new requirements are just another way for privatized Medicaid to deny treatment to save money; it has nothing to do with patient well fair.
15. The program should be discontinued. It is a joke.
16. The website is not clear on who has completed risk assessments. Sometimes it will say no but patient has completed and vice-versa.

Complexity of rules and regulations/too many restrictions
1. #3 - 2 programs complicate the system. #4 - Members do not take the responsibility to complete the forms. #5,6 - They get everything for free so why cap the $1000; they never get to see the value of service they receive paying $0. #7 - They can pay more than $3; they always come in with designer purses, fancy nails, tan, hair dyed and designer jeans. Also post on FB all their vacations and excursions that they have money for.
2. A lot of extra leg work to figure out, what does patient qualify for? Does that fall under their benefit max? What happens if emergency and have to go over?
3. Should not have to jump through hoops and add complications to something that is basically charity.
4. Too many rules and hoops to jump through. I like the idea of making people be accountable/responsible for their own health and care, but I don't know that many of the people on it can function at that level. I don't like that any of that falls on me.
5. Constantly changing rules. Must submit claim within 30 days or won't pay. Cannot back date after get pre-authorization, i.e., must do pre-auth before work done (even when know it will get pre-authorization).
6. Too many rules and hoops to jump through. I like the idea of making people be accountable/responsible for their own health and care, but I don't know that many of the people on it can function at that level. I don't like that any of that falls on me.
7. This is a nightmare to manage. We do not have a problem with a yearly maximum, but when you start saying some services are not counted toward yearly max, you are setting us all up to fail. Not only does the doctor's reimbursement incredibly low and lower each year, then they are faced with the possibility that we may miss what the patient is entitled to for services. Did they do their risk assessment? Did they pay their premium (Do you really think $3/mo is worth the risk the doctor may take?) We feel we should just take our disability patients with no reimbursement and quit the program. Way too many stipulations. The loser will be the provider. Work will be completed and reimbursement will be denied. We spend more time on IWP patients checking eligibility, remaining benefits, etc. And have had issues that Delta's website is incorrect. Why should we participate in such a program? It is only going to get worse managing our IWP after June 30th.
8. It is a good idea, but you still lose money for every procedure. I ended up dropping it and seeing a few existing patients and not charging them anything. The time it takes to jump through the hoops for authorization was a waste too. The fiasco of them changing what was allowed, even when a procedure had been pre-authorized, that was the last straw for our office.
9. Way too complex for the insured and way too much trouble for provider.
10. Constantly changing rules. Must submit claim within 30 days or won't pay. Cannot back date after get pre-auth (i.e.) must do pre-auth before work done (even when know it will get pre-auth).
11. It is a good idea, but you still lose money for every procedure. I ended up dropping it and seeing a few existing patients and not charging them anything. The time it takes to jump through the hoops for authorization was a waste too. The fiasco of them changing what was allowed, even when a procedure had been pre-authorized, that was the last straw for our office.

Preference for DWP 1.0
1. I personally advocated and think it works better for the budget to have the phase I, II, III in the 2014 plan. No annual, earned over time are the key things. Now with the annual max, it was necessary because everyone was eligible day one, costs too much! The Previsor is excellent and can be used to really care for our patients. I miss the fee paid for OHI in 2014.
2. We agree the member should be responsible for their dental health. Not monetary. Maximum is too low, reimbursement too low so few offices participate. We are no longer accepting new comprehensive patients. Emergencies only. The bonus for offices was a great idea.

3. The tiered (earned benefit) approach was the most appealing version of DWP due to increased reimbursement and patient accountability.
4. This plan seems designed to eliminate dental coverage for the most needy. Where the original DWP plan encouraged patient participation, this plan only punishes the neediest.
5. Neg toward 2.0 because payment for services went down from 1.0 to 2.0 and I also believe they should have to pay a co-pay of $3-$5 at each visit.
6. I liked the graduated benefits of the original plan and the reimbursement of the original DWP. Providers were misled into signing onto the plan, then rates decreased with the combining DWP and Medicaid.
7. Original plan had graduated benefits that were earned by going to preventive appointments. Why was that eliminated? Instead they put in this self-risk assessment and then ask providers who are barely being compensated to help them fill these out!? Then it's not really a self-assessment.
8. I liked the graduated benefits of the original plan. I also liked the reimbursement rate of the original DWP. Providers were misled into signing up, and then the reimbursement rates plummeted with combining DWP and Medicaid. Also, we have many patients who struggle mentally, so the self-risk assessment is ridiculous. We are taking (or reducing) benefits on the wrong people! And having staff fill them out is equally ridiculous.
9. Go back to the fee schedule DWP, was originally started with drop to annual benefit maximum.
10. Go back to DWP 1.0 with a $2000 maximum. Please increase the reimbursement rates to previous levels under DWP 1.0. The public health clinics are not sustainable at these rates. We need to at least be able to break even. I work at the Story County Dental Clinic.

Non-participation/dropping participation

1. I do not participate.
2. If the reimbursement was better we would participate. Too low. Lose money.
3. Too convoluted for us to participate.
4. Do not participate.
5. I do not participate.
6. We provided XIX care for 35 years, now we are out.
7. I gave XIX 35 years, now we are out.
8. I don't participate.
9. My experience with DWP ended Jan 2017. I am unaware of changes.
10. We were very positive with the DWP 1.0 but when it changed things became very negative towards it. We are debating rather to drop the program and not take patients with it. We currently are not taking any new patients with DWP or Medicaid because of the coverages
11. Annual benefit maximum of 1,000 has adversely affected my practice. My procedures (full mouth extractions) usually go over the 1000 max. The patient is then required to cover the difference. They rarely do this. They will schedule and then no-show b/c they owe money. We will be dropping the Wellness Program soon.
12. It's been such a mess, I honestly can say I am glad I'm not a part of it anymore. God bless those that are.

No Comments

1. No.
2. None.
3. No.

Positive Comments

1. 1) Positive-annual max. 2) Positive-start with core benefits-then earn more benefits. 3) Negative-large percentage are emergency and need stabilization treatment.
2. $3 premiums should be higher. Maximum hardly covers the work they need, they should see the value of benefit. I like the idea of requirements the DWP member must complete to make them have some responsibility.
3. I personally advocated and think it works better for the budget to have the phase I, II, III in the 2014 plan. No annual, earned over time are the key things. Now with the annual max, it was necessary because everyone was eligible day one, costs too much! The Previsor is excellent and can be used to really care for our patients. I miss the fee paid for OHI in 2014.
4. Personally, I like a maximum. Extractions should not be included in max benefits. Make program easier for dentists, so people are either covered or not. Too much messing around with people who are on basic. Calendar year.
5. Benefit levels are too much work to track as a provider. We don't do this with any other insurance company. We would prefer to know that they either have benefits or they don't. The concept of healthy behaviors is beneficial. However, none of our patients were aware that they needed to do it or that it affected their coverage. We like the idea of a max to help teach patients understand how benefits work. That being said, we thought it should apply to all services not just select benefits. Overall, we felt the idea was good but a lot of the responsibility to inform and educate fell on the provider at the consequence of providing services and potentially not being compensated.
6. I like the $1000 annual benefit maximum but sometimes feel extractions shouldn't count towards it. Patients who need full mouth extractions go over this limit so we are forced to leave some teeth behind and then the patient must return for emergency extractions as they occur. This prolongs the patient's condition and takes up extra chair time for us.
7. DWP 2.0 is better than 1.0. We were providers in the original program and it was very complicated to follow.
8. I like the benefit levels tied to behavior requirement because these patients should be responsible for something in order to get these dental benefits.
9. Except for the fee structure everything else is good. This group of people don't show up for their appointments for some reason!
10. I do participate in this program. I like the idea of the required preventive visits and an annual maximum. But the reimbursements are almost at embarrassing levels. Increase the levels and more dentists will participate, it's really that simple. We don't expect reimbursements to match our fees, but 50% would do wonders.
11. It is good to have an annual maximum in keeping with the structure of most traditional insurance programs.

12. Benefit levels do not pay for overhead, requirement for annual preventive to keep benefits is fine. Paperwork and rule changing was inconsistent and difficult.
13. No.
14. Annual benefit max is helpful.
15. Even though patients are capped at $1000 yearly maximum, they'd still have to get a lot of work done to even come close to that max with how little this plan reimburses. For example, we treatment planned $3300 of work for a patient and he was only at $800/$1000 max. That's less than 30% reimbursement, which is pretty good.
16. Healthy behavior requirements are a great idea, but many patients seem to be unaware these requirements exist, and further more don't seem to care. The penalty for not completing the requirement is not significant enough for them to care about reduced benefits.
17. I like the benefit maximum, though some FM extractions exceed the limit.
18. We think, just like our other patients, that DWP patients who are regular prophy's should come twice per calendar year for preventive. They should also have a max of benefits as many require a great amount of treatment. They should finish the survey to keep up with benefits.
19. Benefits should be higher, the premium should be much higher - $30. Healthy behavior requirements are excellent. This helps Wellness people rise and improve and discourages failure to use services.
20. Fee for service doesn't work. I commend the effort in creating this program to provide dental care to the underserved. Expanding facilities i.e. Broadlawns, Davenport Community Health, etc. Paying dentists per diem rate to teach students/monitor them. Providing acute care and continuing the program (preventative, minor restorative) is perfectly fair and paying providers at current rates will not create an increase in participants.
21. As practices that are busy anything that keeps processing more efficient and increases the reimbursement would help. You are addressing the accountability of the patients, but I hear from other offices that the failure rates of appointments are very high.
22. Yes, the benefits are great, the reimbursement rate is the problem.
23. Too many rules and hoops to jump through. I like the idea of making people be accountable/responsible for their own health and care, but I don't know that many of the people on it can function at that level. I don't like that any of that falls on me.
24. I feel healthy benefit requirements are an excellent idea, but not easily tracked and difficult for providers to ensure patient maintains without constantly communicating without insurance company. I feel there should be an annual maximum but as without most insurances $1000 doesn't cut it anymore.
25. I like the concept of the healthy behaviors requirements and putting more on the patient to keep them engaged in their oral health. The major downside is that it creates a lot of work for the office to make sure the patient qualifies for the treatment they will be receiving.
26. I think it's good to have the member be held accountable for their own benefit. I also think that the $3 could be raised to at least $10, this would at least have some more accountability, and would cover the cost of the mailings that are sent out to communicate with the client
27. It is a good idea, but you still lose money for every procedure. I ended up dropping it and seeing a few existing patients and not charging them anything. The time it takes to jump through the hoops for authorization was a waste too. The fiasco of them changing what was allowed, even when a procedure had been pre-authorized, that was the last straw for our office.
28. Annual benefit maximum is appropriate and needed.

Has your acceptance of new DWP (either Delta Dental or MCNA Dental) patients changes since DWP 2.0 was implemented in August 2017?- Yes, please describe how it changes?

All survey respondents

No longer accepting new DWP patients
1. Changed to no accept new patients and stop seeing ones that miss appt's no call no show and do not come regularly.
2. Stopped completely, went from accepting in a controlled way to accepting my community zip code, to not more patients but remain in network to provide care to current patients.
3. We no longer accept DWP insurance as of December 2018.
4. We stopped accepting new patients.
5. No longer accepting new patients.
6. We do not accept new patients.
7. We have reached maximum capacity for accepting new Delta Wellness patients. Largely due to poor reimbursement.
8. Quit taking.
9. Won't accept.
10. We only take DWP (carrier) and decided not to accept any new patients with this insurance.
11. We stopped seeing as many new patients.
12. Yes, we quit it.
13. No new patients accepted.
14. Quit, losing money on pts, can no longer treat them.
15. No longer taking DWP.
16. We serve current patients but do not accept new patients.
17. I used to accept all DWP patients without restrictions. Now I only see established patients.
18. Not accepting new DWP.
19. No new Delta Wellness patients.
20. I no longer accept new DWP patients.
21. No longer accepting new patients.
22. Quit taking new patients.
23. We stopped when reimbursement lowered.
24. We stopped taking new pts due to poor reimbursement.
25. We've stopped taking new DWP's.
26. We no longer accept new patients.
27. When fees reduced, stopped taking these patients.
28. We have lost most of our Wellness patients and are not accepting new.
29. We no longer accept new patients due to poor reimbursement.

30. Not taking any new patients.
31. We stopped accepting new. We could not afford the drastic decrease in reimbursement of all procedures.
32. We were accepting new patients but now we are not.
33. We no longer accept new patients.
34. We stopped taking new patients. They don't pay us enough to be able to see more patients than what we already have.
35. Not accepting new patients.
36. We no longer accept any DWP patients.
37. I stopped seeing new patients.
38. We were accepting new Delta DWP patients.
39. Stopped accepting new in July 2016 when fees changed.
40. Stopped taking new patients.
41. Stopped taking.
42. We no longer accept new patients.
43. Stopped taking any new pts.
44. We stopped taking new patients with this program.
45. We stopped accepting new patients.
46. We no longer accept new Wellness patients.
47. Don't see any new patients. Reimbursement too low.
48. We started taking limited numbers with DWP, now we are not taking any new.
49. We are not taking any new patients with DWP any longer, just our current ones.
50. No longer accepting any new patients. Fee schedule has decreased dramatically since we elected to participate initially. Cannot afford to do most Tx requiring lab work for these pts because fee schedule doesn't even cover our lab fees.
51. We have stopped accepting new DWP.
52. We no longer accept new patients, as it is hurting our office.
53. Won't accept any new.
54. As of April 4, 2019, we are not accepting new Medicaid/DWP pts.
55. We had to stop seeing/accepting new DWP pts because we are too busy and the benefit levels were hard to keep on top of.
56. Do not accept new patient.
57. No more patients.
58. Unable to take new patients due to low reimbursement percentages.
59. Stop taking new patients.
60. Stopped seeing new patients.
61. We cannot afford to see any new patients with DWP.
62. Prior we are some new. We are now no new patients.
63. We only take Delta patients and at first we reduced our intake of new patients to just 5 per month, now we take no new.
64. We see no new patients.
65. No longer accepting new patients.
66. No new patients.
67. Do not accept.
68. We are no longer accepting new DWP.
69. We do not accept them.
70. No longer accept.
71. Not accepting patients now.
72. I do not take any new ones and I've lost my past Title 19 patients.

Reduced acceptance of new DWP patients

1. Less, very challenging, to treat/manage w/1000 limit.
2. Much less, no new.
3. We see 5 new DWP (carrier) a month and existing patients on DWP.
4. Accepting less.
5. We now accept less DWP.
6. Dramatically, the bonus is gone and fees reduced to below cost of doing business.
7. We limit the number of new patients and dropped (carrier).
8. Taking less.
9. Reduced desire to accept new patients with the benefit.
10. I am taking far less new patients, and refer for more services because of costs.
11. Fewer providers and had to limit number we could see. Also, less reimbursement.
12. Limited new patients to 2 per week, new 2.0 was not as good as previous plan.
13. Used to see all.
14. Fee schedule for DWP went down to Title XIX levels, try to see not as many.
15. We did not previously accept DWP, now we see some.
16. We have cut back the number of patients.
17. We used to accept all Delta DWP patients.
18. Fewer patients because of changes to annual maximum and patient-reported surveys, and fee schedule went down.
19. Accept fewer.
20. Starting to limit number of new pts per month because being bombarded by them since other offices don't accept.
21. Starting to limit numbers because there are not many office taking them and we can't take them all.
22. Decrease.
23. Limited number of new pts seen.
24. We are inundated (50%). We have had to reduce significantly to 43% DWP/Medicaid.
25. Yes, we had to put a limit on number we have, so many needs, high failure rate, poor reimbursement and rate shows.
26. We were no longer able to see these patients at any time due to the cut in reimbursement. We had to limit the time we saw them.

27. Can't treat near as much or as many due to reimbursement levels.
28. Taking fewer.
29. We accept less patients.
30. We accept less patients.
31. Lesser pay for the dentist, therefore fewer patients are being seen.
32. Accepted more before it became more difficult to know qualifications.

No longer accepting new/existing DWP patients
1. We used to see existing patients with it but now we do not.
2. We stopped accepting all DWP as of November 1, 2018.
3. We cannot afford to see these patients, due to terrible reimbursement.
4. Stopped taking new, asked existing DWP (90%) to find a DWP provider.
5. No longer taking due to reimbursement and no shows received.
6. We no longer see DWP patients.
7. We cannot accept Wellness. It creates a large deficit and production to payment deficit.
8. We stopped seeing all patients with DWP.
9. I no longer accept any.
10. Stopped taking DWP.
11. No longer see these patients.
12. We no longer accept DWP patients at all.
13. We stopped seeing Dental Wellness patients.
14. We were accepting a couple every month or so, now we are accepting none. The reimbursement has gone down considerably since the program started.
15. We used to accept new DWP but not new Title XIX, now we since they are combined, we don't accept either.
16. We stopped taking adults with this due to poor reimbursements.
17. Yes, when they cut the fee schedule, we could no longer afford to treat DWP patients.
18. We have stopped accepting DWP.
19. We stopped accepting them, as a private practice owner who does lots of deep sedation and surgery, many of these patients literally cost me money because of abysmally low reimbursement.
20. I'm an associate at a private practice that does not take DWP.
21. Stopped taking new, asked existing DWP (90%) to find a DWP provider.
22. I stopped accepting all DWP in 2019 due to too many negative changes with DWP, negative to provider at least.

No longer enrolled/could not enroll as DWP provider
1. We dropped DWP and no longer accept it at all.
2. Dropped enrollment as provider effective Jan 1, 2019.
3. We were not enrolled in DWP 1.0 we were enrolled in first version.
4. No longer participate in DWP.
5. Our office discontinued being providers.
6. We dropped our provider status.
7. Dropped being DWP provider.
8. After seeing pending changes, our office ended our DWP contract July 1.
9. We are not (carrier) providers so we cannot accept DWP patients.
10. No longer see adults in the Medicaid programs, children only.
11. We used to see Delta DWP, we dropped it with changes.
12. We terminated participation.
13. We have not accepted DWP since 2015.
14. Our office went from accepting any DWP patients with (carrier) under DWP 1.0 to no longer being a provider for DWP 2.0
15. Couldn't get enrolled/paid with my current employer. Bureaucratic nightmare.

Accept new DWP patients under special circumstances
1. We no longer accept new comprehensive patients, we no longer fabricate dentures or partials for DWP.
2. No longer taking new pts unless family member.
3. Prior to Aug 2017. I accepted all new DWP patients, now I only accept if they are family members of an existing patient.
4. Significantly reduced wait list to only accepting family of existing patients.
5. No longer accepting new patients unless referral.
6. Only accepting new patients w/in same household of existing patients.
7. Did see referrals of family members of current patients.
8. Reject patients with no remaining benefits or preventive only coverage.
9. We used to accept any and all, but now we only accept DD patient in our county.

Began/increased acceptance of new DWP patients
1. We did not previously accept DWP, now we see some.
2. We accept more since we don't have so many steps that must be taken from pt or Dr to receive care

Other
1. No.

2. Most other offices are not actually accepting new patients.
3. People can't afford over the 1,000 maximum to do treatment.
4. Restrictions limit caring for the patient!
5. Reimbursement is very poor.
6. The first DWP was much better.
7. The payment schedule was better when it was first implemented so we took new pt.'s with Wellness.
8. Why do we need an insurance company to manage this! Instead, keep administration (i.e. waiting checks or managing accounts) simple and have at least 60-88% reimbursement to providers and know the providers you're paying.
9. Reimbursements don't even meet overhead expense.
10. People can't afford to get treatment over the 1000 benefit.
11. The fee schedule is barely covering the cost of materials. It is much more difficult to get procedures approved since this was implemented.
12. need a larger balance of full pay patients to survive.
13. This program is an office financial disaster. It is impossible to provide fine care at the reimbursement levels we receive.
14. Pediatric not covered.
15. We have started same day appointments only.
16. We now prior authorize every patient's treatment as some are large and may have cost to patients.

What are the main reason(s) why your DWP participation changed since DWP 2.0 was implemented un August 2017?

All survey respondents

Reimbursement
1. Did not feel the tiered services were worth our time vs reimbursement rate. Too many stipulations.
2. Low reimbursement and patients don't keep their appointments.
3. Due to very low reimbursement fees.
4. The reimbursement is so low, it does not cover the materials to restore teeth. Therefore, we cannot accept new patients, they have too much treatment.
5. Broken appts. Low fee reimbursement. Too many rules, which lead to confusion.
6. We reached maximum capacity of the number of patients we are able to accept, the reimbursement rate is currently 45% of our normal fee schedule.
7. Reimbursement is awful and too many hoops to jump through.
8. Lowered reimbursement. No incentive bonus program. Lose money on every patient.
9. Authorization was poor. Payment poor. Total experience was bad.
10. I lose money on every Wellness patient. The reimbursement is only 35-40% of my fee.
11. Reimbursement of our other dentist is on pregnancy leave.
12. Can't run business on low payments.
13. Bonus is gone, reduced fees, a local gov't sponsored clinic opened in Mason City 2 million!
14. Too much hassle, too low reimbursements, too many pre-authorizations, too many denials, too much bookkeeping.
15. Fees. We only get 38% of fees charged!
16. Levels of reimbursement and the amount of documentation needed for reimbursement was the main reason to drop (carrier) plan.
17. It is a headache to check eligibility esp. for dentures. Got burned, had coverage then next month didn't. More people wanting in. Poor reimbursement.
18. Limited reimbursement, no profit realized for the practice.
19. The payout was more, fee schedules higher.
20. Implementing the $1,000 max, reducing the reimbursement rates drastically, eliminating the bonus for doing the risk assessments.
21. See above.
22. Better reimbursement, more like traditional commercial plans, encourages preventative care.
23. Lower reimbursement rate.
24. Reimbursement.
25. Fee schedule.
26. Reduced fees, maximum and bonus.
27. As reimbursement rates go down and yearly maximums go into effect, there is less and less we can do for these patients without losing money or providing sub-standard care.
28. 1) Pay for reimbursement was decreased. 2) Annual benefit maximum for patient was decreased.
29. Poor reimbursement, determine red tape to get claim, pain, etc.
30. 1) Fee schedule lower than DWP 1.0. 2) Annual maximum imposed.
31. The slashing of reimbursement to Medicaid level reimbursement. This was a bait and switch.
32. Their fee reimbursement.
33. 1) They changed the structure and fee schedule. 2) Lowered fees.
34. In order for us to make any money on the visits we would have to shorten them to less time than we could provide care that is expected in our office for our patients.
35. After 38 years participating in Adult Medicaid and many unfulfilled promises of increased reimbursement, the adult Medicaid fees were increased by approx. 1% and DWP 1.0 fees were decreased by about 20%. With approximately 30% of patients Medicaid participants low reimbursement made continued participation unsustainable.
36. Reimbursement decrease, elimination of previous bonus pool. Patient confusion of benefits. No specialist participation.
37. 1) Lower reimbursement rates. 2) Stricter guidelines for patients. 3) Dependability of patients.
38. Lack of reimbursement.
39. Reimbursements dropped drastically.
40. Poor reimbursement.
41. The change from DWP 1.0 to DWP 2.0 when reimbursement was drastically reduced. The increased administrative burden to provide needed treatment and the uncertainty of which services will be approved.

42. Reimbursement amounts continue to decrease while provider expenses, lab fees, materials, etc. continue to increase.
43. Reimbursement rate decrease. High patient failure rate.
44. Lower reimbursement.
45. Limit of 1000 and poor reimbursement.
46. Lack of reimbursement.
47. The reimbursement rates are too low. I can't afford to take on more. The new requirements are too much paperwork. The whole program is broken.
48. Fees are horribly unfair and have led to access problems for Wellness patients in this area.
49. 1) Poor reimbursement. 2) Too many no-show patients.
50. Too many hoops/regulations for amount of reimbursement that historically had been considered charity or taking our fair share of the underserved community. No offense but typically patients fail their reserved appointment which adds to the loss of revenue.
51. Poor compensation.
52. Reimbursements for procedure were incredibly low!
53. See above. Denial of rules of treatment by Delta that reduced our efficiency of treatment (which is standard treatment for all patients) and at times denied reimbursement because we did not do it their way.
54. Poor reimbursement. Annual max.
55. Very low reimbursement for services rendered.
56. Reimbursement rates.
57. Fee reimbursement is less than 50% of our charges. Patients are not all responsible for their appointment-failures.
58. Reimbursements very low.
59. Fee schedule too low.
60. 1) Reimbursements went down. 2) Paper work went up.
61. 1) Lack of coverage. 2) Poor payments. 3) Failed appointments. 4) Prior authorization.
62. Lower reimbursement. Too complicated.
63. Reimbursement rates.
64. Lower reimbursement rates.
65. Lower reimbursement.
66. Reimbursement.
67. 1) Reimbursements so low, difficult to cover overhead, especially with an increase in DWP. 2) Removable treatments reimbursements won't cover the lab bill.
68. Low reimbursement rates.
69. Low reimbursement, high no show rate.
70. Too many patients, too much write-off. Not sustainable at 50%. Poor attendance, poor attitudes/demanding attitudes. Smelly waiting room with BO/smoke/muddy shoes/theft of stupid things (coasters, TP, coffee creamers, plants, music system). Headaches. Low reimbursement.
71. Reimbursement decreased again, can't afford to take it, losing money, not even breaking even!
72. Fee reimbursement primarily, also pts not being respectful of our time, not taking ownership for their own health.
73. The reimbursement is way too low, it barely covers overhead.
74. Reimbursement was cut.
75. Too many rules (etc. X-rays after seal of CRN) causing unnecessary radiation along with no reimbursement.
76. Coverage is horrible. Too much documentation and regulations to negotiate to get paid nothing.
77. We made changes because reimbursement dropped dramatically and rules dramatically increased.
78. Low reimbursement.
79. Much lower reimbursement.
80. Reimbursement too low.
81. Decreased reimbursement levels.
82. Low payments made on treatment.
83. As stated above, we started taking DWP. Now we only see new ones if they are living in a nursing home or skilled facility (local). The other patients we started seeing required extensive dental treatments and we just don't get reimbursed enough to continue seeing more patients.
84. We stopped after taking so many with DWP since the reimbursement to us is not very high. It's hard to pay for the supplies we use on the patients when the rate is lower than half on most.
85. The changes in the fee schedule have dramatically decreased. It seems with every change, the fee schedule is reduced and our responsibilities increase in checking patient eligibility. We have a decent number of patients with DWP, but fees are so low that they don't even cover what I pay my hygienists' wages for the time spent, and don't even cover lab bills, much less other expenses for removable and repairs.
86. Reimbursement considerably decreased with DWP 2.0
87. 1) Poor reimbursement. 2) Low quality patients who are not reliable.
88. Patients don't understand anything about their insurance. Our office does not get paid hardly anything after we see these patients.
89. Poor compliance of patients and low reimbursement (lose money on many patients).
90. Poor reimbursement. Lack of patient responsibility.
91. The fees went lower.
92. The reimbursement for DWP 1.0 was subsidizing my T19 patients because the reimbursement for T19 was so low. Once DWP reimbursement was lowered to T19 levels, we could no longer afford to see DWP not T19 patients so we were forced to dismiss them all from the practice.
93. Poor reimbursement. You lied about reimbursement rates. It loses us money.
94. Poorer reimbursement, increased time required to learn the new system for staff atop an already disproportionate amount of time dedicated to DWP 1.0, poor patient involvement = lots of missed appointments.
95. Reimbursement levels ridiculously low.
96. Cost to payment ratio/most patients need a lot of treatment and ca not offer great patient care due to max, etc. Patients unreliable, no call, no show. Write offs on non-payment of claims, etc.
97. 1) Too much staff time to get paid poorly. 2) Limitations of care due to annual max.
98. Max of $1000 means you are at the cap in 1-2 visits. Extremely low reimbursement.

99. It did not pay enough to cover our chair time.
100. Reimbursement.
101. Tired off reduced payments, other businesses don't have to sell milk or gas at a lost to Medicaid patients, why should I have to sell dental care to them at a loss to my business?
102. Rules, new fee schedule.
103. Cannot afford to see them.
104. Reimbursement rates are terrible.
105. We feel trapped into continuing treatment for the ones we already accepted. I'm not sure how you expect to have dentists see new patients when you roll out a program with one set of rates and then replace those rates with Medicaid rates. With the rate of failed Medicaid/IHW appointments, it is not easy to stay profitable seeing patients with that insurance. Rates are a joke. You attracted dentists with the original rates, now dentists are frustrated with the new rates. It is easier just not to see those patients. On top of this, the red tape and hours of work to get reimbursement just isn't worth it. Many times we just write off the amount because the fight with Medicaid/(carrier) will cost more in manpower hours than the reimbursement itself.
106. At 20% of our fee, how can we afford to see them?
107. Poorer reimbursements than with DWP 1.0 and more difficulty obtaining coverage for patients.
108. The fee schedule, no shows.
109. Fee schedule. 70% reimbursement dropped to 30%. Office currently has 60 to 70% overhead so why pay the patients to come in.
110. Fee Schedule.
111. Confirming eligibility the first of the month was a nightmare. Led to cancelling patients last minute. We would have a prior authorization for partial or complete dentures and if it took more than 1-2 weeks to complete patient may have lost eligibility and we here are left with dentures. There needs to be some sort of wiggle room. Reimbursement became so low it was a joke. Entitled patients not worth it.
112. Lower reimbursement, difficulty with patient compliance with the assessment forms, annual maximum is a pain to keep track of, eligibility is unknown from month to month, etc.
113. because Title XIX combined with DWP and the reimbursements decreased, we could no longer only accept new DWP because it allowed all previous Title XIX also. We were overloaded with new patients and the reimbursement was so low we could not continue, so we stopped taking all DWP..
114. Poor reimbursements.
115. The reimbursement rates are far less and some rates don't even cover the lab costs to do treatment.
116. Lesser payout for the dentist.
117. significant reduction in compensation.
118. Reimbursements have dropped.
119. Cannot afford to see patients and be reimbursed and lose thousands of dollars. Not break even, I mean lose money.
120. Too low of reimbursement.
121. discontinued (carrier), terrible customer service. Delta is easy to work with, reimbursement could be better.
122. reimbursement has been cut by a significant amount and i find the extent of documentation required to provide basic treatment is simply ridiculous.
123. Low reimbursements, difficulty getting pre-authorizations, pre-authorizations not being upheld as allowed procedures
124. Reimbursement level and the fact that now all the reduced reimbursements go back to insurance companies pockets instead of the State of Iowa.
125. As above, too many negative changes affecting reimbursement to provider/oral surgeon.
126. Low reimbursement.
127. The reimbursement is too low to justify taking new DWP. The $1000 cap makes it difficult to provide comprehensive care so not only am I not making money but I also can't provide the patient with the level of care I would like to provide. You can't bring me to a burning building and hand me a watering can to put out the fire.
128. I cannot afford to be in the program.

Administrative burden

Difficulty tracking benefits, eligibility, educating patients.

1. We were left doing a lot of leg work to: check benefits, see if premiums were paid, see if pt. had full or basic benefits, check maximums, and educating patients on how all of these things work. We could no longer keep up with the program.
2. Too much hassle, too low reimbursements, too many pre-authorizations, too many denials, too much bookkeeping.
3. Front desk was spending too much time trying to get payment for services rendered or approval for recommended treatment.
4. The entire program is difficult to manage and is burden for the provider, so we thought by eliminating one of the plans it might make it less complex.
5. Have to spend lots more staff time checking benefits and confirming benefits with (carrier) and (carrier).
6. Poorer reimbursement, increased time required to learn the new system for staff atop an already disproportionate amount of time dedicated to DWP 1.0, poor patient involvement equals lots of missed appointments.
7. 1) Too much staff time to get paid poorly. 2) Limitations of care due to annual max.
8. We feel trapped into continuing treatment for the ones we already accepted. I'm not sure how you expect to have dentists see new patients when you roll out a program with one set of rates and then replace those rates with Medicaid rates. With the rate of failed Medicaid/IHW appointments, it is not easy to stay profitable seeing patients with that insurance. Rates are a joke. You attracted dentists with the original rates, now dentists are frustrated with the new rates. It is easier just not to see those patients. On top of this, the red tape and hours of work to get reimbursement just isn't worth it. Many times we just write off the amount because the fight with Medicaid/(carrier) will cost more in manpower hours than the reimbursement itself.
9. The maximum benefit and the fact it's harder to keep track of benefits (as some pts have slipped into emergency coverage only at this point) which adds more time used by front desk for every DWP pt we see.
10. Detailed earlier. Managing maximum and not all services are applied. Add that to all the other issues and done.
11. 1) These people need multiple major things. 2) Never know when they are basic.
12. Impossible to treat their patients with $1000 max. Never know when they go basic and leave me with bill.
13. $1000 max. Two types of coverage.

14. It is a headache to check eligibility esp. for dentures. Got burned, had coverage then next month didn't. More people wanting in. Poor reimbursement.
15. More difficult to know how much work can be done w/maximum benefit.
16. Too complicated to keep track of patients.
17. Hard to track the benefit provided by DWP if patient seen in other offices.
18. Have to spend lots more staff time checking benefits and confirming benefits with (carrier) and Delta.
19. The maximum benefit and the fact it's harder to keep track of benefits (as some pts have slipped into emergency coverage only at this point) which adds more time used by front desk for every DWP pt we see.
20. Poorer reimbursements than with DWP 1.0 and more difficulty obtaining coverage for patients.
21. Further cuts in the benefit and frustration with rules patients can't/don't follow/understand.
22. Reimbursement decrease, elimination of previous bonus pool. Patient confusion of benefits. No specialist participation.
23. Patients don't understand anything about their insurance. Our office does not get paid hardly anything after we see these patients.
24. Pre-auth for DWP wasn't recognized by (carrier) if patient switched insurance. Insurance eligibility is month to month. Received an audit for endo (carrier). The staff at DWP, XIX and (carrier) seem to be uninformed and we get different answers for the same question. If the call center employees don't know FAQ, how can an office know?
25. Too complicated to keep track of patients.
26. The changes in the fee schedule have dramatically decreased. It seems with every change, the fee schedule is reduced and our responsibilities increase in checking pt. eligibility. We have a decent number of patients with DWP, but fees are so low that they don't even cover what I pay my hygienists' wages for the time spent, and don't even cover lab bills, much less other expenses for removable and repairs.
27. Confirming eligibility the first of the month was a nightmare. Led to cancelling patients last minute. We would have a prior authorization for partial or complete dentures and if it took more than 1-2 weeks to complete patient may have lost eligibility and we here are left with dentures. There needs to be some sort of wiggle room. Reimbursement became so low it was a joke. Entitled patients not worth it.
28. Lower reimbursement, difficulty with patient compliance with the assessment forms, annual maximum is a pain to keep track of, eligibility is unknown from month to month, etc.
29. Patient switch back and forth between plans and annual benefits.

Issues with annual maximum

1. Impossible to treat their patients with $1000 max. Never know when they go basic and leave me with bill.
2. $1000 max. Two types of coverage.
3. $1,000 maximum. (carrier) reps are rude. Pre-auth for denture is ridiculous.
4. Implementing the $1,000 max, reducing the reimbursement rates drastically, eliminating the bonus for doing the risk assessments.
5. Reimbursement. Maximum lower.
6. Reduced fees, maximum and bonus.
7. Care of patient restricted due to $1000 max and assessment if not completed reduces status to basic services.
8. As reimbursement rates go down and yearly maximums go into effect, there is less and less we can do for these patients without losing money or providing sub-standard care.
9. 1) Pay for reimbursement was decreased. 2) Annual benefit maximum for patient was decreased.
10. Limit of 1000 and poor reimbursement.
11. Poor reimbursement. Annual max.
12. Cost to payment ratio/most patients need a lot of treatment and cannot offer great patient care due to max, etc. Patients unreliable, no call, no show. Write offs on non-payment of claims, etc.
13. 1) Too much staff time to get paid poorly. 2) Limitations of care due to annual max.
14. Max of $1000 means you are at the cap in 1-2 visits. Extremely low reimbursement.
15. People max out of benefits. They have not completed oral health assessment. The basic eligibility.
16. The maximum benefit and the fact it's harder to keep track of benefits (as some pts have slipped into emergency coverage only at this point) which adds more time used by front desk for every DWP patient we see.
17. Detailed earlier. Managing maximum and not all services are applied. Add that to all the other issues and done.
18. Lower reimbursement, difficulty with patient compliance with the assessment forms, annual maximum is a pain to keep track of, eligibility is unknown from month to month, etc.
19. The limit of 1000 per year limits my ability to provide complete treatment. Often the amount of work (ex. full mouth extractions and sedations) goes over 1.000. The patients then have a balance and often do not pay.
20. Annual maximum.
21. The reimbursement is too low to justify taking new DWP. The $1000 cap makes it difficult to provide comprehensive care so not only am I not making money but I also can't provide the patient with the level of care I would like to provide. You can't bring me to a burning building and hand me a watering can to put out the fire.

Pre-authorizations issues/paperwork

1. 1) Lack of coverage. 2) Poor payments. 3) Failed appointments. 4) Prior authorization.
2. Pre-auth for DWP wasn't recognized by (carrier) if patient switched insurance. Insurance eligibility is month to month. Received an audit for endo (carrier). The staff at DWP, XIX and (carrier) seem to be uninformed and we get different answers for the same question. If the call center employees don't know FAQ, how can an office know?
3. Authorization was poor. Payment poor. Total experience was bad.
4. Too much hassle, too low reimbursements, too many pre-authorizations, too many denials, too much bookkeeping.
5. $1,000 maximum. (Carrier) reps are rude. Pre-auth for denture is ridiculous.
6. Front desk was spending too much time trying to get payment for services rendered or approval for recommended treatment.
7. Confirming eligibility the first of the month was a nightmare. Led to cancelling patients last minute. We would have a prior authorization for partial or complete dentures and if it took more than 1-2 weeks to complete patient may have lost eligibility and we here are left with dentures. There needs to be some sort of wiggle room. Reimbursement became so low it was a joke. Entitled patients not worth it.
8. low reimbursements, difficulty getting pre-authorizations, pre-authorizations not being upheld as allowed procedures

9. In the cases where treatment plans are large and extensive, we require payment in full from the prior auth amount prior to surgery.
10. Levels of reimbursement and the amount of documentation needed for reimbursement was the main reason to drop (carrier) plan.
11. Poor reimbursement, determine red tape to get claim, pain, etc.
12. The reimbursement rates are too low. I can't afford to take on more. The new requirements are too much paperwork. The whole program is broken.
13. Cluster/mess! Paperwork nightmare, can't believe this is our best foot forward as a State.
14. 1) Reimbursements went down. 2) Paper work went up.
15. Coverage is horrible. Too much documentation and regulations to negotiate to get paid nothing.

Failed appointments

1. Low reimbursement and patients don't keep their appointments.
2. Broken appts. Low fee reimbursement. Too many rules, which lead to confusion.
3. Too many patients cancelling on short notice.
4. 1) Lower reimbursement rates. 2) Stricter guidelines for patients. 3) Dependability of patients.
5. Reimbursement rate decrease. High patient failure rate.
6. 1) Poor reimbursement. 2) Too many no-show patients.
7. Too many hoops/regulations for amount of reimbursement that historically had been considered charity or taking our fair share of the underserved community. No offense but typically patients fail their reserved appointment which adds to the loss of revenue.
8. Fee reimbursement is less than 50% of our charges. Patients are not all responsible for their appointment-failures.
9. 1) Lack of coverage. 2) Poor payments. 3) Failed appointments. 4) Prior auth.
10. Lack of payment for services. Multiple appt failures. Lack of pt. appreciation of services provided.
11. Low reimbursement, high no show rate.
12. Too many patients, too much write-off. Not sustainable at 50%. Poor attendance, poor attitudes/demanding attitudes. Smelly waiting room with BO/smoke/muddy shoes/theft of stupid things (coasters, TP, coffee creamers, plants, music system). Headaches. Low reimbursement.
13. See above - pts were late to appts, failure rate very high, large number of needs, poor oral hygiene and poor eating habits, lots of high caries risk and no behavior change, prob w/referrals.
14. Poor compliance of patients and low reimbursement (lose $ on many patients).
15. Poorer reimbursement, increased time required to learn the new system for staff atop an already disproportionate amount of time dedicated to DWP 1.0, poor patient involvement = lots of missed appointments.
16. Cost to payment ratio/most patients need a lot of treatment and cannot offer great patient care due to max, etc. Patients unreliable, no call, no show. Write offs on non-payment of claims, etc.
17. The fee schedule, no shows.
18. 1) Poor reimbursement. 2) Low quality patients who are not reliable.
19. Poor reimbursement. Lack of patient responsibility.
20. Confirming eligibility the first of the month was a nightmare. Led to cancelling patients last minute. We would have a prior authorization for partial or complete dentures and if it took more than 1-2 weeks to complete patient may have lost eligibility and we here are left with dentures. There needs to be some sort of wiggle room. Reimbursement became so low it was a joke. Entitled patients not worth it.

Complexity of rules & regulations/too many restrictions

1. Did not feel the tiered services were worth our time vs reimbursement rate. Too many stipulations.
2. Pre-auth for DWP wasn't recognized by (carrier) if patient switched insurance. Insurance eligibility is month to month. Received an audit for endo (carrier). The staff at (carrier), Title XIX and (carrier) seem to be uninformed and we get different answers for the same question. If the call center employees don't know FAQ, how can an office know?
3. Broken appts. Low fee reimbursement. Too many rules, which lead to confusion.
4. Reimbursement is awful and too many hoops to jump through.
5. Too many hoops/regulations for amount of reimbursement that historically had been considered charity or taking our fair share of the underserved community. No offense but typically patients fail their reserved appointment which adds to the loss of revenue.
6. Lower reimbursement. Too complicated.
7. Too many rules (etc. X-rays after seal of CRN) causing unnecessary radiation along with no reimbursement.
8. We made changes because reimbursement dropped dramatically and rules dramatically increased.
9. Rules, new fee schedule.
10. We feel trapped into continuing treatment for the ones we already accepted. I'm not sure how you expect to have dentists see new patients when you roll out a program with one set of rates and then replace those rates with Medicaid rates. With the rate of failed Medicaid/IHW appointments, it is not easy to stay profitable seeing patients with that insurance. Rates are a joke. You attracted dentists with the original rates, now dentists are frustrated with the new rates. It is easier just not to see those patients. On top of this, the red tape and hours of work to get reimbursement just isn't worth it. Many times we just write off the amount because the fight with Medicaid/(carrier) will cost more in manpower hours than the reimbursement itself.
11. Red tape.
12. Required post op radiographs of crowns, denied payment on completed work even with perfect crowns.

Claim denials/delayed payments

1. Claim coverage is very lacking which causes us the provider to write off almost the entire bill.
2. Too much hassle, too low reimbursements, too many pre-authorizations, too many denials, too much bookkeeping.
3. Required post op radiographs of crowns, denied payment on completed work even with perfect crowns.
4. Poor customer service (carrier), poor payment (carrier).

5. Denial of rules of treatment by Delta that reduced our efficiency of treatment (which is standard treatment for all patients) and at times denied reimbursement because we did not do it their way.
6. Lack of payment for services. Multiple appt failures. Lack of patient appreciation of services provided.
7. Cost to payment ratio/most patients need a lot of treatment and cannot offer great patient care due to max, etc. Patients unreliable, no call, no show. Write offs on non-payment of claims, etc.
8. In the cases where treatment plans are large and extensive, we require payment in full from the prior auth amount prior to surgery.

Patient lack of understanding of plan and lack of compliance with HBs requirements
1. Further cuts in the benefit and frustration with rules patients can't/don't follow/understand.
2. Reimbursement decrease, elimination of previous bonus pool. Patient confusion of benefits. No specialist participation.
3. Patients don't understand anything about their insurance. Our office does not get paid hardly anything after we see these patients.
4. Further cuts in the benefit and frustration with rules patients can't/don't follow/understand.
5. Care of patient restricted due to $1000 max and assessment if not completed reduces status to basic services.
6. 1) Lower reimbursement rates. 2) Stricter guidelines for patients. 3) Dependability of patients.
7. People max out of benefits. They have not completed oral health assessment. The basic eligibility.
8. Lower reimbursement, difficulty with patient compliance with the assessment forms, annual maximum is a pain to keep track of, eligibility is unknown from month to month, etc.

Issues with benefit levels (covered services)
1. Did not feel the tiered services were worth our time vs reimbursement rate. Too many stipulations.
2. Further cuts in the benefit and frustration with rules patients can't/don't follow/understand.
3. 1) They changed the structure and fee schedule. 2) Lowered fees.
4. 1) Lack of coverage. 2) Poor payments. 3) Failed appointments. 4) Prior auth.
5. Coverage is horrible. Too much documentation and regulations to negotiate to get paid nothing.
6. People max out of benefits. They have not completed oral health assessment. The basic eligibility.
7. Because of the drop in coverage we no longer are accepting any new patients

Too many DWP patients/ busy practice
1. Overabundance of DWP.
2. We reached maximum capacity of the number of patients we are able to accept; the reimbursement rate is currently 45% of our normal fee schedule.
3. We had to stop seeing/accepting new DWP pts because we are too busy, and the benefit levels were hard to keep on top of.
4. Overload of pts as fewer dentists are accepting this plan.
5. 1) Too many calling from outside our area. 2) A few local dentists retired so too busy with new patient load to take more.
6. Our practice has grown tremendously in the past few years due to other dentists around the area retiring. We did not have any more room in our schedule to take on any more patients with this insurance.

High patient treatment needs
1. 1) These people need multiple major things. 2) Never know when they are basic.
2. The reimbursement is so low, it does not cover the materials to restore teeth. Therefore, we cannot accept new patients, they have too much treatment.
3. Patients were late to appts, failure rate very high, large number of needs, poor oral hygiene and poor eating habits, lots of high caries risk and no behavior change, prob w/referrals.
4. As stated above, we started taking DWP. Now we only see new ones if they are living in a nursing home or skilled facility (local). The other patients we started seeing required extensive dental treatments and we just don't get reimbursed enough to continue seeing more patients.
5. Cost to payment ratio/most patients need a lot of treatment and cannot offer great patient care due to max, etc. Patients unreliable, no call, no show. Write offs on non-payment of claims, etc.

Provider bonus eliminated/non-incentives
1. Lowered reimbursement. No incentive bonus program. Lose money on every patient.
2. Bonus is gone, reduced fees, a local gov't sponsored clinic opened in Mason City 2 million!
3. Implementing the $1,000 max, reducing the reimbursement rates drastically, eliminating the bonus for doing the risk assessments.
4. Reimbursement decrease, elimination of previous bonus pool. Patient confusion of benefits. No specialist participation.

Practice changes
1. See above.
2. Do not want to see any new DWP patients, due to office changes.

3. The dentist that was accepting DWP left the office. 4. Staff and doctor charges. Two doctors resigned and we no longer have capacity for Medicaid/DWP.

Customer services/availability of information
1. Pre-auth for DWP wasn't recognized by (carrier) if patient switched insurance. Insurance eligibility is month to month. Received an audit for endo (carrier). The staff at (carrier), Title XIX and (carrier) seem to be uninformed and we get different answers for the same question. If the call center employees don't know FAQ, how can an office know? 2. $1,000 maximum. (carrier) reps are rude. Pre-auth for denture is ridiculous. 3. Poor customer service (carrier), poor payment Delta. 4. discontinued (carrier), terrible customer service. Delta is easy to work with, reimbursement could be better.

Negative experience with carrier
1. We are not credentialed with (carrier). They are very unfriendly and threatened to sue if we didn't join. They are rude to our patients that want to switch to (carrier). It has been a very bad experience. 2. I stopped accepting (carrier) patients because (carrier) was so difficult to work with. Plus their requirements were different from (carrier) making overall treatment more confusing and difficult and time consuming.

Preference for DWP 1.0
1. The merge is what caused me to no longer be a provider. 2. because Title XIX combined with DWP and the reimbursements decreased, we could no longer only accept new DWP because it allowed all previous Title XIX also. We were overloaded with new patients and the reimbursement was so low we could not continue, so we stopped taking all DWP

Other
1. (Carrier) and (carrier) require providers to be participating members of each. We are not. 2. We accept more since we don't have so many steps that must be taken from patient or doctor to receive care. 3. Too many offices not seeing them. 4. A local gov't sponsored clinic opened in Mason City 2 million! 5. To keep Medicaid patients that were changed to DWP. 6. Because of all the Medicaid patients that changed to DWP. 7. Medicaid should be run by the State. As a taxpayer I am upset that we don't simplify our State run system instead of paying money to an insurance company who is going to take our money in and not pay out what it takes us. This whole idea makes no sense! 8. Joined private practice.

Has your acceptance of new Medicaid-enrolled children since DWP 2.0 was implemented in August 2017?- Yes, please describe how it changes?

All survey respondents

No longer accepting new Medicaid-enrolled children
1. Same as the other reason (no longer accept new). 2. Stopped all new patients. 3. We are not accepting any new patients. 4. Quit taking. 5. 95% were NO SHOWS. 6. No new unaffiliated patients. 7. We are not accepting new patients with this insurance. 8. Stopped taking any new pts. 9. No longer accepting. 10. No new patients. 11. Stopped taking new patients. 12. No longer accepting any new patients, considering discontinuing even for current patients. 13. We are not accepting new patients. 14. Won't accept any more. 15. Not seeing new Medicaid pts. 16. Do not accept. 17. Quit accepting new patients. 18. We stopped seeing new patients. 19. Stopped accepting new Medicaid enrolled children. 20. Not accepting any NEW patients with XIX. 21. Stopped accepting them in 2019.

22. No new patients.
23. We are no longer accepting new Medicaid-enrolled children.
24. I won't accept any new ones.

Reduced acceptance of new Medicaid-enrolled children
1. Less.
2. Limiting number of new patients.
3. Had to reduce number. See question #13.
4. Limited.
5. Just this month because we are getting booked out more than 3 months and one assistant is out with shoulder surgery.
6. We accept limited number of new pt.'s.
7. We had to limit the amount of patients we were seeing.
8. Same as #13 (Can't treat near as much or as many due to reimbursement levels).

Accept new Medicaid-enrolled children under special circumstances
1. Lower to just family members of existing patients.
2. No longer accepting new children unless referral.
3. Only family members of existing patients or emergencies.
4. We only except them for review by doctor.
5. No new pts, only emergency Tx for new children pts.
6. We have stopped accepting new XIX (with the exception of dentist referrals).
7. We only see new ones if they are in pain and we do it for free. Not worth all the filing and jumping through the hoops for 20% reimbursement.
8. no longer accepting except emergencies.

No longer accepting new/existing Medicaid-enrolled children
1. We no longer see Medicaid-enrolled children at all.
2. No longer seeing them.

No longer enrolled/couldn't enroll as Medicaid provider
1. Stopped being a provider.
2. See DWP responses (Couldn't get enrolled/paid with my current employer. Bureaucratic nightmare).

Other
1. Stopped taking DWP.
2. prior to Aug 2017 my dentist father died.
3. Cannot afford to stay in practice and see patients at this reimbursement level.

What are the main reason(s) why your Medicaid participation changed since DWP 2.0 was implemented in August 2017?

All survey respondents

Reimbursement
1. Due to extremely low reimbursement fees and no shows.
2. See prior answer (#14).
3. Lowered reimbursement. My overhead has increased. Bad opinion of (carrier) due to DWP.
4. No shows, low reimbursement rates.
5. Reimbursements and no show rate.
6. Low reimbursement rates.
7. Low reimbursement. High no show rate.
8. See question #14.
9. Keep increasing members but not funding. Expect dentists to pay for the program.
10. Low reimbursement.
11. Reimbursement no shows/cancelations.
12. Same as question #14.
13. Very poor payment.
14. Reimbursement too low.
15. Same as #14.
16. Low reimbursement, failed appointments.
17. Fee schedule, also see #14 above.
18. Reimbursement again.
19. 1) Poor reimbursement. 2) Too many broken appointments.
20. The fee rate.
21. Unreliable patients, poor reimbursement.

22. Poor reimbursement. Lack of responsibility.
23. The reimbursement for DWP 1.0 was subsidizing my T19 patients because the reimbursement for T19 was so low. Once DWP reimbursement was lowered to T19 levels, we could no longer afford to see DWP not T19 patients so we were forced to dismiss them all from the practice.
24. Reimbursement, attendance of pt.'s, too many hoops, enrollment changes too much.
25. Low reimbursements.
26. Rules, fees.
27. Cannot afford to see them.
28. Tired of the bait and switch or payment and coverage.
29. 1. Rates; 2. Failed appointments; 3. Red tape dealing with getting reimbursement for claims. All the hours paying someone to fight with Medicaid is more than the reimbursement in most cases."
30. The reimbursement continues to go down and we cannot afford to see them.
31. Low reimbursement and difficulty in verifying benefits.
32. Reimbursement is low.
33. Crappy fee schedule.
34. Same as above.
35. We want to be there for the children. We want them to be in optimum oral health. Taking more children than adults due to reimbursement.
36. Too many hassles with reimbursement to provider as a specialist/oral surgeon.
37. Program has lots of demanding rule and no profit.

Cancelled/failed appointments

1. Due to extremely low reimbursement fees and no shows
2. Non-compliance.
3. No shows, low reimbursement rates.
4. Reimbursements and no-show rate.
5. Low reimbursement. High no show rate.
6. See question #14.
7. Reimbursement no shows/cancelations.
8. Again, late shows, high failure, no contact info or changed phone numbers, high needs, poor diets, poor oral hygiene.
9. Low reimbursement, failed appointments.
10. 1) Poor reimbursement. 2) Too many broken appointments.
11. Unreliable patients, poor reimbursement.
12. Reimbursement, attendance of pt.'s, too many hoops, enrollment changes too much.
13. 1. Rates; 2. Failed appointments; 3. Red tape dealing with getting reimbursement for claims. All the hours paying someone to fight with Medicaid is more than the reimbursement in most cases.

Too many patients/ busy practice

1. Our office is too busy.
2. Overabundance of DWP/Medicaid.
3. Patient load increased dramatically in March (see #14) so not taking hardly any new patients.
4. Our practice has grown tremendously in the past few years due to other dentists around the area retiring. We did not have any more room in our schedule to take on any more patients with this insurance.
5. Too many patients, too much write-off. Not sustainable at 50%. Poor attendance, poor attitudes/demanding attitudes. Smelly waiting room with BO/smoke/muddy shoes/theft of stupid things (coasters, TP, coffee creamers, plants, music system). Headaches. Low reimbursement.
6. Just short on assistant these last few months. We will always see children.
7. The demand was getting too large.
8. The numbers of children on Medicaid in our area is very high. We do have some great referrals for other offices.
9. Staff and doctor charges. Two doctors resigned and we no longer have capacity for Medicaid/DWP.
10. only dentist in practice

Complexity of rules & regulations/too many restrictions

1. Coverage is horrible. Too much documentation and regulations to negotiate to get paid nothing.
2. Reimbursement is awful and too many hoops to jump through.
3. Reimbursement, attendance of pt.'s, too many hoops, enrollment changes too much.
4. Rules, fees.
5. 1. Rates, 2. Failed appointments, 3. Red tape dealing with getting reimbursement for claims. All the hours paying someone to fight with Medicaid is more than the reimbursement in most cases.
6. Red Tape.
7. Program has lots of demanding rule and no profit.
8. Difficulty in verifying benefits.

Negative experience with program

1. State changes to insurance overall. This part was more of collateral damage from adult patients. We as an office decided to forego all Medicaid patients regardless of age.
2. Lowered reimbursement. My overhead has increased. Bad opinion of (carrier) due to DWP.
3. Made a decision to not take any more new DWP/Medicaid patients, frustration w/the program.
4. Tired of it.

Attitudes towards Medicaid patients
1. Too many patients, too much write-off. Not sustainable at 50%. Poor attendance, poor attitudes/demanding attitudes. Smelly waiting room with BO/smoke/muddy shoes/theft of stupid things (coasters, TP, coffee creamers, plants, music system). Headaches. Low reimbursement.
2. Again, late shows, high failure, no contact info or changed phone numbers, high needs, poor diets, poor oral hygiene.
3. Poor reimbursement. Lack of responsibility.

Issues with benefit levels (covered services)
1. Coverage is horrible.
2. Tired of the bait and switch or payment and coverage.
3. No longer taking on new Medicaid patients due to the low coverages

Administrative burden
Difficulty tracking benefits, eligibility, educating patients.
1. Fee schedule, also see #14 above- The changes in the fee schedule have dramatically decreased. It seems with every change, the fee schedule is reduced and our responsibilities increase in checking pt. eligibility. We have a decent number of patients with DWP, but fees are so low that they don't even cover what I pay my hygienists' wages for the time spent, and don't even cover lab bills, much less other expenses for removable and repairs.
2. Reimbursement, attendance of pt.'s, too many hoops, enrollment changes too much.

Claim denials/delayed payments
1. Claim coverage is very lacking which causes us the provider to write off almost the entire bill.
2. See above- We got the run-around from Medicaid after the switch so we stopped taking new. We didn't get paid for seven months.

Pre-authorizations issues/paperwork
1. low reimbursements, difficulty getting pre-authorizations, pre-authorizations not being upheld as allowed procedures

Other
1. We take limited numbers according to what we are told to accept and how our practice is doing financially.
2. The reimbursement for DWP 1.0 was subsidizing my T19 patients because the reimbursement for T19 was so low. Once DWP reimbursement was lowered to T19 levels, we could no longer afford to see DWP not T19 patients so we were forced to dismiss them all from the practice.

What is the most important change that could be made to improve the Dental Wellness Plan?

All survey respondents

Reimbursement
1. Pay more on claims to take the burden off the provider.
2. At least return to the previous fee schedule prior to partnering with Medicaid.
3. Better reimbursement.
4. Increase reimbursement. Bonus program needs to be redone. I feel deceived, signed up for DWP because of bonus reimbursement, then took away bonus!
5. Higher reimbursements.
6. Reimburse at a reasonable rate, perhaps 80% customary fees.
7. Increase reimbursements.
8. Increase reimbursement, especially removable pros rates.
9. Higher reimbursement.
10. Reimbursement rates.
11. Fully funding it would solve problems with participation. A lot of people are on it but drive nice cars, wear brand clothing and take vacations. Clearly are not hurting for money, just don't want to spend it on healthcare.

12. Higher reimbursement and annual max.
13. 1) Simplify program. 2) Better reimbursement.
14. Having reimbursement be greater. A lot of work and not being compensated.
15. Limited number of services covered and it would allow better reimbursement rates. My frustration with both Medicaid and Dental Wellness is very high. Extremely high amount of $$ lost, wasted clinic time. Huge loss for my office.
16. Increase reimbursement rates.
17. Better reimbursement, higher amount paid in benefit period.
18. Reimbursement rate. Our overhead just goes up, we can't maintain a viable business with low reimbursement rates.
19. Increase reimbursement levels, stop paying for some services.
20. Reimbursement rates.
21. Reimbursement rates. I didn't like the fact it was more paperwork for much less reimbursement.
22. Reimbursement rates to practices need to go up and adjustments lower. Strict rules for patients on guidelines to keep their benefits and paying premiums.
23. Higher reimbursement rates to the providers.
24. Reimbursement rates. If the funding is too limited to provide better reimbursement, then the income levels to qualify for coverage should be modified to allow for better coverage for a smaller pool of patients most in need of the assistance. As it stands now, no dentists locally are accepting new patients w/DWP and most have stopped seeing even their existing patients. We are one of the few still seeing existing DWP patients, and have only continued to do so because we have a large pool of nuns who have been very good patients and they would have nowhere else to do. Currently, it is bad enough here (Dubuque) that our Community Health Center is scheduling 8 months out and has stopped accepting any new patients because patients have nowhere to go and they can't manage the patient load.
25. Raising reimbursement levels, I have been practicing 38 years and can't recall reimbursement amts ever increasing for any procedures. An interesting study would be to compare reimbursements at beginning of each of past 4 decades and the % of increase or decrease.
26. 1) Better reimbursement. 2) Patients not meeting requirements for full benefits should be held to the maximum; patients with full benefits shouldn't have a maximum.
27. Pay our dentists more. Make patients more aware of their insurance.
28. 1) Dramatically increase the reimbursement rates. 2) Dramatically decrease the number of people eligible for it. Should be limited to the physically/mentally disabled.
29. Reimbursement levels.
30. Increase rates.
31. Increase reimbursement and remove self assessment.
32. Increase reimbursements and more dentists will participate.
33. Improve reimbursement, don’t require us to sign up for Medicaid to be a provider.
34. I would like to see a program where providers were reimbursed for prophy, exam, films and BASIC restorations at the same level as good private insurance. I think participation would increase. Only pay for a select group of basic services but at a rate that a practice can operate or without a loss or trying to work too fast.
35. You can't expect offices to tailor to IHW/Medicaid. You need to tailor towards them. Other than providing for the needy (which could be argued with Medicaid fraud/abuse), what is the incentive for dentists to treat these people? You have to offer enough incentive to attract dentist to participate and stay with the program. Adding health assessments and burdens on offices makes no sense. I would never add more of a workload to my employees for lower reimbursements and more red tape. You are expected to known the program manual frontwards and backwards and it is just not feasible when we are contracted with 100 different insurance companies.
36. The reimbursement rates must be increased or no dentist will be able to afford to see any of them.
37. Reimbursement rates improve, patients be more informed on their policy.
38. Higher reimbursement rates-does not cover cost of patient care.
39. Higher reimbursement rates and less administrative work to verify benefits.
40. Reimbursement rate needs to increase.
41. Fee schedule and removal of benefit maximums. allow fee negotiation on up to 10 procedures as the expense of other.
42. Better Reimbursement for the dentist.
43. Make reimbursement 65% so general dentists can afford to accept it. No general dentists accept it in my area so as a specialist I was seeing all of them and they don’t qualify without seeing a general dentist the way the changes are now.
44. Higher reimbursement rates. Higher annual maximum. Don't roll your eyes. You don't go to work every day and expect to not get paid for your services, why should I? I can even swallow not getting paid (enough to cover my overhead) and consider it community service but when I can't provide comprehensive care because of the annual max, you're asking me to not get paid, stress about providing substandard care, doing it with my hands tied behind my back and then waiting a bad review to come from it. Where's the incentive besides basic human decency??

Administrative burden changes

1. 1) Simplify program. 2) Better reimbursement.
2. Revert back to qualifications in place 20 years ago, get rid of administrative hurdles. Streamline approval. Have procedures that are accepted and those that aren't on a last available to providers.
3. You can't expect offices to tailor to IHW/Medicaid. You need to tailor towards them. Other than providing for the needy (which could be argued with Medicaid fraud/abuse), what is the incentive for dentists to treat these people? You have to offer enough incentive to attract dentist to participate and stay with the program. Adding health assessments and burdens on offices makes no sense. I would never add more of a workload to my employees for lower reimbursements and more red tape. You are expected to known the program manual frontwards and backwards and it is just not feasible when we are contracted with 100 different insurance companies.
4. Higher reimbursement rates and less administrative work to verify benefits
5. Less paperwork for the staff/dentist.
6. Simplify it and allow dentist to control who they take and what they do.

Changes to annual maximum

1. Higher reimbursement and annual max.
2. 1) Better reimbursement. 2) Patients not meeting requirements for full benefits should be held to the maximum; patients with full benefits shouldn't have a maximum.
3. fee schedule and removal of benefit maximums. allow fee negotiation on up to 10 procedures as the expense of other.
4. Higher reimbursement rates. Higher annual maximum. Don't roll your eyes. You don't go to work every day and expect to not get paid for your services, why should I? I can even swallow not getting paid (enough to cover my overhead) and consider it community service but when I can't provide comprehensive care because of the annual max, you're asking me to not get paid, stress about providing substandard care, doing it with my hands tied behind my back and then waiting a bad review to come from it. Where's the incentive besides basic human decency??

Healthy behavior requirement changes
1. Reimbursement rates to practices need to go up and adjustments lower. Strict rules for patients on guidelines to keep their benefits and paying premiums.
2. 1) Better reimbursement. 2) Patients not meeting requirements for full benefits should be held to the maximum; patients with full benefits shouldn't have a maximum.
3. Increase reimbursement and remove self-assessment.

Revise enrollment eligibility
1. Fully funding it would solve problems with participation. A lot of people are on it but drive nice cars, wear brand clothing and take vacations. Clearly are not hurting for money, just don't want to spend it on healthcare.
2. Reimbursement rates. If the funding is too limited to provide better reimbursement, then the income levels to qualify for coverage should be modified to allow for better coverage for a smaller pool of patients most in need of the assistance. As it stands now, no dentists locally are accepting new patients w/DWP and most have stopped seeing even their existing patients. We are one of the few still seeing existing DWP patients, and have only continued to do so because we have a large pool of nuns who have been very good patients and they would have nowhere else to do. Currently, it is bad enough here (Dubuque) that our Community Health Center is scheduling 8 months out and has stopped accepting any new patients because patients have nowhere to go and they can't manage the patient load.
3. 1) Dramatically increase the reimbursement rates. 2) Dramatically decrease the number of people eligible for it. Should be limited to the physically/mentally disabled.

Covered services and benefits
1. Limited number of services covered and it would allow better reimbursement rates. My frustration with both Medicaid and Dental Wellness is very high. Extremely high amount of $$ lost, wasted clinic time. Huge loss for my office.
2. Increase reimbursement levels, stop paying for some services.
3. I would like to see a program where providers were reimbursed for prophy, exam, films and BASIC restorations at the same level as good private insurance. I think participation would increase. Only pay for a select group of basic services but at a rate that a practice can operate or without a loss or trying to work too fast.

Revise oversight and administration of program
1. Have all State based under 1 oversight group/structure who has knowledge of dentistry both business and ethics. Dentistry has competing forces: 1) creating revenue, 2) follow ethics and morals to treat within reasonable standards. These forces require previous experience in dentistry and requires for profit companies to get lost.
2. State management instead of private insurers.

Address issue of failed appointments
1. Find some way to get patients to show up for the appointments we save for them.

Provider Network Availability
1. Make reimbursement 65% so general dentists can afford to accept it. No general dentists accept it in my area so as a specialist I was seeing all of them and they don't qualify without seeing a general dentist the way the changes are now.

We are interested in any other comments you may have about the Dental Wellness Plan. All survey respondents

Reimbursement
1. When I signed up originally with DWP, the reimbursement was at a semi-reasonable level. When it joined Medicare, the rates dropped about 20%. The term BAIT AND SWITCH came to mind because I didn't want to refuse the patients that I was committed to, but felt it was inappropriate to lower rates.
2. Only other downfall is the plan does not reimburse well.
3. Reimbursement.
4. Please make simple and pay more.

5. We get many calls, sometime from great distances looking for a dentist that takes Wellness. I feel that higher reimbursement rates would help dentists that take Wellness and may encourage others to take some. We feel that if every dentist takes a few Wellness patients it would help bottom line is to increase reimbursement.
6. In regards to reimbursement we are referring all composites because it does not cover costs. I personally liked the tiered benefit plan. Pre-authorizations are coming back slower than previously.
7. The bottom line is the fee schedule. Example, the lab fee to have a denture made is almost as high as the reimbursement fee, partials are worse!
8. Reward the patients and doctors who care. We have always felt it is our duty to help lower income patients but this is also a business that needs to be profitable.
9. Increase fees, reimbursement rate.
10. The decision to reduce DWP reimbursement levels back to Medicaid fee schedule was a stab in the back to providers trying to help this population despite all the other challenges.
11. Reimbursement amounts do not cover provider expenses, lab fees, material cost, supplies.
12. Bring back bonuses. No incentives for dentists to take this. Reimbursement is very poor.
13. The whole program stinks because the payments don't cover the cost of providing the treatment. The DWP should have been scrapped after the funding went away. It really bothers me the way dentists are treated.
14. I think most dentists would like to see more of these patients but it's just so expensive to run a clinic. With the digital world it's not only the expense of buying the equipment but the monthly fees, storage, etc. involved with having it. You feel like you have to get the maximum dollar for every hour you are open. Normal dental insurance reimbursement rates are going down also as costs are going up. This doesn't help with accepting new Title XIX/DWP patients. I don't know if it would help to increase the reimbursement rate some but it may.
15. You will continue to see more and more dentist choose to not commit to DWP due to the low reimbursement rates.
16. DWP has created an urgent problem in an environment where there are too many patients and not enough providers accepting new patients, with a reimbursement rate of 33-37% you will continue to lose valued providers. I'm sure those at the helm of this organization wouldn't go to work for 33% of their wages.
17. Again, reimbursement rate is a burden!
18. Hard to cover lab costs/overhead w/the low reimbursement rates.
19. If the reimbursement rate was more we would be able to accept more patients. We do accept new patients with Hawk I.
20. Lab fees for denture/partial procedures and repairs are higher than reimbursement fee. Cannot add tooth/clasp, rebase, etc. without losing money.
21. Too many rules. Low rates and yet much more work for business team.
22. Any associates whose production is adjusted by the decrease in DWP reimbursements and then is paid at a % of production (say 35% or 40%) is crazy to Tx the DWP or Medicaid patients.
23. Difficult to institute, low pay scale.
24. Reduce the paperwork for my staff to file claims and most of all raise reimbursement rates to a fair level.
25. Reimbursement should be more!
26. Other partner dentist in practice stopped accepting new DWP when fee/benefit structure reduced to Medicaid reimbursement.
27. Payment is woefully inadequate. Let us take loss of tax bill.
28. I believe that this is not an access problem. It is a funding problem. I saw Medicaid dental patients for about 25 years, but it becomes impossible or crazy to keep doing it with the incredibly low reimbursement, bad behavior of patients, like not keeping appts., and crazy cumbersome added paper work and regulations to provide.
29. My overhead is too high. Medicaid reimbursement is too low and it takes 3x the manpower to collect the minimum reimbursement. Not planning on taking it any time soon.
30. It is too bad you reduced coverage rates for people who were taking it.
31. All practice overhead increases annually. Reimbursement stays the same or decreases annually. Why?
32. It is totally broken and everyone just keeps trying to put a band aid on it. It has to be funded higher. Why are dentists being reimbursed a substantially less percentage than physicians or pharmacies for welfare patients? We are close to cancelling our Medicaid provider number and just seeing those who are truly in need and doing it for free. The reimbursement isn't worth it and there are many patients on the plans that should not be.
33. Reimbursements cannot support the work we do. Lab work costs more than the reimbursement for all removable appliances.
34. This is the highest risk population in general. They tend to have low health understanding/education and high medical needs. There are almost no specialists which can see the pts in a timely manner(in my area) and they tend to be the least able group to travel far. They tend to require more chair time for proper explanation/understanding as well as medical screening. They have very low reimbursement rates. This makes it so very few providers see them. (It easy to lose money seeing these pts with the rate/time ratio as they don't even cover overhead, especially when other pts could have been seen instead) DWP insurance makes it "look" like they are covered when most, in fact, can NOT find proper care. I don't think its working from a public health stand point.
35. Fees are too low.
36. At the present time, given the level of reimbursement, you might as well go home and do something productive.
37. Cut the red tape for filing claims and getting reimbursement. Allow Doctors to write-off the difference between their fee and the DWP payment on their taxes- at current reimbursement rates the doctors aren't even close to covering their costs to perform any services rendered.
38. get rid of the max, and increase rates.
39. The lack of access to affordable healthcare is a serious issue. Dentistry is no different. It is becoming a service that only "wealthy" citizens are able to afford. In my opinion, this starts with government plans such as the DWP, that are completely causing the opposite effect of what they are intended to do. They are in place, so that low-income families can afford dental care, however most providers can not afford to accept these plans. As a business owner, I would lose money by accepting patients that participate in DWP or Medicaid. I want to help the underserved as much as anyone, but I also have to operate a business in a way that is sustainable. If reimbursement to providers for these programs was more reasonable, providers like me would not have such high fees for the rest of our patients. It is a chain reaction that affects everyone from the patient to the provider. Poor reimbursement for government funded healthcare insurance plans causes providers to not enroll, which leads to low access to care. This further leads to providers needing to increase their customary fee schedule, which increases the cost of care for patients that are not enrolled in these programs.
40. The pay is no good. But that is not my concern. The 1000.00 limit is the problem in my oral surgery practice.
41. Improve reimbursement or discontinue the plan.

42. Administrative aspect is nightmare. Increase overhead with low reimbursement makes no sense.

Patient accountability

1. Somehow need to make a way for patients to be accountable for their appts and ones they miss multiple times.
2. Educate the patients into making their appointment, understanding what benefits are and respecting the time the doctor and staff are spending with patients.
3. Find a better way to record missed appointments and hold patients responsible for them.
4. I generally don't like entitlement programs. The patients tend to feel entitled and not really thankful to anyone. I think patients have a better attitude when they are paying something for their dental services.
5. Difficult group of pts. - miss many appts w/no consequences, not a reliable patient population.
6. Broken appointments. Don't care if they miss appointments.
7. In contrast to what we were promised at the onset of DWP, reimbursement rates which were not great to begin with, have decreased, and the reliability of the patients has not increased. The same problems exist for DWP patients as previous XIX patients.
8. 1) Reimbursement obviously is too low to financially benefit and practice. 2) Patients need more responsibility for themselves copays/appt etc. to make them invested in their health.
9. We found it helped broken appts if pts were warned that they would be dismissed from practice.
10. We believe patients that have to pay just a little or have some responsibility to get the benefits really helps the patient keep their appointments and follow the rule of the program. When the only consequences are to the dentist-patients don't really care and really abuse the program.
11. The patients should have to pay a premium just like everyone else who has dental insurance.
12. I like the idea of encouraging patients to take some responsibility for their dental health but the DWP doesn't seem to be the solution.
13. I believe that this is NOT an access problem. It is a funding problem. I saw Medicaid dental patients for about 25 years, but it becomes impossible or crazy to keep doing it with the incredibly low reimbursement, bad behavior of patients, like not keeping appts., and crazy cumbersome added paper work and regulations to provide.
14. Failure rates are too high with this demographic in our area.
15. Concern over litigation from high risk clientele. Concern over patients keeping scheduled appts.
16. 1) Cost for patient of some kind - $3/month. 2) Accountability for patient. 3) High no show rate.
17. Please have these patients more invested financially than they are now. They don't realize the value of the care they are receiving. It would help with dentist involvement. It would keep patients out of the office that truly don't care enough to be there. No call/No show rates would also potentially drop if there was a financial penalty to the patient.
18. The biggest challenge though is unreliability of the patient population (i.e. missed appointments or late arrivals).

Lack of patient knowledge about program and its requirements

1. This is the highest risk population in general. They tend to have low health understanding/education and high medical needs. There are almost no specialists which can see the pts in a timely manner (in my area) and they tend to be the least able group to travel far. They tend to require more chair time for proper explanation/understanding as well as medical screening. They have very low reimbursement rates. This makes it so very few providers see them. (It easy to lose money seeing these pts with the rate/time ratio as they don't even cover overhead, especially when other pts could have been seen instead) DWP insurance makes it "look" like they are covered when most, in fact, cannot find proper care. I don't think it's working from a public health standpoint.
2. Patients do not understand the plan, there is a large amount of time used to explain treatment, insurance plan, etc.
3. Educate the patients into making their appointment, understanding what benefits are and respecting the time the doctor and staff are spending with patients.
4. Patients routinely complain about not receiving DWP information. Their confusion about their insurance costs my practice $ and time sorting out their individual plans/explaining the program/protocols to them.
5. Most people know nothing about their coverage. Very difficult to get them in to specialists.

Reduce administrative burdens

1. Please make simple and pay more.
2. I think someday the legal profession will hear of this loss of benefits due to a form not being completed, or a 3.00 premium being paid, and some patient will be harmed as a direct result of not receiving treatment planned care in a timely manner, and this will come back on our dentists and DWP administrators.
3. It's way more work to get a procedure covered i.e. having to send x-rays, narratives, charting, etc. Also, there is no reason a person should have DWP as a secondary plan, if they get private ins through an employer, they should not qualify, it only hurts the providers.
4. The administrative burden and the low reimbursement rate are forcing me to decide if treating this population makes financial sense for my business.
5. The cost of running a practice is so high these days and the amount of time trying to find specialists who take this insurance in our area, verifying eligibility, lost appointments, etc. is too great of a toss.
6. Reduce the paperwork for my staff to file claims and most of all raise reimbursement rates to a fair level.
7. Make a simplified system that providers are proud of! We are tax payers as well and we do care about providing for our fellow taxpayers.
8. I believe that this is NOT an access problem. It is a funding problem. I saw Medicaid dental patients for about 25 years, but it becomes impossible or crazy to keep doing it with the incredibly low reimbursement, bad behavior of patients, like not keeping appts., and crazy cumbersome added paper work and regulations to provide.
9. We do not need any plans that add to the amount of paperwork my staff already faces.
10. My overhead is too high. Medicaid reimbursement is too low and it takes 3x the manpower to collect the minimum reimbursement. Not planning on taking it any time soon.
11. It started out decent, but sometimes I wonder if the administrative burden is worth participating.
12. Better to allow participation for 3 months. Period then month to month. The scramble to verify eligibility of remaining funds per patient is a time drain, especially difficult for me first of each month.
13. Administrative aspect is nightmare. Increase overhead with low reimbursement makes no sense.

Complexity of rules & regulations/too many restrictions
1. Too many rules. Low rates and yet much more work for business team. 2. I believe that this is NOT an access problem. It is a funding problem. I saw Medicaid dental patients for about 25 years, but it becomes impossible or crazy to keep doing it with the incredibly low reimbursement, bad behavior of patients, like not keeping appts., and crazy cumbersome added paper work and regulations to provide. 3. This is the highest risk population in general. They tend to have low health understanding/education and high medical needs. There are almost no specialists which can see the pts in a timely manner (in my area) and they tend to be the least able group to travel far. They tend to require more chair time for proper explanation/understanding as well as medical screening. They have very low reimbursement rates. This makes it so very few providers see them. (It easy to lose money seeing these pts with the rate/time ratio as they don't even cover overhead, especially when other pts could have been seen instead) DWP insurance makes it "look" like they are covered when most, in fact, cannot find proper care. I don't think its working from a public health standpoint. 4. Cut the red tape for filing claims and getting reimbursement. 5. Allow Doctors to write-off the difference between their fee and the DWP payment on their taxes- at current reimbursement rates the doctors aren't even close to covering their costs to perform any services rendered. 6. See example I printed. There are many other examples, but this confusing handbook information is evidence. 7. Never do Medicaid again in current state. Seems like whole process is structured to frustrate patient and doctor. 8. So many rules - difficult to keep track. 9. Let DDS practice. Letting them treat as they see fit and not so many stipulations. 10. Our office is too afraid of the logistics of DWP in treatment planning and patient estimates to participate.

Financial concerns regarding practice viability
1. I feel like I lose money with each visit. I decided to take fewer patients and take really good care of them. Endo/crowns etc. I feel like it's giving back to the State that helped educate me. 2. I think most dentists would like to see more of these patients but it's just so expensive to run a clinic. With the digital world it's not only the expense of buying the equipment but the monthly fees, storage, etc. involved with having it. You feel like you have to get the maximum dollar for every hour you are open. Normal dental insurance reimbursement rates are going down also as costs are going up. This doesn't help with accepting new Title XIX/DWP patients. I don't know if it would help to increase the reimbursement rate some but it may. 3. Lab fees for denture/partial procedures and repairs are higher than reimbursement fee. Cannot add tooth/clasp, rebase, etc. w/o losing money. 4. All practice overhead increases annually. Reimbursement stays the same or decreases annually. Why? 5. This is the highest risk population in general. They tend to have low health understanding/education and high medical needs. There are almost no specialists which can see the pts in a timely manner (in my area) and they tend to be the least able group to travel far. They tend to require more chair time for proper explanation/understanding as well as medical screening. They have very low reimbursement rates. This makes it so very few providers see them. (It easy to lose money seeing these pts with the rate/time ratio as they don't even cover overhead, especially when other pts could have been seen instead) DWP insurance makes it "look" like they are covered when most, in fact, can NOT find proper care. I don't think its working from a public health stand point. 6. The lack of access to affordable healthcare is a serious issue. Dentistry is no different. It is becoming a service that only "wealthy" citizens are able to afford. In my opinion, this starts with government plans such as the DWP, that are completely causing the opposite effect of what they are intended to do. They are in place, so that low-income families can afford dental care, however most providers can not afford to accept these plans. As a business owner, I would lose money by accepting patients that participate in DWP or Medicaid. I want to help the underserved as much as anyone, but I also have to operate a business in a way that is sustainable. If reimbursement to providers for these programs was more reasonable, providers like me would not have such high fees for the rest of our patients. It is a chain reaction that affects everyone from the patient to the provider. Poor reimbursement for government funded healthcare insurance plans causes providers to not enroll, which leads to low access to care. This further leads to providers needing to increase their customary fee schedule, which increases the cost of care for patients that are not enrolled in these programs.

Review enrollment eligibility
1. It is totally broken and everyone just keeps trying to put a band aid on it. It has to be funded higher. Why are dentists being reimbursed a substantially less percentage than physicians or pharmacies for welfare patients? We are close to cancelling our Medicaid provider number and just seeing those who are truly in need and doing it for free. The reimbursement isn't worth it and there are many patients on the plans that should not be. 2. We have numerous pts that have 1.0 insurance and Medicaid as 2.0, why is this? Legislators are not aware that this is happening either? 3. It's way more work to get a procedure covered i.e. having to send x-rays, narratives, charting, etc. Also, there is no reason a person should have DWP as a secondary plan, if they get private ins through an employer, they should not qualify, it only hurts the providers. 4. Way more than the needy are covered and then the needy aren't covered enough. 5. Terrible program. Cannot understand why some people are eligible for it. We see patients of record, but no new patients. 6. State could do a better job at vetting patients on the DWP, most come in with iPhone X's and drive brand new cars. Most talk about taking trips and not working because they make more money by staying home and being on welfare. Legislation needs to change.

Dropping participation
1. Terrible plan. Seems like soon very few dentists will take it, Delta must be making a lot of money. 2. You will continue to see more and more dentist choose to not commit to DWP due to the low reimbursement rates. 3. DWP has created an urgent problem in an environment where there are too many patients and not enough providers accepting new patients, with a reimbursement rate of 33-37% you will continue to lose valued providers. I'm sure those at the helm of this organization wouldn't go to work for 33% of their wages. 4. It is totally broken and everyone just keeps trying to put a band aid on it. It has to be funded higher. Why are dentists being reimbursed a substantially less percentage than physicians or pharmacies for welfare patients? We are close to cancelling our Medicaid provider

number and just seeing those who are truly in need and doing it for free. The reimbursement isn't worth it and there are many patients on the plans that should not be.

5. The lack of access to affordable healthcare is a serious issue. Dentistry is no different. It is becoming a service that only "wealthy" citizens are able to afford. In my opinion, this starts with government plans such as the DWP, that are completely causing the opposite effect of what they are intended to do. They are in place, so that low-income families can afford dental care, however most providers cannot afford to accept these plans. As a business owner, I would lose money by accepting patients that participate in DWP or Medicaid. I want to help the underserved as much as anyone, but I also have to operate a business in a way that is sustainable. If reimbursement to providers for these programs was more reasonable, providers like me would not have such high fees for the rest of our patients. It is a chain reaction that affects everyone from the patient to the provider. Poor reimbursement for government funded healthcare insurance plans causes providers to not enroll, which leads to low access to care. This further leads to providers needing to increase their customary fee schedule, which increases the cost of care for patients that are not enrolled in these programs.

Negative experience with plan

1. The decision to reduce DWP reimbursement levels back to Medicaid fee schedule was a stab in the back to providers trying to help this population despite all the other challenges.
2. The whole program stinks because the payments don't cover the cost of providing the treatment. The DWP should have been scrapped after the funding went away. It really bothers me the way dentists are treated.
3. Terrible plan. Seems like soon very few dentists will take it, Delta must be making a lot of money.
4. Horrible plan, complete failure.
5. It is totally broken and everyone just keeps trying to put a band aid on it. It has to be funded higher. Why are dentists being reimbursed a substantially less percentage than physicians or pharmacies for welfare patients? We are close to cancelling our Medicaid provider number and just seeing those who are truly in need and doing it for free. The reimbursement isn't worth it and there are many patients on the plans that should not be.

Pre-authorization requirements

1. In regards to reimbursement we are referring all composites because it does not cover costs. I personally liked the tiered benefit plan. Pre-authorizations are coming back slower than previously.
2. Pre-authorization process has become more complicated. Administrative costs to me challenging.
3. Require less procedures to need preauthorized.
4. The old pay on auth system was more user friendly. We do like that it is a one stop shop for all varieties of (carrier) IA.
5. Pre-authorization of benefits take too long and are too frequently denied.

Issues with annual maximums

1. Get rid of the max, and increase rates
2. The pay is no good. But that is not my concern. The 1000 limit is the problem in my oral surgery practice.

Preference for DWP 1.0

1. In regards to reimbursement we are referring all composites because it does not cover costs. I personally liked the tiered benefit plan. Pre-authorizations are coming back slower than previously.

Provider incentives

1. Reward the patients and doctors who care. We have always felt it is our duty to help lower income patients but this is also a business that needs to be profitable.
2. The decision to reduce DWP reimbursement levels back to Medicaid fee schedule was a stab in the back to providers trying to help this population despite all the other challenges.
3. Bring back bonuses. No incentives for dentists to take this. Reimbursement is very poor.
4. It is totally broken and everyone just keeps trying to put a band aid on it. It has to be funded higher. Why are dentists being reimbursed a substantially less percentage than physicians or pharmacies for welfare patients? We are close to cancelling our Medicaid provider number and just seeing those who are truly in need and doing it for free. The reimbursement isn't worth it and there are many patients on the plans that should not be.

Benefits levels (covered services)

1. Way more than the needy are covered and then the needy aren't covered enough.
2. If we are trying to cut costs to raise reimbursement rates, it seems reasonable that only certain procedures would be available for these patients as a way to streamline costs.
3. With the benefit maximum, patients that ARE motivated to complete treatment (i.e. those that follow through with the requirements and keep appointments) are often disheartened or discouraged to find out that their "insurance" covers such a limited amount. In my practice, as an oral surgeon, this most frequently comes up when patients are referred for extraction of multiple teeth, but also have restorative needs (fillings, crowns, RPDs, CU/CL denture). By the time the non-restorable teeth are removed (or really only a few of the teeth) these patients have often exceeded their maximum. We have had issues with patients then following through with any treatment as many of them cannot come up with their estimated portion of the bill (even with reduced levels of reimbursement).
4. Keep the benefits provided basic.

Customer service/availability of information
1. Till I took this survey, I did not know all the details of maximums and benefit levels, nor do I know how to find out what each individual patient has. 2. Some of your employees are so rude! 3. Your call center is awesome! 4. Your website is hard, (carrier) much easier, not sure why they can't both be set up the same way.

Distribute patient burden
1. Philosophically, it would be good to have every licensed dentist see a few of these pts (1-2 every month) so that no one office feels compelled to see them all. 2. Whatever the plan needs to be offered but how to spread coverage to all dentists, so a few are not being overburdened. 3. 1) I truly believe that if every dentist saw a little and did their part, it would work better for everyone. 2) Unless you are a dentist whose office is operating in the red, you can take a little DWP.

Specialists availability
1. Lack of referring specialists in a huge problem. Allow referral sources we either full (meaning a 76 month wait) or a 2-3 hr. drive away. 2. Most people know nothing about their coverage. Very difficult to get them in to specialists. 3. The cost of running a practice is so high these days and the amount of time trying to find specialists who take this insurance in our area, verifying eligibility, lost appointments, etc. is too great of a toss.

Program oversight and administration
1. When you privatized this program it was ruined! 2. Get the State out of privatized insurance.

Provider network availability
1. We get many calls, sometime from great distances looking for a dentist that takes Wellness. I feel that higher reimbursement rates would help dentists that take Wellness and may encourage others to take some. We feel that if every dentist takes a few Wellness patients it would help bottom line is to increase reimbursement.

No comment
1. I am a specialist who does not use DWP so my only exposure to DWP comes from teaching (adjunct) at dental school. 2. No.

Other
1. No plan would ever keep me from seeing the children. 2. Things need to change! 3. I do my best for my patients. It is time their insurance carrier did too. 4. Need more than day notice for major changes. We get email on June 28 at 2:30 to learn about major changes effective July 1. 5. If the Iowa legislature would have manned up to our own Iowa program and paid for it, instead of yielding to the fed's DHS rules to get money, we would still have a good program. 6. Put pts back on Medicaid. 7. Want something for nothing. 8. Good luck on the study, doctor and I hope the Dental School Talent Show went well! 9. Good luck! 10. Your survey will be skewed if there is a government clinic in the community, i.e. socialized medicine. 11. It seems to be revolving back to old Title XIX. 12. The lack of access to affordable healthcare is a serious issue. Dentistry is no different. It is becoming a service that only "wealthy" citizens are able to afford. In my opinion, this starts with government plans such as the DWP, that are completely causing the opposite effect of what they are intended to do. They are in place, so that low-income families can afford dental care, however most providers can not afford to accept these plans. As a business owner, I would lose money by accepting patients that participate in DWP or Medicaid. I want to help the underserved as much as anyone, but I also have to operate a business in a way that is sustainable. If reimbursement to providers for these programs was more reasonable, providers like me would not have such high fees for the rest of our patients. It is a chain reaction that affects everyone from the patient to the provider. Poor reimbursement for government funded healthcare insurance plans causes providers to not enroll, which leads to low access to care. This further leads to providers needing to increase their customary fee schedule, which increases the cost of care for patients that are not enrolled in these programs. 13. If the goal is to help as many people as possible, the program would lower their overhead if they simply issued people on XIX, DWP, etc. a pre-paid card only good at dental offices. It would allow the person to choice the dentist of their choice, as well as their care. As it stands, the current model is one that has a bureaucracy (with little to no dental knowledge) wedged between the doctor and patient. I assure you, more doctors would accept my proposed scheme and it would be cheaper than building and maintaining a dental office within a CHC. 14. Please contact me to discuss what we can do to make DWP work for patients, providers, and the State of Iowa.

15. People with low income or disability should still be on a separate insurance plan so we can continue to see them.
16. DWP insurers should sit down with dentists and formulate a plan that is fair and works within the State budget. If you want DWP participants to QUALIFY for the plan have them do that before they get the benefit, not after.
17. It is totally broken and everyone just keeps trying to put a band aid on it. It has to be funded higher. Why are dentists being reimbursed a substantially less percentage than physicians or pharmacies for welfare patients? We are close to cancelling our Medicaid provider number and just seeing those who are truly in need and doing it for free. The reimbursement isn't worth it and there are many patients on the plans that should not be.

Positive comments

1. Design placing compliance back at patient's responsibility is excellent. Provider fee scale forces excessive loss of profit for participating providers.
2. Your call center is awesome!
3. In our experience, we enjoy our Dental Wellness patients. They appreciate their care.
4. Doctor and I have had discussions about the program. We wish we could change the mindset of the majority of the underserving population. This is a very generous program. Remove the fee-for-service from the formula and it would have a future.
5. I like the idea of encouraging patients to take some responsibility for their dental health but the DWP doesn't seem to be the solution.
6. I am looking forward to continued improvements.
7. (Carrier) website is great to use. Good job! I only accept (carrier).
8. I like that the patient has a copay, free means they have no investment and thereby take advantage of services but have no ownership.

Section 2

Healthy Behaviors Program: Disenrollment Survey Report 2019

Natoshia Askelson
Assistant Professor, Community and Behavioral Health**
Research Fellow, Health Policy Research Program*

Brad Wright
Associate Professor, Family Medicine****, Health Management & Policy**
Affiliate, Health Policy Research Program*

Patrick Brady
Graduate Research Assistant*
PhD Candidate, Community and Behavioral Health**

Montana Scott
Research Assistant*
Community and Behavioral Health**

Eliza Daly
Research Assistant, Health Policy Research Program*
Community and Behavioral Health**

Brooke McInroy
Research Associate, Health Policy Research Program*

Elizabeth Momany
Senior Research Scientist, Health Policy Research Program*

Peter Damiano
Director and Distinguished Research Fellow*
Bernstein Professor, Preventive & Community Dentistry***

*University of Iowa Public Policy Center
**University of Iowa College of Public Health
***University of Iowa College of Dentistry and Dental Clinics
****University of North Carolina at Chapel Hill

Background

The Iowa Health and Wellness Plan (IHAWP) is Iowa's version of the Medicaid expansion, approved by the federal government under a Section 1115 Demonstration waiver. Enrollment into IHAWP began on January 1, 2014. Originally, the IHAWP included two separate plans: 1) the Wellness Plan (WP) and the Marketplace Choice Plan (MPC). The WP was a more traditional, Medicaid-like program for adults with incomes from 0-100% of the Federal Poverty Level (FPL) who were not eligible for Medicaid through a categorical program. In the MPC, individuals selected a Qualified Health Plan (QHP) from eligible private plans in the Health Insurance Marketplace. Medicaid paid the health plan premiums for members in the MPC. MPC members originally could choose from two QHPs: CoOportunity Health, a non-profit health co-op, and Coventry Health Care of Iowa, a national managed care company based in Bethesda, MD. More information regarding the formulation and implementation of the IHAWP can be found online at http://dhs.iowa.gov/ime/about/initiatives/iowa-health-and-wellness-plan..

One feature of the IHAWP that is unique for a Medicaid plan is the healthy behaviors incentive program (HBP). IHAWP members can avoid paying a premium for their insurance after their first year of coverage by participating in the HBP. The HBP requires members to have a yearly medical or dental exam (a wellness visit) and complete a health risk assessment (HRA) to avoid paying a premium the following year. If the member does not complete these requirements during their first year of coverage, they may be required to pay a monthly premium ($5 or $10, depending on income). Members whose earnings are between 101% and 138% of the Federal Poverty Level must then pay the monthly premium or claim financial hardship to avoid being disenrolled.

The IHAWP changed in significant ways in its first 2 years. The first major change occurred within the MPC plan. CoOportunity Health withdrew as an option for MPC members at the end of November 2014. Approximately 9,700 CoOportunity Health members were automatically transitioned (while retaining their designation as MPC members) to WP coverage on December 1, 2014. MPC members who were not in CoOportunity Health remained in Coventry, the other QHP available to MPC members. Then, at the end of November 2015, Coventry Health ended services to MPC members and MPC members were placed in the traditional fee-for-service (FFS) program beginning December 2015. The 1115 waiver for the MPC program was not renewed. Early in calendar year 2015, there was a policy decision to transition members into one of three managed care plans. The transition to the three Medicaid Managed Care Organizations (MCOs) was implemented on April 1, 2016. The three Medicaid MCOs were Amerigroup Iowa, Inc., AmeriHealth Caritas Iowa, Inc., and UnitedHealthcare Plan of the River Valley, Inc. Following this, two MCOs withdrew and no longer offered coverage for IHAWP members and one MCO entered. AmeriHealth Caritas exited at the end of November 2017 and UnitedHealthcare exited at the end of June 2019. A new MCO, Iowa Total Care, a subsidiary of Centene, replaced UnitedHealthcare in early July 2019. Iowa Total Care, along with Amerigroup Iowa, are the two current Medicaid MCOs.

Wellness Exam

The wellness exam was defined as an annual preventive exam (New Patient CPT Codes: 99385 18-39 years of age, 99386 40-64 years of age; Established Patient CPT Codes: 99395 18-39 years of age, 99396 40-64 years of age) from any plan-enrolled physician, Rural Health Clinic (RHC), Federally Qualified Health Center (FQHC) or Advanced Registered Nurse Practitioner (ARNP). The exams were part of the preventive services covered by the plans and therefore did not cost the member anything out-of-pocket. A 'sick visit' could count towards the requirement of the preventive exam, if wellness visit components were included and the modifier 25 is added to the CPT code. Additionally, in January of 2015, a dental "well exam" also counted as a wellness exam. This included the dental codes D0120 (periodic oral

evaluation), D0140 (limited oral examination), D0150 (comprehensive oral examination), and D0180 (comprehensive periodontal exam). Members could also meet the wellness exam requirement by contacting Iowa Medicaid Enterprise (IME) and informing them that they have completed a well exam.

Health Risk Assessment

A health risk assessment (HRA) is a survey tool that was intended for use by members and providers to evaluate a member's health status. The HRA survey asked members about their health and their experiences in receiving health services. IME has identified Assess My Health as the preferred HRA tool. Members can complete their HRA themselves. IME provides a toll-free phone number for members to call to complete the survey and provides access to the tool on the IME website for members to complete the survey online.

Objective of the Current Report

This report provides an outline of the analyses and results from the 2019 IHAWP Disenrollment Survey. We focused on understanding the experiences of IHAWP members who had recently been disenrolled from the program due to failure to pay the required premiums. As we explain below, disenrollment has a significant impact on IHAWP members. By better understanding these experiences and the impact of disenrollment, we can better prevent future disenrollment and its consequences.

Methods

The 2019 IHAWP Disenrollment Survey was conducted between May and August of 2019. Surveys were mailed on a rolling monthly basis to members who were disenrolled from the IHAWP program for non-payment in the prior three months. For example, surveys mailed in May were sent to members who had been disenrolled as of February 1.

The monthly samples were drawn from Medicaid enrollment data. Individuals who had been disenrolled for failure to pay the IHAWP premium were identified through discontinuance data provided monthly and matched back to enrollment data to provide names and mailing addresses. In some cases, surveys were sent to multiple members in one household. The monthly groups varied in size as the monthly number of disenrolled members changed (Table 1).

Table 1. Sample Size for 2019 Disenrollment Survey by Survey Month & Disenrollment Month

Survey Month (Disenrollment Month)	N
May (February)	186
June (March)	186
July (April)	2
August (May)	251
Total	625

Survey packets were initially mailed to each group at the beginning of the survey month. The packets included the survey and a cover letter, which described the survey, stated that participation was completely voluntary, and provided a phone number to ask questions or opt out of the study. Respondents were given the option to complete the survey on paper or online by entering a unique access code. To maximize response rates for the survey, both a premium and an incentive were used.

Each initial packet included a $2 bill, and respondents who returned a completed the survey were sent a $20 Wal-Mart gift card.

One week after the initial survey packets were mailed, a postcard reminder was sent. Three weeks after the initial mailing, a reminder survey packet was sent to those who had not returned a completed survey.

Response Rate

There were 109 disenrolled IHAWP members who responded to the survey for an overall unadjusted response rate of 17%. Table 2 shows the response rates for each monthly group.

Table 2. IHAWP Disenrollment Survey Response Rates

	Total Eligible	Completed	Response Rate (%)
May	186	40	22
June	186	35	19
July	2	0	0
August	251	34	14
Total	625	108	17
Adjusted* Total	**463**	**109**	**24**

*Adjusted for ineligibles: Removed respondents who no longer had a valid address or were out of Iowa.

Analyses

Frequencies and descriptive statistics were produced. Data were tabulated using SPSS.

Results

Demographics

Disenrolled members who responded to the survey were mostly young adults, with 48.6% reporting that they were 34 or younger. Demographic characteristics of respondents are shown in Table 3 and 4. The majority of respondents were female (65.7%), white (80.7%), employed at least part time (74.1%), and had at least a high school degree or equivalent (98%), with 53.6% having at least some college experience or higher.

Table 3. Demographic Characteristics of Survey Respondents

	Respondents (n = 109)		Non-Respondents (n = 516)	
Characteristic	**n**	**percent**	**n**	**percent**
Age				
18 to 24	24	22.0	151	29.3
25 to 34	29	26.6	149	28.9
35 to 44	15	13.8	71	13.8
45 to 54	19	17.4	88	17.0
55 to 64	21	19.3	55	10.7
65 or older	1	0.9	2	0.4
Gender				
Male	36	33.3	250	48.4
Female	71	65.7	266	51.6
Other	1	0.9	0	0.0
Race & Ethnicity*				
American Indian/Alaska Native	1	0.9	N/A	
Asian	2	1.8	N/A	
Black/African American	11	10.1	N/A	
Hispanic/Latino	12	11.0	N/A	
Middle Eastern/North African	0	0.0	N/A	
Native Hawaiian or other Pacific Islander	1	0.9	N/A	
White	88	80.7	N/A	
Other race or ethnicity	1	0.9	N/A	

*Respondents were able to select multiple responses

Note: Non-respondents' characteristics are based on administrative data while respondent characteristics are based on self-reported data

Table 4. Employment and Educational Characteristics of Survey Respondents (n = 108)

Characteristic	**n**	**percent**
Employment		
Employed full time	53	49.1
Employed part time	27	25.0
Not employed	28	25.9
A homemaker	8	19.5
A student	3	7.3
Retired	4	9.8
Disabled/Unable to work	8	19.5
Temporarily laid off	1	2.4
Looking for work	17	41.5
Education		
8th grade or less	1	0.9
Some high school, but did not graduate	1	0.9
High school graduate or GED	48	44.4
Some college or 2-year degree	48	44.4
4-year college graduate	9	8.3
More than 4-year college degree	1	0.9

Accessing Resources – Respondent Participation in Assistance Programs and Access to Food, Internet & Health Materials

Nearly half of survey respondents (44%) participated in the Supplementary Nutrition Assistance Program, but participation for all other government assistance was under 10% (Table 5). When asked how often respondents worry about running out of food and not being able to buy more, 36.7% indicated that they sometimes worry, while 33% said they often worry (Table 6).

Table 5. Participation in Government Assistance Programs* (n=109)

Name of Government Assistance Program	n	percent
Supplemental Nutrition Assistance Program (SNAP)	48	44.0
Free or reduced school lunch program	9	8.3
Special Supplemental Nutrition Program for Woman Infants and Children (WIC)	3	2.8
Housing Assistance	4	3.7
Supplemental Security Income (SSI)	4	3.7
Temporary Assistance for Needy Families (TANF)	0	0.0
General Assistance (GA)	6	5.5

*Respondents were able to select multiple responses

Table 6. Self-Reported Food Insecurity of Respondents (n=109)

Characteristic	n	percent
In the last 12 months, how often respondents worried whether their food would run out before they got money to buy more		
Often	36	33.0
Sometimes	40	36.7
Never	33	30.3
In the last 12 months, how often respondents found that the food that they bought just didn't last and you didn't have money to get more		
Often	32	29.4
Sometimes	45	41.3
Never	32	29.4

When asked how often they need someone to help read instructions, pamphlets, or other written material from your doctor 15.6% of respondents noted that they often, sometimes or always need assistance (Table 7).

Table 7. Self-Reported Health Literacy of Respondents (n=109)

Characteristic	n	percent
How often respondents need someone to help read instructions, pamphlets, or other written material from your doctor?		
Always	4	3.7
Often	2	1.8
Sometimes	11	10.1
Rarely	9	8.3
Never	83	76.1

Health Characteristics of Survey Respondents

Almost half of respondents reported their overall health (47.7%) and mental and emotional health (40.3%) were fair or poor. About two thirds (64.5%) of respondents reported that their health status has not changed since enrollment while almost a third (30.8%) indicated that their health has gotten worse since they were disenrolled from IHAWP (Table 8).

The most cited chronic physical health conditions (Table 9) reported by respondents were back or neck problems (36.7%), allergies or sinus problems (35.8%), dental, tooth, or mouth problems (32.1%), overweight/obese (27.5%), and high blood pressure (23.9%).When focusing on emotional and mental chronic health conditions, respondents' top reported conditions were anxiety (59.6%), depression (43.1%), post-traumatic stress disorder (PTSD) (13.8%), and emotional problems other than depression or anxiety (11.9%), while respondents experienced all other conditions at rates less than 10% (Table 10).

Table 8. Self-Reported Health Status of Respondents

Characteristic	**n**	**percent**
Self-rated overall health (n=109)		
Excellent	3	2.8
Very good	11	10.1
Good	43	39.4
Fair	41	37.6
Poor	11	10.1
Self-rated overall mental and emotional health (n=109)		
Excellent	6	5.5
Very good	16	14.7
Good	43	39.4
Fair	37	33.9
Poor	7	6.4
Health status since disenrollment (n=107)		
My health has gotten worse	33	30.8
My health did not change	69	64.5
My health has gotten better	5	4.7

Table 9. Self-Reported Physical Health Conditions Lasted or Expected to Last for at Least Three Months (n=109)

Chronic Physical Health Condition*	n	percent
Allergies or sinus problems	39	35.8
Arthritis, rheumatism, bone or joint problems	24	22.0
Asthma	16	14.7
Back or neck problems	40	36.7
Bladder or bowel problems	9	8.3
Bronchitis, emphysema, COPD, or other lung problems	6	5.5
Cancer, other than skin cancer	3	2.8
Dental, tooth, or mouth problems	35	32.1
Diabetes	11	10.0
Migraine headaches	25	22.9
Digestive disease or stomach problems such as recurrent indigestion, heartburn, or ulcers	19	17.4
Overweight/obese	30	27.5
Hearing, speech, or language problems	8	7.3
Heart problems	6	5.5
High blood pressure	26	23.9
A physical disability	7	6.4
Any other chronic physical health condition (excluding mental health)	18	16.5

*Respondents were able to select multiple responses

Table 10. Self-Reported Emotional or Mental Health Conditions Lasted or Expected to Last for at Least Three Months (n=109)

Chronic Mental Health Condition*	n	percent
Anxiety	65	59.6
Depression	47	43.1
Emotional problems other than depression or anxiety	13	11.9
Drug- or alcohol- related problems	3	2.8
Attention problems	9	8.3
A learning disability	7	6.4
Post-traumatic stress disorder (PTSD)	15	13.8
Bipolar disorder	10	9.2
Schizophrenia or Schizoaffective disorder	1	0.9
Any other mental health condition	1	0.9

*Respondents were able to select multiple responses

Healthy Behavior Program

Over a third (39.4%) of respondents had heard of the Healthy Behavior Program (Table 11).

Almost half (45.9%) of respondents reported not getting a medical wellness exam (described as medical check-up or routine care to survey respondents) in the last year (Table 12). Top cited reasons for not getting a medical wellness exam included not having a doctor (30.8%) and not being able to take time

off of work (26.9%), (Table 12). Most respondents (62%) reported not getting a dental wellness exam (Table 13). Respondents cited not having a dentist (40.3%) as the top reason for not doing so (Table 13).

Table 11. Awareness of Healthy Behavior Program (n=109)

Characteristic	n	percent
Heard about the Healthy Behaviors Program		
Yes	43	39.4
No	66	60.6

Table 12. Medical Wellness Exam Completed Last Year & Reason for Lack of Completion

Characteristic	n	percent
Completed a medical check-up or wellness exam within the last year (n=109)		
Yes	59	54.1
No	50	45.9
Reason for not getting a medical check-up* (n=52)		
I had already had a medical check up this year	6	11.5
I am not sure where to go to get a medical check-up	7	13.5
It is hard to get an appointment for a medical check-up from my doctor	2	3.8
I don't currently have a doctor	16	30.8
I don't like my current doctor	1	1.9
Getting transportation to my doctor's office is hard	5	9.6
I don't like getting a medical check-up	2	3.8
I don't believe I need a medical check-up	8	15.4
I can't get time off from work	14	26.9
I can't get child care	0	0.0
Other	12	23.1
*Respondents were able to select multiple responses		

Table 13. Dental Wellness Exam Completed Last Year & Reason for Lack of Completion

Characteristic	n	percent
Completed a dental check-up within the last year (n=108)		
Yes	41	38.0
No	67	62.0
Reason for not getting a dental check-up* (n=72)		
I had already had a dental check up this year	4	5.6
I am not sure where to go to get a dental check-up	11	15.3
It is hard to get an appointment for a dental check-up from my doctor	6	8.3
I don't currently have a dentist	29	40.3
I don't like my current dentist	3	4.2
Getting transportation to my dentist's office is hard	5	6.9
I don't like getting a dental check-up	4	5.6
I don't believe I need a dental check-up	4	5.6
I can't get time off from work	15	20.8
I can't get child care	0	0.0
Other	18	25.0
*Respondents were able to select multiple responses		

More than half of respondents (61.5%) indicated that they had not completed a health risk assessment (Table 14). For those who had not completed a health risk assessment, being unaware that they were supposed to complete an assessment (56.5%) was the most cited reason (Table 14)

Table 14. Health Risk Assessment Completed Last Year & Reason for Lack of Completion

Characteristic	n	percent
Completed a health risk assessment or screening within last year (n=109)		
Yes	42	38.5
No	67	61.5
Reason for not completing a health risk assessment or screening* (n=69)		
I wasn't aware I was supposed to complete the health risk assessment	39	56.5
I forgot	8	11.6
I do not have internet access	11	15.9
I did not think it was important	8	11.6
I do not know how to use the internet	3	4.3
I lost the letter	7	10.1
I didn't know how to use my PIN to log in	3	4.3
The health risk assessment was about information my health care provider already has	3	4.3
The health risk assessment was too long to complete	0	0.0
I didn't know how to turn it into the clinic	5	7.2
Other	4	5.8

*Respondents were able to select multiple responses

Experience with Disenrollment & Gaps in Health Care Coverage

At the time they received the survey, 78% of respondents were aware that they had been disenrolled while 22% were unaware of their disenrollment. Two thirds (65.9%) of respondents did not know they were being disenrolled before it happened. When asked what they did to prepare for being enrolled, about 70% did not do anything to prepare for disenrollment while others filled prescriptions (12.7%) or went to see a health care provider (10.9%) (Table 15).

Table 15. Disenrollment Experience – Awareness, Timing of Notification & Actions Taken

Characteristic	n	percent
Aware of Disenrollment (n=109)		
Yes	85	78.0
No	24	22.0
Knew before it was going to happen (n=88)		
Yes	30	34.1
No	58	65.9
Actions taken before disenrollment, if disenrollment was known in advance* (n=55)		
I filled prescription before I was disenrolled	7	12.7
I went to see a health care provider before I was disenrolled	6	10.9
I went to see a dentist before I was disenrolled	2	3.6
I did not do anything to prepare for being disenrolled	39	70.9
Other	9	16.4

*Respondents were able to select multiple responses

Of the respondents that were aware of their disenrollment (n=85), the majority (73%) reported that they were notified via mailed letter. When these respondents were asked why they thought they had been disenrolled, unpaid premiums were cited most often (63.6%), followed by making too much money (17.0%). Just over 15% of these respondents reported that they did not know the reason for their disenrollment (Table 16).

Table 16. Mode of Discovery of Disenrollment & Perceived Reason for Disenrollment

Characteristic	n	percent
Discovery of disenrollment (n=89)		
I received a letter telling me I was disenrolled	65	73.0
I was told when I went to get health care	13	14.6
I was told when I went to get dental care	3	3.4
I was told when I went to get a prescription filled	7	7.9
Other	1	1.1
Perceived reason for disenrollment* (n=88)		
I did not pay premiums/contributions	56	63.6
I made too much money	15	17.0
I did not pay co-pays	7	8.0
I did not return proper paperwork	4	4.5
I do not know	14	15.9
Other	8	9.1

*Respondents were able to select multiple responses

For the respondents who reported being disenrolled, 29.5% of respondents reported calling either the Department of Human Services (DHS), Iowa Medicaid Enterprise (IME), or Iowa Health Link to reenroll, 26.1% did not take any action to reenroll in any health insurance program after being disenrolled, while 15.9% looked for new insurance, and 12.5% called their MCO (Table 17).

Table 17. Actions Taken After Disenrollment (n=88)

Action*	n	percent
I called DHS/IME/Iowa Health Link to reenroll	26	29.5
I went online to reenroll	9	1.2
I went to DHS or other offices to reenroll	8	9.1
I appealed the disenrollment decision	7	8.1
I called my MCO	11	12.5
I talked to my doctor's office	4	4.5
I looked for new insurance	14	15.9
I did nothing after I was disenrolled	23	26.1
Other	4	4.1

*Respondents were able to select multiple responses

Over 70% of respondents spent at least some time without any health insurance. While having no health insurance, over a third (39.4%) of these respondents delayed getting check-ups or other preventative care. They also reported not seeking health care when they needed it (36.7%), delaying filling of prescriptions (35.8%), and delaying dental care (31.2%) (Table 18).

Table 18. Gaps in Health Care Coverage & Actions Taken During That Time

Characteristic	n	percent
Respondent experienced any period of time in the last 4 months without health insurance (n=108)		
Yes	77	71.3
No	31	28.7
Actions taken while having no health insurance coverage* (n=76)		
I delayed getting prescriptions filled	39	51.3
I tried to stretch my medicine so it would last longer	28	36.8
I stopped taking prescribed medications	33	43.4
I did not seek health care when I needed it	40	52.6
I delayed getting check-ups or other preventative care	43	56.6
I delayed getting dental care	34	44.7
I paid more money for health care, dental care or prescriptions than I would have if I had insurance	24	31.60

*Respondents were able to select multiple responses

Premium Payment

Just under 40% of respondents reported that they either disagreed or strongly disagreed that they were aware that they owed a monthly premium and 90.7% indicated that there were months when they did not pay. Top cited reasons for lack of payment included not having the money (57.0%), not knowing that they needed to pay (45.6%), forgetting to pay (24.1%), and not understanding the invoices or bills that they received (11.4%). Only 41.7% of respondents were aware of the financial hardship option for those unable to pay. At the time of the survey, 47.7% of respondents had not paid their premiums, and of those respondents, 51.5% were concerned about their debt being sent to collections (Table 19).

Table 19. Premium Payment – Awareness, Ability to Pay, Reason for Lack of Payment, Awareness of Financial Hardship, Debt Status & Concern About Debt

Characteristic	n	Percent
Awareness of premium owed while on IHAWP (n=106)		
Strongly Disagree	25	23.6
Disagree	17	16
Neither agree nor disagree	23	21.7
Agree	30	28.3
Strongly agree	11	10.4
"Were there months when you did not pay your premiums?" (n=107)		
Yes	97	90.7
No	10	9.3
Reason for not paying monthly premiums* (n=79)		
I did not know I needed to pay	36	45.6
I did not have the money	45	57.0
I forgot to pay	19	24.1
I did not know how to pay or who to pay	4	5.1
I did not receive invoices or bills telling me to pay	14	17.4
I did not understand the invoices or bills I received	9	11.4
Other	14	17.7
Awareness of the "financial hardship" option if unable to pay (n=108)		
Yes	45	41.7
No	63	58.3
Respondent reported that they have paid their premiums to the State of Iowa (n=107)		
Yes	36	33.6
No	51	47.7
I do not owe a debt to the state	20	18.7
Concern over debt being sent to collections (n=66)		
Yes	34	51.5
No	32	48.5

*Respondents were able to select multiple responses

Experience with Health System

Slightly under half (44%) of respondents reported needing care right away in the emergency room or at a doctor's office in the last six months and 54.1% reported making a check-up or routine care appointment. The majority (64.2%) had a personal doctor (Table 20).

Table 20. Experience with Health System – Need for Care, Routine Care Visits, Personal Doctor

Characteristic	n	Percent
Respondent reporting have had an illness, injury or condition that needed care right away in the clinic, emergency room or doctor's office in the last six months (n=109)		
Yes	48	44.0
No	61	56.0
Appointment made for check-up or routine care in last six months (n=109)		
Yes	59	54.1
No	50	45.9
Respondent has a personal doctor (n=109)		
Yes	70	64.2
No	39	35.8

*Respondents were able to select multiple responses

Value of and Health Insurance Status

The majority of respondents reported which MCO they were enrolled in (80.8%) while a little under a fifth (19.3%) were unsure or did not know (Table 21). When asked why they had applied for the IHAWP, 40.4% reported it was because they were required to have health insurance, 15.6% reported that their doctor's office or hospital encouraged them to apply, and 13.8% reported it was because their health had gotten worse (Table 22). When asked about their current health insurance status, 47.6% of respondents had health insurance coverage, including 17.1% who reenrolled in IHAWP and 30.5% who obtained coverage from another source. At the time of the survey, just under half (43.8%) of respondents had no health insurance (Table 23). Nearly a third (28.2%) reported they had been able to reenroll in the IHAWP. Of those that were able to reenroll, 71.4% reported that it was either easy or very easy while 28.7% reported that it was either difficult or very difficult to reenroll (Table 24). Most respondents (88%) agreed or strongly agreed that they valued having health insurance coverage (Table 25).

Table 21. Percent of Respondents Covered Under Each MCO as Reported by Respondents (n=109)

MCO (deidentified)	n	percent
MCO 1	33	30.3
MCO 2	55	50.5
Unsure or don't know	21	19.3

Table 22. Reason for applying for IHAWP (n=109)

Reason*	n	percent
I am required to have health insurance	44	40.4
The doctor's office or hospital encouraged me to apply	17	15.6
My caseworker encouraged me to apply	4	3.7
My health got worse	15	13.8
I/my spouse lost a job and our insurance	12	11
Our cost for health insurance at work went up	6	5.5
My family situation changed	8	7.3
Other	28	25.7

*Respondents were able to select multiple responses

Table 23. Current health insurance status (n=105)

Status*	n	Percent
I am reenrolled in IHWAP	18	17.1
I am trying to reenroll in IHWAP	13	12.4
I am looking for health insurance	6	5.7
I have purchased health insurance privately	0	0.0
I am waiting to get health insurance from my employer	1	1.0
I have health insurance from my employer	19	18.1
I am on Medicaid/Title 19	9	8.6
I am on Medicare	4	3.8
I have no health insurance	46	43.8
*Respondents were able to select multiple responses		

Table 24. Able to Reenroll & Level of Ease Associated with Reenrollment in IHAWP

Characteristic	n	Percent
Able to reenroll in IHAWP (n=103)		
Yes	29	28.2
No	74	71.8
Ease of reenrollment (n=35)		
Very easy	6	17.1
Easy	19	54.3
Difficult	5	14.3
Very difficult	5	14.3

Table 25. Value of Health Insurance Coverage (n=108)

Level of Agreement	n	percent
Strongly agree	65	60.2
Agree	30	27.8
Neither agree nor disagree	7	6.5
Disagree	0	0.0
Strongly disagree	6	5.6

Conclusion

This survey of members who have been disenrolled from the IHAWP provides the evaluation with further information to better understand the experience and impact of disenrollment.

About 40% of respondents had heard of the Healthy Behaviors Program with approximately 50% self-reporting completing a medical wellness exam and approximately 40% self-reporting completing a dental wellness exam, and 40% self-reporting completing a health risk assessment. Despite the reporting that they had completed the activities, these individuals were disenrolled for failure to pay their premiums.

Less than 25% of respondents were unaware they had been disenrolled at the time of the survey, but the majority of members who completed the survey did not know they were going to be disenrolled

before it happened. After being disenrolled, 21.5% of respondents did not take any action. Nearly 60% were not aware they could claim a financial hardship, despite almost 42% reporting the reason they did not pay was because they did not have the money.

Disenrollment had a significant impact on the respondents, with many reporting delays filling prescriptions, stretching medicine, or not seeking medical care when it was needed. Despite high levels of reported value of having health insurance, only 45.9% of respondents had any insurance coverage at the time of the survey. For those that were able to reenroll in the IHAWP, 28.7% % rated the process as difficult or very difficult to complete.

By understanding the experience of those who were disenrolled from the IHAWP, we can better prevent future disenrollment and the consequences of disenrollment.

Section 3

Healthy Behaviors Incentive Program Completion and Outcomes Report

Brad Wright
Associate Professor, Family Medicine****, Health Management & Policy**
Affiliate, Health Policy Research Program*

Natoshia Askelson
Assistant Professor, Community and Behavioral Health**
Research Fellow, Health Policy Research Program*

Monica Ahrens
Graduate Research Assistant, Biostatistics**

Elizabeth Momany
Senior Research Scientist, Health Policy Research Program*

Peter Damiano
Director and Distinguished Research Fellow*
Bernstein Professor, Preventive & Community Dentistry***

*University of Iowa Public Policy Center
**University of Iowa College of Public Health
***University of Iowa College of Dentistry and Dental Clinics
****University of North Carolina at Chapel Hill

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Executive Summary

On January 1, 2014 Iowa implemented the Iowa Health and Wellness Plan (IHAWP). IHAWP originally expanded coverage for low income Iowans through two new programs: the Marketplace Choice Plan and the Wellness Plan. The **Wellness Plan** is designed to provide coverage for adults aged 19-64 years with income up to and including 100 percent of the Federal Poverty Level (FPL). It is administered by the Iowa Medicaid Enterprise (IME), and members have access to the Medicaid provider network established for this program. The **Marketplace Choice Plan** was designed to provide coverage for adults aged 19-64 years with income from 101-138 percent of the Federal Poverty Level (FPL) (133 percent plus the 5 percent income disregard). The Marketplace Choice Plan allowed members to choose certain commercial health plans available on the health insurance marketplace, with Medicaid paying the member's commercial health plan premiums.

A component of IHAWP called the Healthy Behavior Incentive (HBI) Program, encourages members to complete several healthy behaviors in an effort to encourage prevention and reduce longer term costs. Members are incentivized to complete a wellness exam (annual physical or dental exam) and a health risk assessment (HRA), in exchange for having their monthly premium waived. These premiums are $5 per month for individuals with incomes between 51 – 100% FPL (the original Wellness Plan) and $10 per month for individuals with incomes between 101 – 138% FPL (the original Marketplace Choice Plan).

The Marketplace Choice Plan ended on January 1, 2016, and all of these members were transitioned to the Wellness Plan. Then, starting April 1, 2016, all Wellness Plan members were enrolled into Medicaid managed care. Because of these changes in the program over time, we do not report separate results for Wellness Plan and Marketplace Choice members. Instead, we assign individuals to a **lower-income group (≤100% FPL)** and a **higher-income group (101 – 138% FPL).**

Objective of the Current Evaluation Report

This report has three main objectives. First, we document rates of healthy behavior completion among IHAWP members using 2014 to 2018 data. This will further our understanding of overall rates of compliance with the HBI program requirements five years into the program. Second, we model healthy behavior completion as a function of several member-level characteristics. This will further our understanding of which members are most and least likely to complete the healthy behaviors. This is important, because the members who are least likely to complete the healthy behaviors are at greater risk of being charged monthly premiums and potentially being disenrolled from Medicaid. Third, we model several measures of health care utilization as a function of whether a member completed both healthy behaviors in the prior year. This will further our understanding of the potential for the healthy behaviors that are being required to influence patient outcomes.

Key Findings

Completion of wellness exam

- Across all years, Iowa Medicaid Enterprise (IME) data indicate that 36% of lower-income members and 46% of higher-income members completed a wellness exam. (Figure 1)
- From 2014 to 2018, receipt of a wellness exam declined from 39% to 25% among lower-income members, but increased from 33% to 54% among higher-income members. (Figure 4)

Completion of HRA

- Across all years, 17% of lower-income members and 26% of higher-income members completed an HRA. (Figure 2)
- From 2014 to 2018, HRA completion rates decreased from 35% to 10% among lower-income members, but increased from 18% to 32% among higher-income members. (Figure 5)

Completion of both activities

- Across all years, 11% of lower-income members and 18% of higher-income members completed both activities. (Figure 3)
- From 2014 to 2018, completion of both activities decreased from 26% to 7% among lower-income members, but increased from 14% to 23% among higher-income members. (Figure 6)

Likelihood of completing both activities

- On average, we find that members who are younger, male, non-white, live in rural areas, and use the ER more often are less likely to complete both activities.

Relationship between activity completion and outcomes

- In bivariate analyses, we find that completing a wellness exam, HRA, or both is associated with improvements in several outcome measures and worsening of others . (Table 1)
- In more robust multivariable models, however, few of these relationships hold. Completing both activities is associated with a decrease in ED visits among all members. It is also associated with a decrease in return ED visits within 30-days and hospitalizations, but only in 2014. (Table 2)

Table 1. Summary of Bivariate Relationships between Healthy Behavior Completion and Outcomes by Income Level

Measure Number	Question	Association between healthy behavior(s) and outcome for lower-income members (≤ 100% FPL)		Association between healthy behavior(s) and outcome for higher-income members (101 – 138% FPL)	
15	Did engaging in healthy behaviors relate to a change in the percent of members with ambulatory care visits?	Wellness Exam	↑***	Wellness Exam	↑***
		HRA	↑***	HRA	↑**
		Both	↑***	Both	↑***
20	Did engaging in healthy behaviors relate to a change in the likelihood of diabetic members receiving Hemoglobin A1c testing?	Wellness Exam	↑***	Wellness Exam	↑***
		HRA	↑***	HRA	↑**
		Both	↑***	Both	↑***
21	Did engaging in healthy behaviors relate to a change in the likelihood of diabetic members receiving LDL-C screening?	Wellness Exam	↑***	Wellness Exam	↑***
		HRA	↑***	HRA	↑*
		Both	↑***	Both	↑***
25a	Did engaging in healthy behaviors relate to a change in the likelihood of members having an ED visit?	Wellness Exam	↑***	Wellness Exam	↑***
		HRA	↓***	HRA	NA
		Both	↓***	Both	↓**
25b	Did engaging in healthy behaviors relate to a change in the likelihood of the ED being used for non-emergent conditions?	Wellness Exam	NA	Wellness Exam	NA
		HRA	↓***	HRA	NA
		Both	↓***	Both	↓*
26	Did engaging in healthy behaviors relate to a change in the percent of members with a return ED visit within 30 days after index ED visit?	Wellness Exam	↑***	Wellness Exam	NA
		HRA	↓***	HRA	NA
		Both	↓***	Both	↓*
30	Did engaging in healthy behaviors relate to a change in the number of hospitalizations per 1000 members?	Wellness Exam	↓***	Wellness Exam	NA
		HRA	↑***	HRA	↑***
		Both	↓***	Both	NA
31	Did engaging in healthy behaviors relate to a change in the number of 30-day readmissions per 1000 members?	Wellness Exam	NA	Wellness Exam	NA
		HRA	↑***	HRA	NA
		Both	↑***	Both	NA

* p<0.05, ** p<0.01, ***p<0.001

Note: Up arrows indicate increases. Down arrows indicate decreases. Green cells indicate a desirable relationship between the behavior and the outcome. Red cells indicate an undesirable relationship between the behavior and the outcome. "NA" indicates that there is no statistically significant association.

Table 2. Summary of Associations Between Healthy Behavior Completion and Outcomes from Difference-in-Differences Regression Models, 2014 – 2018

Measure Number	Question	Association between completing both healthy behaviors and outcomes of interest	
		2014	2015 – 2018
15	Did engaging in healthy behaviors relate to a change in the percent of members with ambulatory care visits?	NA	NA
20	Did engaging in healthy behaviors relate to a change in the likelihood of diabetic members receiving Hemoglobin A1c testing?	NA	NA
21	Did engaging in healthy behaviors relate to a change in the likelihood of diabetic members receiving LDL-C screening?	NA	NA
25a	Did engaging in healthy behaviors relate to a change in the likelihood of members having an ED visit?	↓*	↓*
25b	Did engaging in healthy behaviors relate to a change in the likelihood of the ED being used for non-emergent conditions?	NA	NA
26	Did engaging in healthy behaviors relate to a change in the percent of members with a return ED visit within 30 days after index ED visit?	↓*	NA
30	Did engaging in healthy behaviors relate to a change in the likelihood of hospitalization or the number of hospitalizations per 1000 members?	↓*	NA
31	Did engaging in a healthy behavior relate to a change in the likelihood of 30-day readmissions or the number of 30-day readmissions per 1000 hospitalized members?	NA	NA

* $p<0.05$, ** $p<0.01$, ***$p<0.001$

Note: Up arrows indicate increases. Down arrows indicate decreases. Green cells indicate a desirable relationship between the behavior and the outcome. Red cells indicate an undesirable relationship between the behavior and the outcome. NA = No Association

Overview of Iowa's Healthy Behaviors Incentive (HBI) Program

As a part of the **Iowa Health and Wellness Plan (IHAWP)**, enrollees are encouraged to participate in an HBI program involving three components: 1) a wellness exam and health risk assessment (HRA), 2) provider incentives (in year 1 only), and 3) healthy behaviors. This program is designed to:

- Empower members to make healthy behavior changes.
- Establish future members' healthy behaviors and rewards.
- Begin to integrate HRA data with providers for clinical decisions at or near the point of care.
- Encourage members to take specific proactive steps in managing their own health and provide educational support.
- Encourage providers to engage members in completion of the healthy behaviors by offering incentive payments.

Starting in 2015, a small monthly contribution by the member may be required depending on family income, although there are no copayments for health care services and prescriptions under the plan. Members with incomes between 51 – 100% FPL will contribute $5 per month, while members with incomes between 101 – 138% FPL will contribute $10 per month. Members with individual earnings less than 51 percent of the Federal Poverty Level ($6,370 per year for an individual, or $8,624 for a family of 2 in 2019) will not have monthly contributions. IHAWP members who complete the wellness exam and the HRA will not be responsible for a monthly contribution.

Members earning over 50% of the FPL are given a 30-day grace period after the enrollment year to complete the healthy behaviors (wellness exam and HRA) in order to have the contribution waived. If members do not complete the behaviors after the grace period has ended, members will receive a billing statement and a request for a hardship exemption form. For members with incomes at or below 100% FPL, all unpaid contributions will be considered a debt owed to the State of Iowa, but will not result in termination from the program. If, at the time of reenrollment, the member does not reapply for or is no longer eligible for Medicaid coverage and has no claims for services after the last premium payment, the member's debt will be forgiven. For members with incomes between 101 – 138% FPL, unpaid contributions after 90 days will result in the termination of the member's enrollment status. The member's outstanding contributions will be considered a collectable debt and subject to recovery. A member whose Medicaid benefits are terminated for nonpayment of monthly contributions must reapply for Medicaid coverage. Iowa's established and federally approved Medicaid waiver policy allows the member to reapply at any time; however, the member's outstanding contribution payments will remain subject to recovery.

Wellness exam

The wellness exam is an annual preventive visit (New Patient CPT Codes: 99385 18-39 years of age, 99386 40-64 years of age; Established Patient CPT Codes: 99395 18-39 years of age, 99396 40-64 years of age) from any plan-enrolled physician, Rural Health Clinic (RHC), Federally Qualified Health Center (FQHC) or Advanced Registered Nurse Practitioner (ARNP). The exams are part of the preventive services covered by the plans and therefore do not cost the member anything out-of-pocket. A 'sick visit' or chronic care visit can count towards the requirement of the preventive exam, if wellness visit components are included and the billing code modifier 25 is used. Starting in January of 2015, members could also complete a preventive dental exam to fulfill this requirement. The following dental codes were included: D0120 periodic oral evaluation, D0140 limited oral examination, D0150 comprehensive oral examination, and D0180 comprehensive periodontal exam.

Health Risk Assessment

A health risk assessment (HRA) is a survey tool that can be used by members and providers to evaluate a member's health. IME has identified Assess My Health as one such tool, although providers can select their own tool if it asks similar questions. Assess My Health is an online form that takes members between 15 and 40 minutes to complete. HRA information can be used by providers to develop plans addressing member needs related to health risks. The HRA may be completed online at any location, including the health care provider's office. Clinics can contact patients to fill out the HRA over the phone, with the clinic inputting the data into the online system.

Provider Incentives

In the first year of the program, providers also had incentives available to them to encourage and support their patients in completing the wellness exam and HRA. For every Wellness Plan member who completes the HRA with the assistance of the provider, the provider receives $25. This aspect of the HBI has been discontinued.

Methodology for Analyses of Healthy Behavior Completion

Data Sources

Data for the current analysis of healthy behavior completion were derived from Medicaid enrollment and claims data, and IME records on completion of wellness exams and health risk assessments, for the period from January 1, 2014 to December 31, 2018.

Study Population

The focus of this portion of the evaluation is the examination of differences in the rates of healthy behavior completion among IHAWP members and the member characteristics associated with the likelihood of completing healthy behaviors. While we previously analyzed these data separately among Wellness Plan and Marketplace Choice Plan members, we no longer do so here, because the Marketplace Choice Plan ended on December 31, 2015 and those members were enrolled in the Wellness Plan. Instead, we report on all IHAWP members aged 19-64 years, stratifying them according to their income. This includes both **lower-income members** ($\leq$ 100% FPL) and **higher-income members** (101 – 138% FPL). At the time of this report, all members are currently enrolled in Medicaid managed care.

Assigning Medicaid Plan Members to Income Groups

Before proceeding with analyses, we assigned IHAWP members to one of the two groups listed above. Starting with monthly data, we used a rolling cohort method. We did this by identifying the first 12 consecutive months in which a member was continuously and exclusively enrolled in IHAWP**.** For example, a member enrolled January 2014 through December 2014 would be in cohort 1, while a member enrolled February 2014 through January 2015 would be in cohort 2, and so on. If a member was enrolled for additional 12-month periods beyond their initial 12 months (e.g., a total of 24, 36, or 48 months' worth of enrollment), they would be included in those cohorts as well. For example, a member enrolled March 2014 through February 2016 would be in cohort 3 from March 2014 to February 2015, cohort 15 from March 2015 to February 2016, and so on. Essentially, the cohort corresponds to the study month in which the member's 12-month continuous enrollment begins, and they enter a new cohort for each successive 12-month period. However, we did not keep partial years of data. For example, if a member was enrolled for 18 months, we kept only their initial 12 months, and dropped the other 6. After assigning members to cohorts, we collapsed the data to provide one observation per person per cohort. This method ensures that we retain as many Medicaid members in our sample as possible, while also ensuring that all members in our sample are exposed to a full year of the program, providing them equal opportunity to engage in HBI program activities, and corresponding to the period of time they have to complete activities before being charged a premium (excluding the additional 30-day grace period).

Identification of Healthy Behaviors

Because it is the source used to make official determinations regarding premium waivers for members, we used IME data to identify receipt of a wellness exam and HRA completion. We conducted sensitivity analyses that excluded completion of dental wellness exams and this did not notably change the results. Therefore, to remain consistent with prior reports, we focus only on documented medical well visits and self-reported completion of the wellness exam.

Univariate Analyses and Summary Statistics

First, we generated summary statistics for our sample, stratified by income level. Next, using all cohorts spanning 2014 – 2018, we examined the completion rate for wellness exams, HRAs, and both activities among both lower-income and higher-income members. T-tests were used to compare the mean completion rates between these groups. Then, using only cohorts that do not span calendar years, we examined the completion rate for wellness exams, HRAs, and both activities among both lower-income and higher-income members in 2014, 2015, 2016, 2017, and 2018. T-tests were used to compare the means between these groups in a given year, and within a group between years.

Multivariate Analyses

Finally, we ran a series of modified Poisson regression models to predict the likelihood of both lower-income and higher-income members completing both healthy behaviors. This approach allows us to directly estimate relative risks, rather than producing odds ratios, which are more difficult to interpret. Specifically, we modeled this outcome as a function of age, gender, race/ethnicity, metropolitan area of residence (defined as metropolitan, non-metropolitan urban, or non-metropolitan rural, using rural-urban continuum codes), number of moves during the 12-month period (to account for lifestyle disruption), number of emergency department visits, number of prescriptions, and an indicator for the presence of each of 24 chronic conditions. We also included a binary variable to indicate the cohort to which a member was assigned.

Results of Analyses of Healthy Behavior Completion

Descriptive statistics for lower-income and higher-income members by completion of healthy behavior requirements are shown in Table 3. While the two groups are remarkably similar, we do note that there are disproportionately more men in the lower-income group.

Table 3. Descriptive Statistics of Population of Interest, 2014 – 2018

	Income ≤ 100%				Income between 101-138%			
	Completed Both Requirements N=44,746		Did Not Complete Both Requirements N=356,236		Completed Both Requirements N=14,838		Did Not Complete Both Requirements N=69,887	
	Value*	Std. Dev.	Value	Std. Dev.	Value*	Std. Dev.	Value	Std. Dev
Average Age	42.2	13.3	35.9	12.1	41.9	12.9	36.8	12.2
% Male	40.5	49.1	45.0	49.7	32.1	46.7	41.0	49.2
% White	66.9	47.1	63.9	48.0	69.2	46.1	66.4	47.2
% Black	5.8	23.4	9.8	29.8	3.7	18.9	6.2	24.1
% Hispanic	4.0	19.5	5.5	22.8	4.8	21.3	6.3	24.3
% Other Race	4.2	20.0	5.5	22.8	5.8	23.3	6.8	25.1
% Unknown Race	19.5	39.6	15.7	36.4	17.2	37.8	15.1	35.8
% Metropolitan	60.7	48.8	60.1	49.0	58.2	49.3	59.6	49.1
% Nonmetropolitan Urban	5.6	23.1	4.7	21.1	5.7	23.2	5.2	22.3
% Nonmetropolitan Rural	34.1	47.4	35.6	47.9	36.3	48.1	35.5	47.9
Number of Moves	0.3	1.2	0.3	1.2	0.2	0.9	0.2	1.0
Number of ER visits	0.6	1.5	0.8	1.8	0.5	1.1	0.5	1.2
Number of Rx drugs	2.0	2.6	1.2	2.0	1.8	2.4	1.0	1.8
Number of Chronic conditions	1.8	1.8	1.5	1.8	1.6	1.7	1.1	1.6

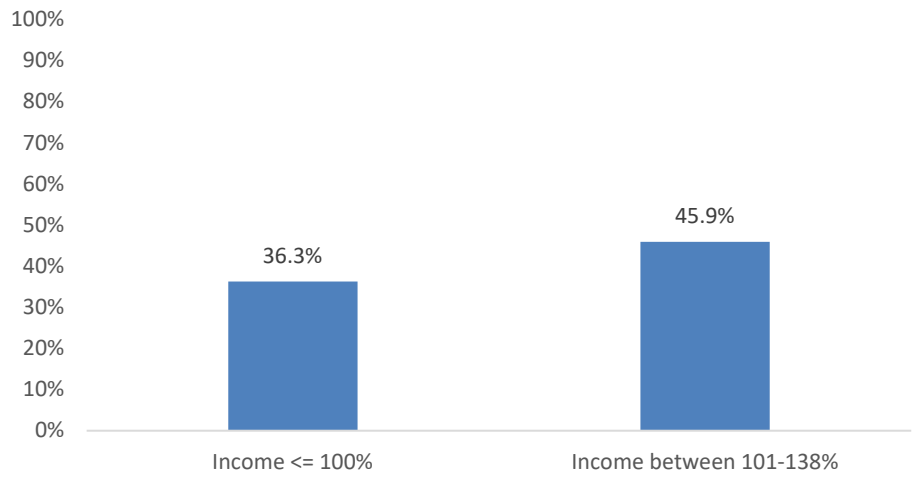
*Note: Values for average age, number of moves, number of ER visits, number of Rx drugs, and number of chronic conditions are means within the lower-income and higher-income groups by completion of both healthy behavior requirements, respectively. Values for all other variables are proportions of the member population in that income and requirement completion group with a given characteristic. For example, in the above table, 66.9% of lower-income members who complete both requirements are white, 5.8% are black, and so forth, such that the race proportions sum to 100% within each column (with differences due to rounding).

Question 1 *Which activities do members complete?*

Measure 1 Proportion of members who had a preventive care visit

We documented the proportion of members completing a wellness exam from 2014 to 2018. As Figure 1 shows, the proportion of lower-income members completing a wellness exam was 36.3%. The corresponding figure among higher-income members was 45.9%. This difference is statistically significant.

Figure 1. Wellness Exam Completion Rates Using DHS Data, 2014 – 2018

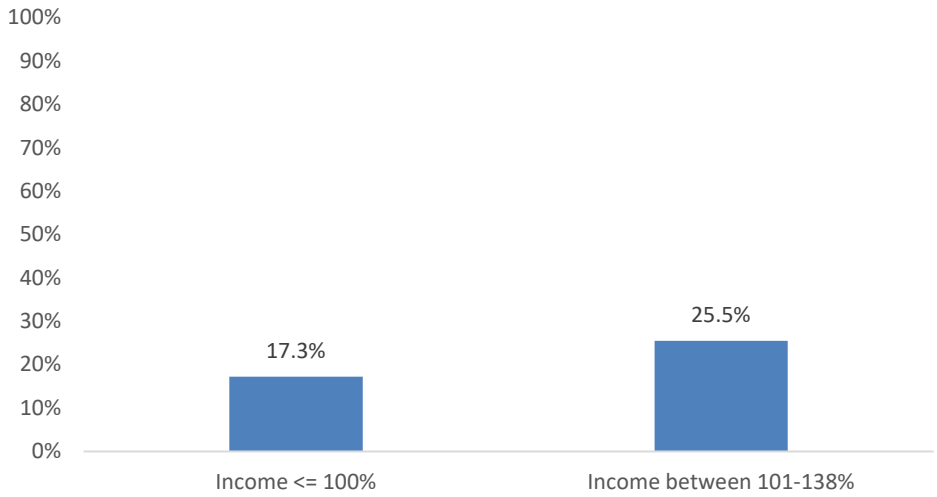


Note: Significantly different at p<0.001.

Measure 2 Proportion of members completing HRA

As Figure 2 shows, 17.3% of lower-income members and 25.5% of higher-income members completed an HRA. This difference is statistically significant.

Figure 2. HRA Completion Rates Using DHS Data, 2014 – 2018

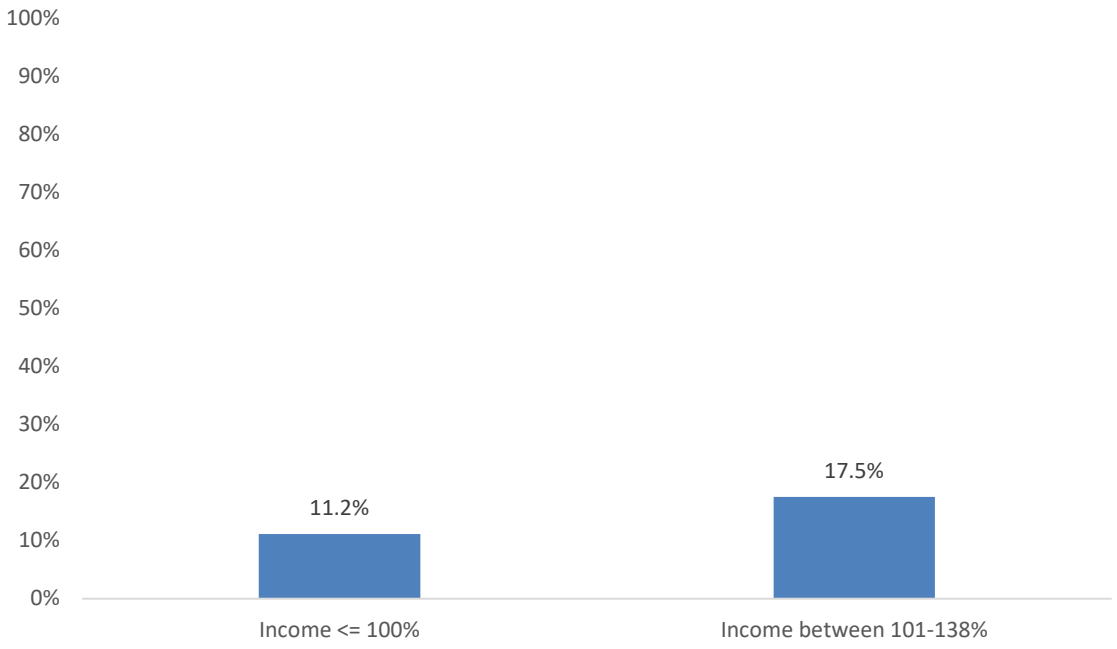


Note: Significantly different at p<0.001.

Measure 3 Whether a member completed both healthy behaviors

Using the data collected by Iowa DHS, we determined the proportion of lower-income and higher-income members who completed both a wellness exam and an HRA from 2014 to 2018. Given the nature of conditional probability, these figures are lower than the figures for completion of each activity when considered independently. As shown in Figure 3, we find that 11.2% of lower-income members completed both activities, compared to 17.5% of higher-income members. This difference is statistically significant. These figures are especially important as they indicate the proportion of members who have completed the activities required to avoid being charged a monthly premium in the following year. Clearly, based on these results, the majority of members will have been subject to a monthly premium in 2015, 2016, 2017, 2018 and/or 2019 (depending on their cohort).

Figure 3. HRA and Wellness Exam Completion Rates Using DHS Data, 2014 – 2018



Note: Significantly different at p<0.001.

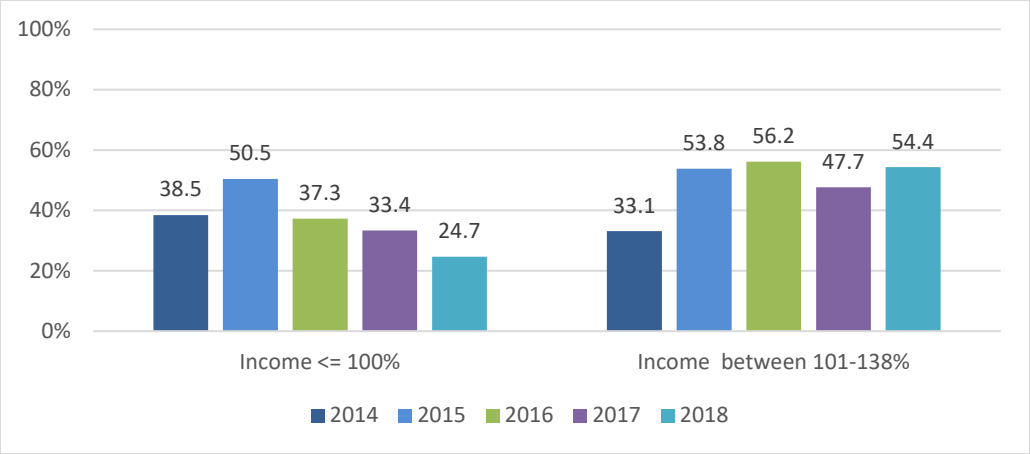
Comparing Annual Rates of Healthy Behavior Completion, 2014 to 2018

In this section, we look specifically at those members who were enrolled for all 12 months of 2014, 2015, 2016, 2017 and/or 2018. This allows us to compare results of the program from year to year, by excluding members in our cohort-based sample whose data spanned calendar years.

Proportion of members who had a preventive care visit, 2014 – 2018

We documented the proportion of members completing a wellness exam in 2014, 2015, 2016, 2017, and 2018 using DHS data. As Figures 4 shows, the proportion of lower-income members completing a wellness exam decreased from 38.5% to 24.7% between 2014 and 2018. By contrast, there was an increase in the completion rate among higher-income members, from 33.1% to 54.4% over the same 2014 to 2018 time period.

Figure 4. Members Enrolled for Full Calendar Year Who Received a Wellness Exam as Identified by DHS Data, by Income and Year 2014 – 2018

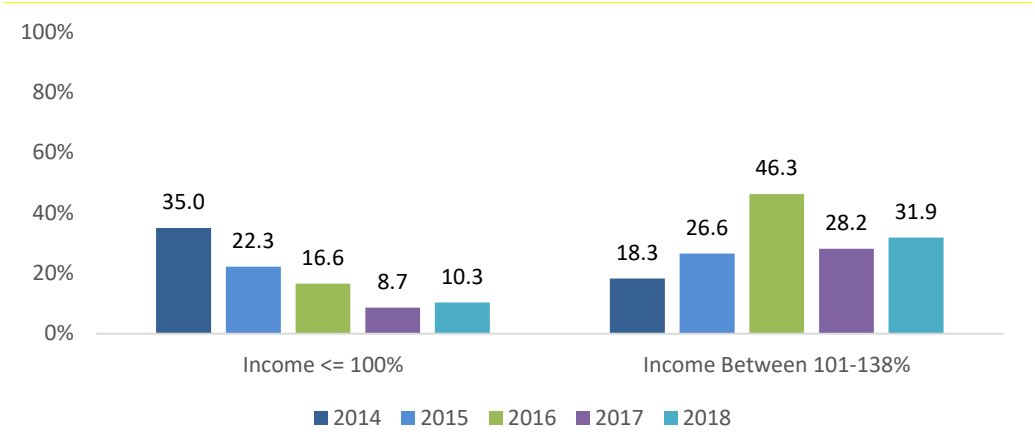


Note: Both the differences between programs within years and the differences between years within programs are statistically significant ($p<0.05$), except for years 2014 vs. 2016 of the lower income group ($p=0.127$) and years 2015 vs. 2016 ($p=0.764$), 2015 vs. 2018 ($p=1.000$), and 2016 vs. 2018 ($p=0.957$) of the higher income group.

Proportion of members completing HRA, 2014 – 2018

As Figure 5 shows, HRA completion rates among lower-income members decreased from 35% in 2014 to 10.3% in 2018. Among higher-income members, the HRA completion rate increased steadily from 18.3% in 2014 to 46.3% in 2016, before dropping to 31.9% in 2018.

Figure 5. Members Enrolled for Full Calendar Year Who Received a HRA as Identified by DHS Data, by Income and Year 2014 – 2018

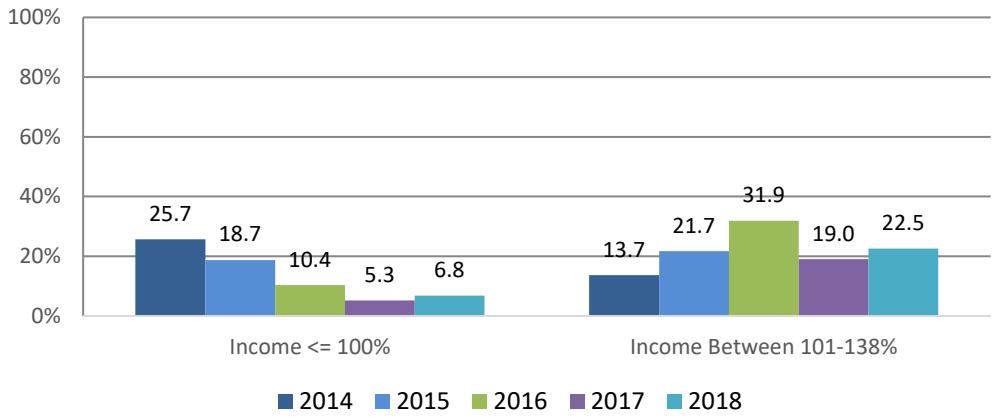


Note: Both the differences between programs within years and the differences between years within programs are statistically significant ($p<0.05$), except for years 2015 vs. 2017 of the higher income group ($p=0.955$).

Whether a member completed both healthy behaviors, 2014 – 2018

Using the data collected by IME we determined the proportion of members who completed both a wellness exam and an HRA in 2014, 2015, 2016, 2017, and 2018. Given the nature of conditional probability, these figures are lower than the figures for completion of each activity when considered independently. As shown in Figure 6, we find that 25.7% of lower-income members completed both activities in 2014, but this figure dropped steadily to 6.8% by 2018. By comparison, 13.7% of higher-income members completed both activities in 2014, and this figure increased steadily to 31.9% in 2016, before dropping back slightly to 22.5% in 2018. These figures are especially important as they indicate the proportion of members who have completed the activities required to avoid being charged a monthly premium in the following year.

Figure 6. Members Enrolled for Full Calendar Year Who Received an HRA and Wellness Exam as Identified by DHS Data, by Income and Year 2014 – 2018



Note: Both the differences between programs within years and the differences between years within programs are statistically significant ($p<0.05$), except for years 2015 vs. 2017 ($p=0.103$) and 2015 vs. 2018 ($p=0.999$) in the higher income group.

Estimating the Likelihood of Healthy Behavior Completion, 2014 to 2018

The results of our modified Poisson regression models estimating the completion of both healthy behaviors as a function of several member-level characteristics, while controlling for any time-invariant unobserved heterogeneity associated with each member's specific cohort (results not included in table), are shown in Table 4, stratified by income.

In general, the models find that the likelihood of completing both activities is higher among members who are older, female, white or unknown race, reside in an urban area, don't move during the year, have fewer ER visits, take more prescription drugs, and have more chronic conditions. By contrast, the likelihood of completing both activities is lower among members who are younger, male, non-white race, reside in rural areas, move more often during the year, and use the ER more frequently. The magnitude and direction of these results is generally consistent across both the lower-income and higher-income models, suggesting that the relationships we identify are not influenced by a person's income level. The likely reason some of the estimates in the higher-income group are not statistically significant is the smaller sample for that group of members.

Table 4. Relative Risk of Completing Both Activities by Income Groups

	Income ≤ 100% N=313,658			Income between 101-138% N=86,543		
	RR	95% CI		RR	95% CI	
Average Age	1.02***	1.02	1.02	1.02***	1.02	1.02
Male	0.69***	0.68	0.71	0.76***	0.74	0.78
Black	0.75***	0.72	0.77	0.74***	0.69	0.80
Hispanic	0.85***	0.81	0.89	0.83***	0.77	0.89
Other Race	0.86***	0.83	0.90	0.92**	0.86	0.97
Unknown Race	1.06***	1.04	1.08	1.08***	1.04	1.12
Metropolitan	1.09***	1.07	1.11	1.03*	1.00	1.06
Nonmetropolitan Urban	1.18***	1.14	1.22	1.03	0.96	1.09
Number of Moves	0.97***	0.96	0.98	1.00	0.99	1.02
Number of ER visits	0.93***	0.92	0.93	0.93***	0.91	0.94
Number of Rx drugs	1.07***	1.06	1.07	1.07***	1.06	1.07
Number of Chronic conditions	1.05***	1.04	1.05	1.03***	1.02	1.04
Constant	0.12***	0.12	0.13	0.06***	0.05	0.06

Note: Relative risks for the cohort-specific fixed effects are not shown.

*P < 0.05 **P < 0.01 ***P < 0.001

Methodology for Assessing Outcomes Associated with Healthy Behavior Completion

Bivariate Analyses

Using all years of available data (2014 – 2018) we calculated utilization rates for several health care outcomes among lower-income and higher-income IHAWP members. We then compared utilization rates within the groups based on members' completion of either one or both of the healthy behaviors (i.e., HRA and/or wellness exam). The specific outcomes we looked at were constructed as either (1) the proportion of members in each group who at any time during the year received: an ambulatory care visit, a hemoglobin A1c test (diabetics only), an LDL cholesterol test (diabetics only), had one or more ED visits, had one or more non-emergent ED visits (among those with any ED visits only), had one or more return visits to the ED within 30 days (among those with any ED visits only), had one or more inpatient hospitalizations, and/or had one or more 30-day readmissions (among those with any hospitalization only); (2) the number of hospital discharges per 1,000 members in each plan category; and (3) the average annual number of readmissions per 1,000 hospitalized members in each plan category. Non-emergent and emergent ED visits were determined using the NYU ED algorithm which assigns probabilities of an ED visit being non-emergent, emergent but primary care treatable, emergent not primary care treatable but preventable, and emergent using ICD-9 codes. We assigned individuals as having had a non-emergent ED visit if the first two categories (non-emergent and emergent but primary care treatable) had a combined probability equal to or greater than 0.5. Remaining ED visits were classified as emergent. We used t-tests to compare the means between members within a program who completed versus did not complete healthy behaviors. All differences were statistically significant at $p<0.001$ unless otherwise noted in the results.

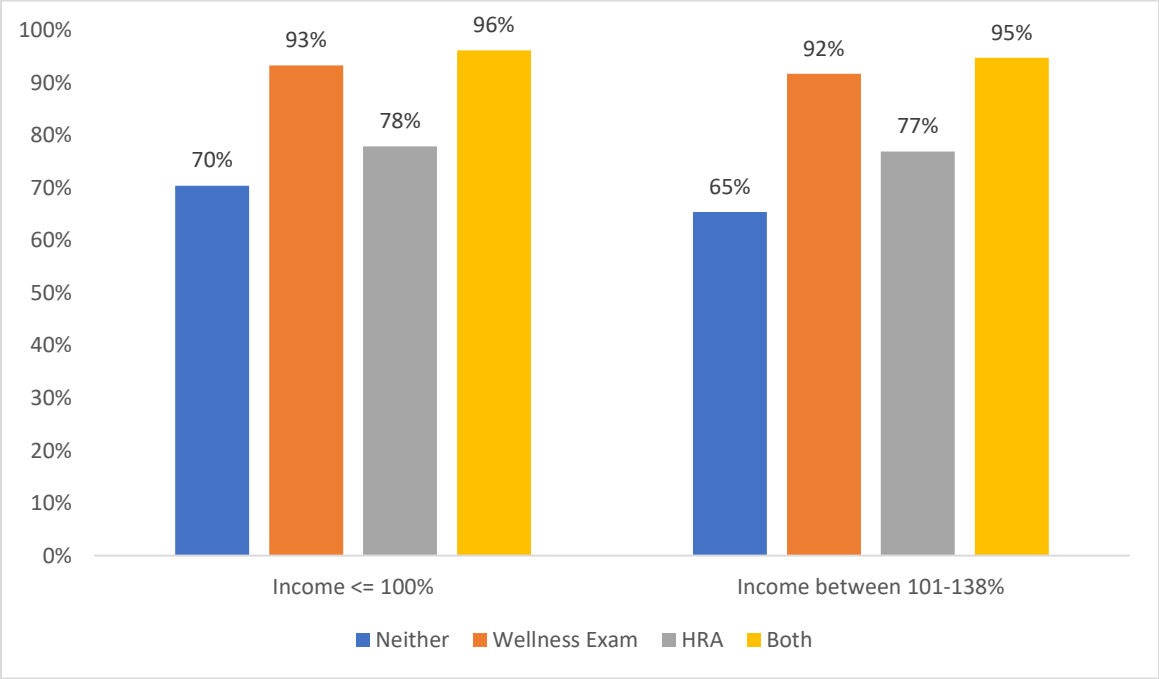
Results of Bivariate Analyses

Question 3 *Is engaging in behavior incentives associated with improved access to care and health outcomes?*

Measure 15 Adults' access to primary care

We assessed access to primary care using the percentage of members who had an ambulatory care visit. Figure 7 compares both lower-income and higher-income IHAWP members, by completion of a wellness exam and/or HRA. The percent of persons having an ambulatory care visit increased significantly when they completed a wellness exam and/or HRA. We suspect that we see these differences because completion of either of these healthy behaviors likely required or resulted from an ambulatory care visit. The results are very similar regardless of income level.

Figure 7. Percentage of Members who had an Ambulatory Care Visit, by Income and Healthy Behavior Completion, 2014 - 2018



† Neither vs. wellness exam is significant at p<0.001

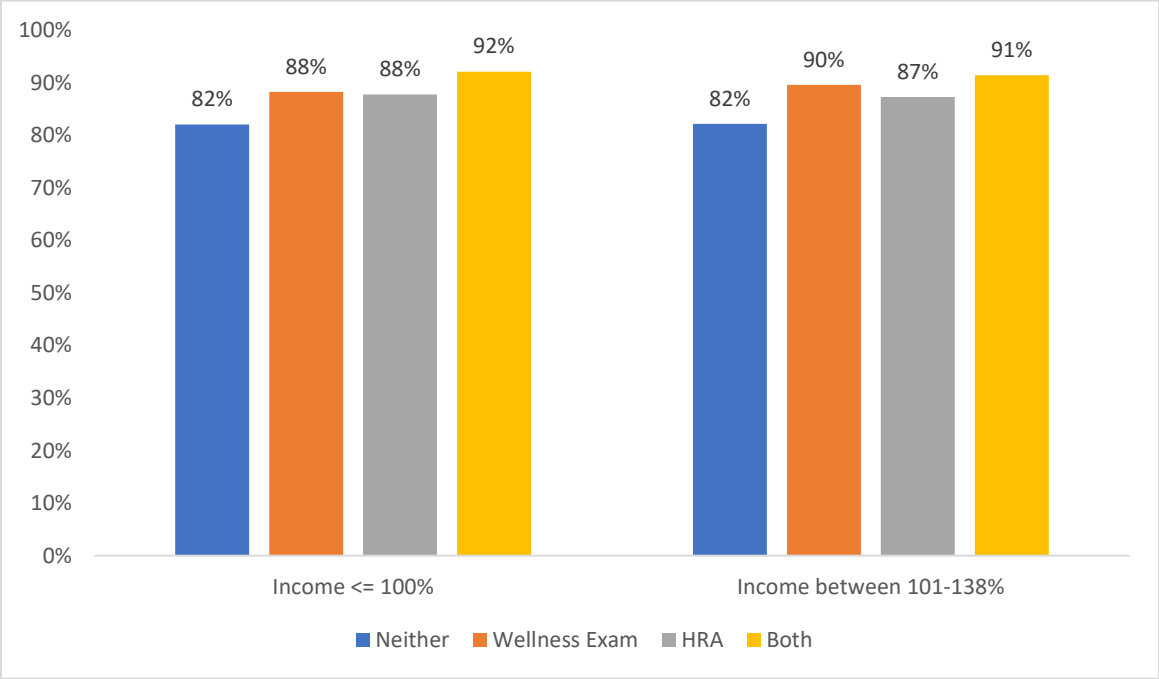
* Neither vs. heath risk assessment is significant at p<0.001

^ Neither vs. both (wellness exam and health risk assessment) is significant at p<0.001

Measure 20 Comprehensive diabetes care: Hemoglobin A1c

We assessed the percentage of members with type 1 or type 2 diabetes who had Hemoglobin A1c testing. **As shown in Figure 8, among lower-income and higher-income IHAWP members with diabetes, those who completed a wellness exam and/or an HRA had higher rates of hemoglobin A1c testing in comparison to those who completed neither health benefit.** It is also important to note that no group had a rate below 82%, which is fairly high. This is important, as even individuals with well-controlled diabetes should have their A1c checked at least annually.

Figure 8. Percent of Members with Diabetes Who had Hemoglobin A1c Testing, by Income and Healthy Behavior Completion, 2014 – 2018



† Neither vs. wellness exam is significant at p<0.001

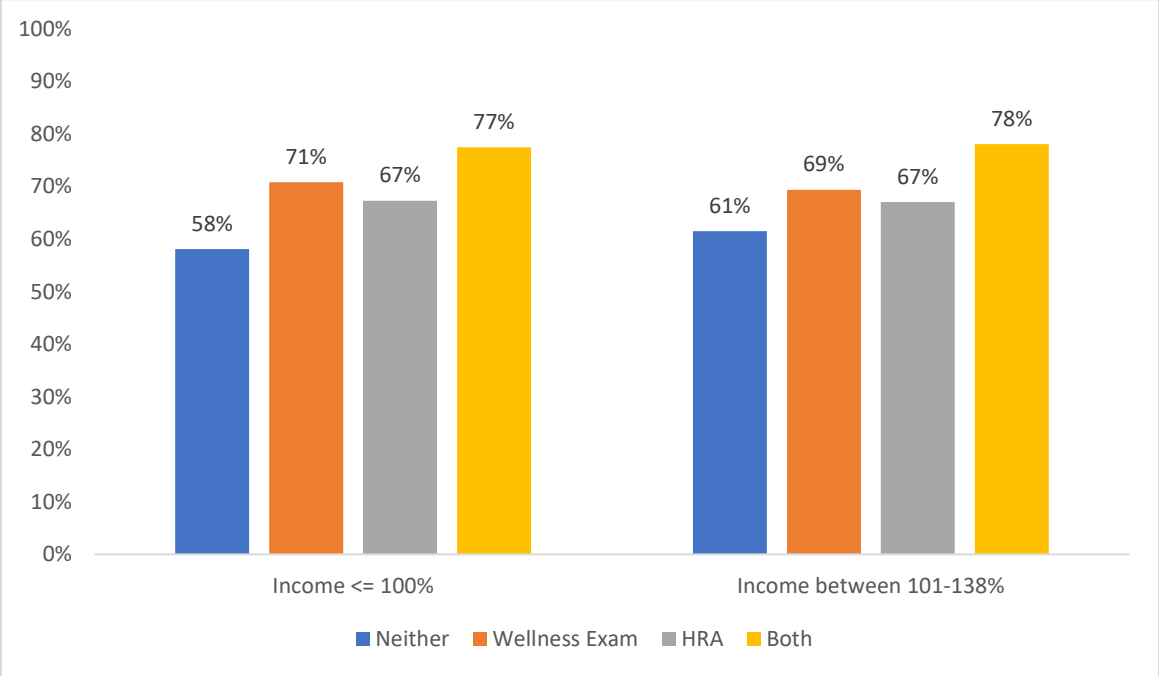
* Neither vs. heath risk assessment is significant at p<0.001 for low-income and p<0.01 for high-income

^ Neither vs. both (wellness exam and health risk assessment) is significant at p<0.001

Measure 21 Comprehensive diabetes care: LDL-C screening

We assessed the percentage of members with type 1 or type 2 diabetes who had LDL-C screening. As we saw in A1c testing, **both lower-income and higher-income members completing a wellness exam and/or an HRA showed higher rates of LDL-C Screening** as shown in Figure 9.

Figure 9. Percent of Members with Diabetes Who had an LDL-C screening, by Income and Healthy Behavior Completion, 2014 - 2018



† Neither vs. wellness exam is significant at p<0.001

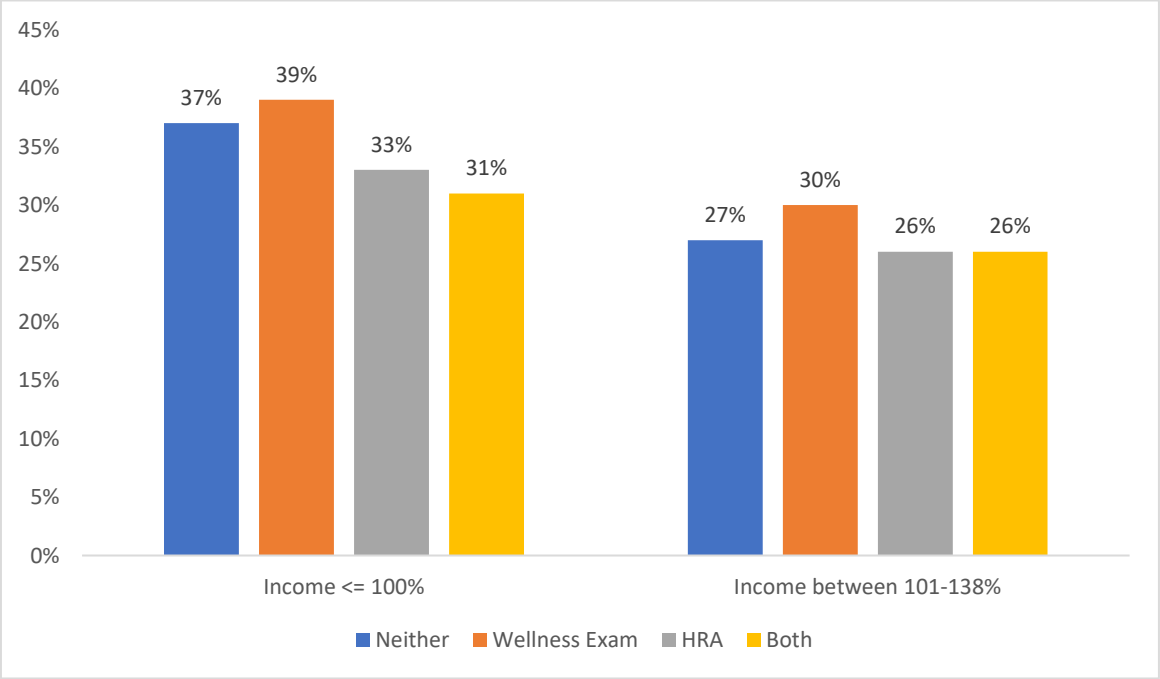
* Neither vs. heath risk assessment is significant at p<0.001 for low-income and p<0.05 for high-income

^ Neither vs. both (wellness exam and health risk assessment) is significant at p<0.001

Measure 25a Emergency Department Use

We assessed the proportion of members who had an ED visit and the average annual number of ED visits per 1000 member months. **When comparing members by completion of one or both healthy behaviors, Figures 10 and 11 show that regardless of income, completing only a wellness exam was associated with an increase in both the likelihood of having an ED visit and the overall volume of ED visits. Among the lower-income group only, completing an HRA was associated with a decrease in both the likelihood of having an ED visit, and the overall volume of ED visits. Finally, among members who completed both requirements, both the likelihood of having an ED visit and the volume of ED visits decreased significantly regardless of income.** To the extent that ED visits represent an inefficient use of the health care system, a lower rate of ED visits can be considered a positive outcome. However, this also assumes that members are receiving care in a more appropriate setting. If they are simply forgoing care, this could be considered a negative outcome.

Figure 10. Proportion of Members with an ED Visit, by Income and Healthy Behavior Completion, 2014 - 2018

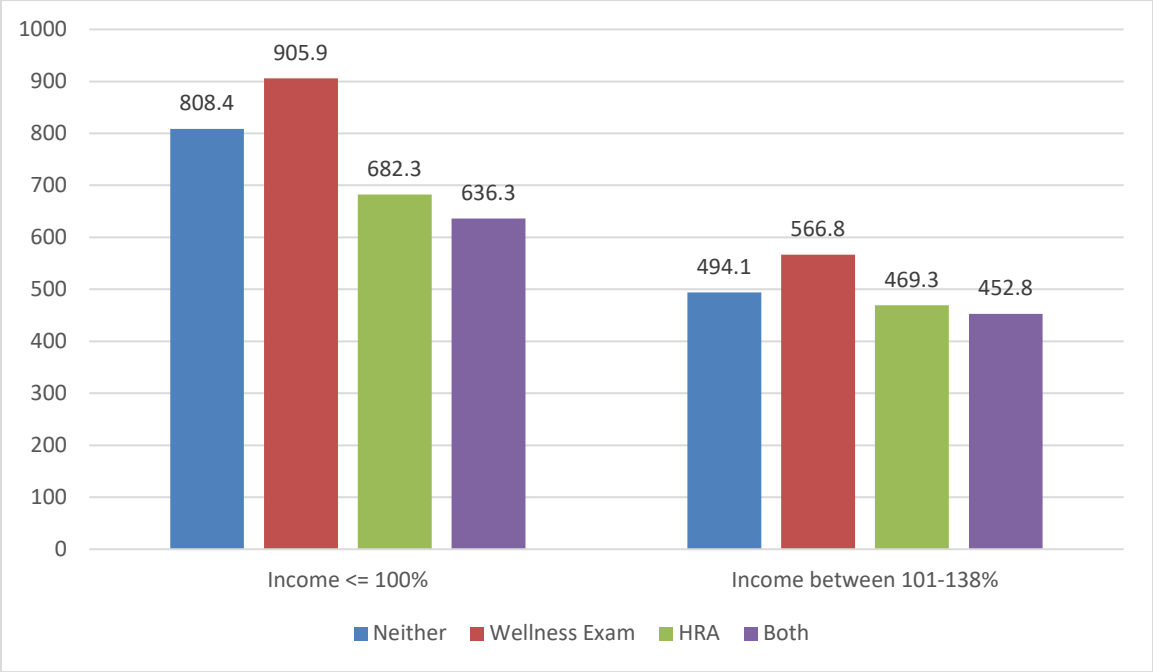


† Neither vs. wellness exam is significant at p<0.001

* Neither vs. heath risk assessment is significant at p<0.001 for low-income group only

^ Neither vs. both (wellness exam and health risk assessment) is significant at p<0.001 for low-income and p<0.01 for high-income

Figure 11. Annual Number of ED Visits per 1000 Members, by Income and Healthy Behavior Completion, 2014 – 2018



† Neither vs. wellness exam is significant at p<0.001

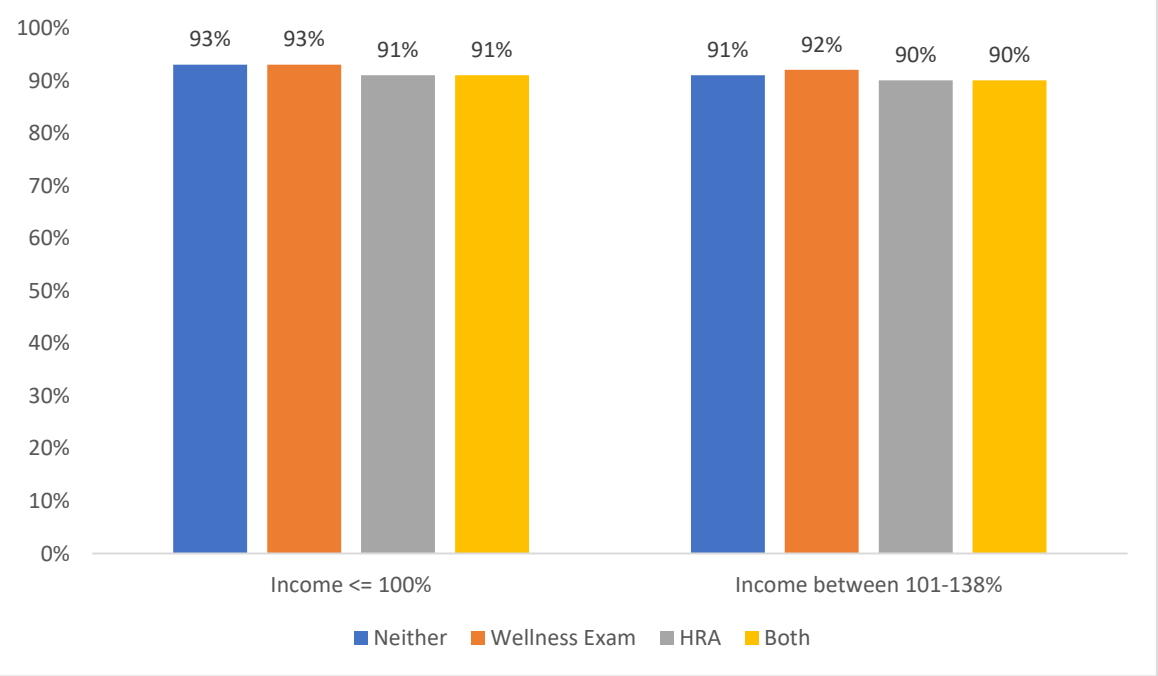
* Neither vs. heath risk assessment is significant at p<0.001 for low-income group only

^ Neither vs. both (wellness exam and health risk assessment) is significant at p<0.001

Measure 25b Non-Emergent Emergency Department Use

To gain a better understanding of how healthy behavior completion may shift patterns of care seeking, we assessed the proportion of members with at least one ED visit who also had at least one non-emergent ED visit. **Figure 12 shows no relationship between receipt of a wellness exam and the likelihood of having a nonemergent ED visit, regardless of income. However, completing an HRA is associated with a 2 percentage point decrease in the likelihood of having a nonemergent ED visit among the lower-income group, and completing both activities is associated with a decrease in the likelihood of having a nonemergent ED visit of 2 percentage points among the lower-income group and 1 percentage point among the higher-income group.** However, it is important to note that the overall rates are extremely high (at or above 90%), such that the observed decreases translate to relative declines of 2.2% and 1.1%. Still, even a small reduction in nonemergent ED visits does suggest the possibility that members are making some changes in their use of costly and potentially avoidable ED care. Again, however, this assumes that members are still receiving care in a more appropriate setting, rather than simply forgoing care.

Figure 12. Proportion of Members with At Least One Non-Emergent ED Visit among Members with At Least One ED Visit, by Income and Healthy Behavior Completion, 2014 - 2018



† Neither vs. wellness exam is not significant for either income group

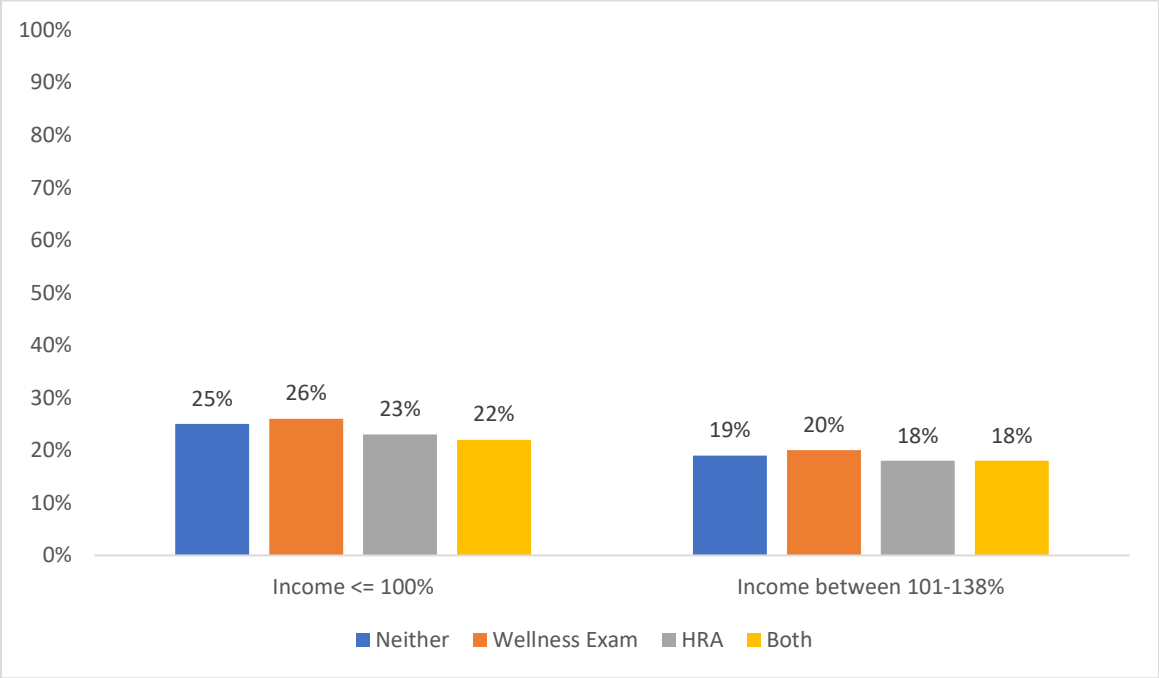
* Neither vs. heath risk assessment is significant at p<0.001 for low-income group only

^ Neither vs. both (wellness exam and health risk assessment) is significant at p<0.001 for low-income and p<0.05 for high-income

Measure 26 Follow-up ED visits

We assessed the percentage of members with a return ED visit within the first 30 days after an index ED visit. We see in Figure 13, that **among the lower-income group only, receipt of a wellness exam is associated with an increased likelihood of a return ED visit, while completion of an HRA is associated with a decreased likelihood of a return ED visit. Completing both a wellness exam and an HRA is associated with a decreased likelihood of a return ED visit, regardless of income.** It is important to note that return ED visits represent a potentially inefficient use of the healthcare system. Thus, a lower rate of return ED visits could be considered a positive outcome, although again this assumes that it is not simply the result of members forgoing needed care.

Figure 13. Percent of Members with an ED visit within first 30 days after index ED visit, by Income and Healthy Behavior Completion, 2014 – 2018



† Neither vs. wellness exam is significant at p<0.001 for low-income group only

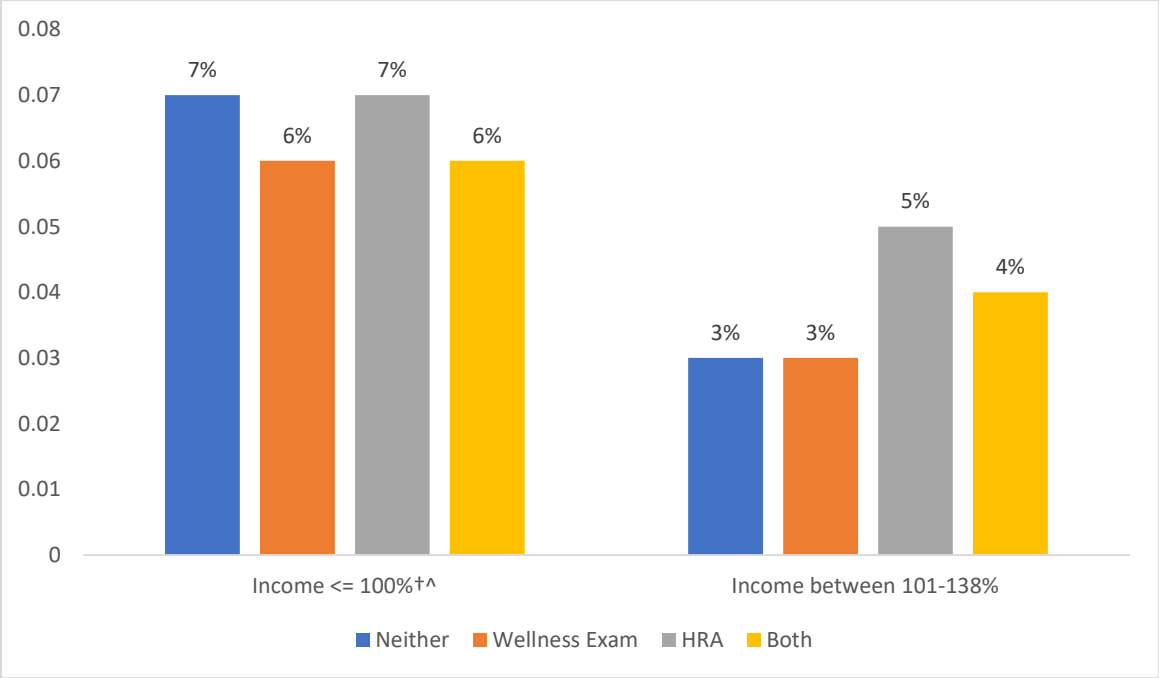
* Neither vs. heath risk assessment is significant at p<0.001 for low-income group only

^ Neither vs. both (wellness exam and health risk assessment) is significant at p<0.001 for low-income and p<0.05 for high-income

Measure 30 Inpatient utilization-general hospital/acute care

We created a variable equal to the proportion of members with a hospitalization and also assessed the volume of hospitalizations per 1000 member months. Figure 14 shows that **completion of a wellness exam or both healthy behaviors is associated with a lower likelihood of hospitalization in the lower-income group, while completion of an HRA is associated with an increase likelihood of hospitalization among higher-income members.** The relationship between completion of healthy behavior requirements and the volume of hospitalizations is shown in Figure 15 and looks very similar to the relationships shown in Figure 14, with the notable difference that completion of an HRA is also associated with an increase in the number of hospitalizations regardless of income.

Figure 14. Proportion of Members with a Hospitalization in a Given Year, by Income and Healthy Behavior Completion, 2014 - 2018

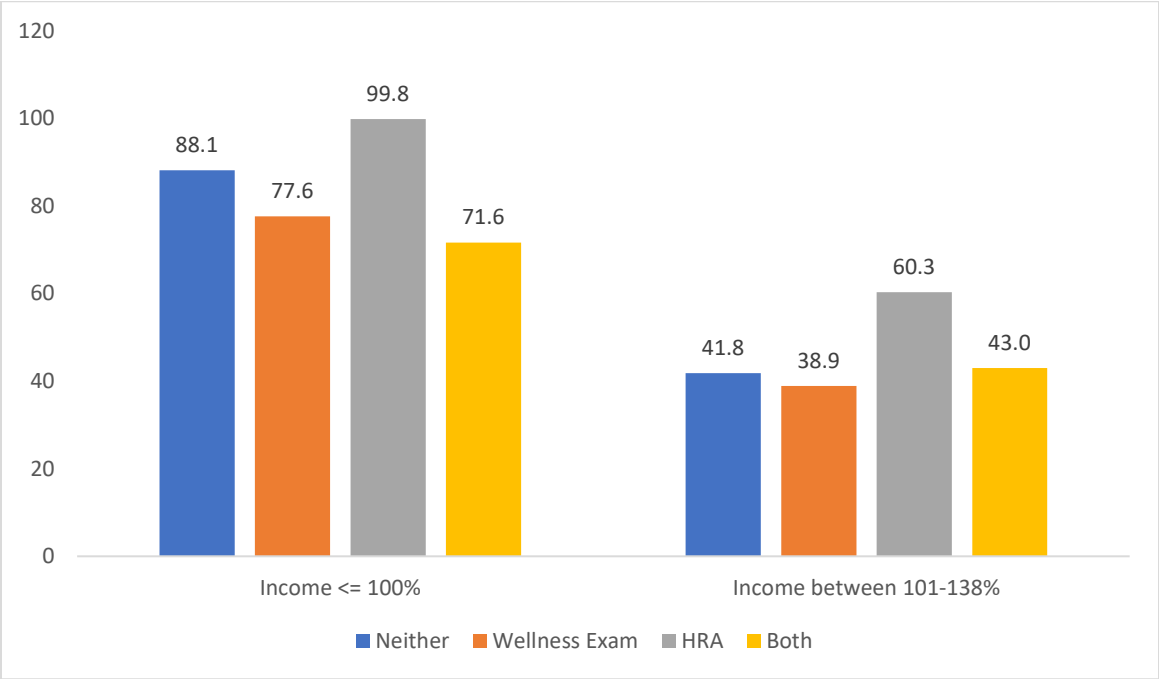


† Neither vs. wellness exam is significant at p<0.001 for low-income group only

* Neither vs. heath risk assessment is significant at p<0.001 for high-income group only

^ Neither vs. both (wellness exam and health risk assessment) is significant at p<0.001 for low-income group only

Figure 15. Annual Number of Hospitalizations per 1000 Members, by Income and Healthy Behavior Completion, 2014 - 2018



† Neither vs. wellness exam is significant at p<0.001 for low-income group only

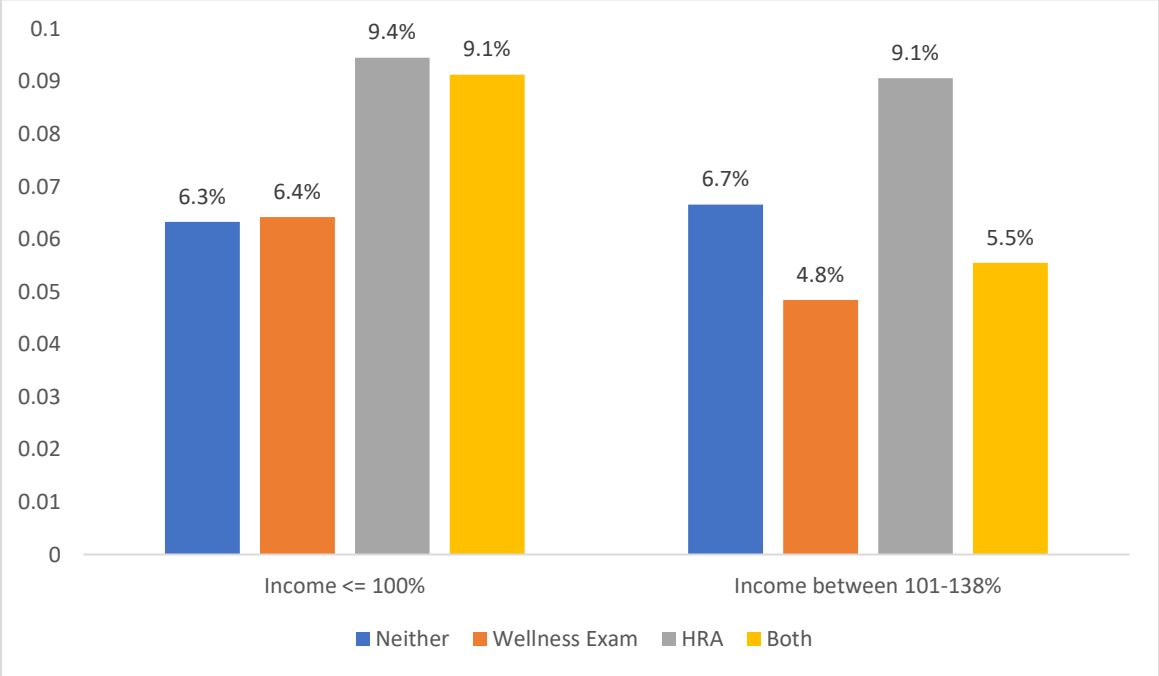
* Neither vs. heath risk assessment is significant at p<0.001

^ Neither vs. both (wellness exam and health risk assessment) is significant at p<0.001 for low-income group only

Measure 31 Plan "all cause" hospital readmissions

Among the subset of members with one or more hospitalizations, we assessed both the likelihood of having a 30-day readmission and the number of 30-day readmissions per 1000 hospitalized members for any diagnosis. Figure 16 shows that, **regardless of income, receipt of a wellness exam was not associated with the likelihood of experiencing a 30-day readmission, while completing an HRA or both activities was associated with an increased likelihood of 30-day readmission among lower-income members only.** Figure 17 shows essentially identical relationships between healthy behavior completion and the volume of 30-day readmissions.

Figure 16. Proportion of Hospitalized Members with a Hospital Readmission in a Given Year, by Income and Healthy Behavior Completion, 2014 - 2018

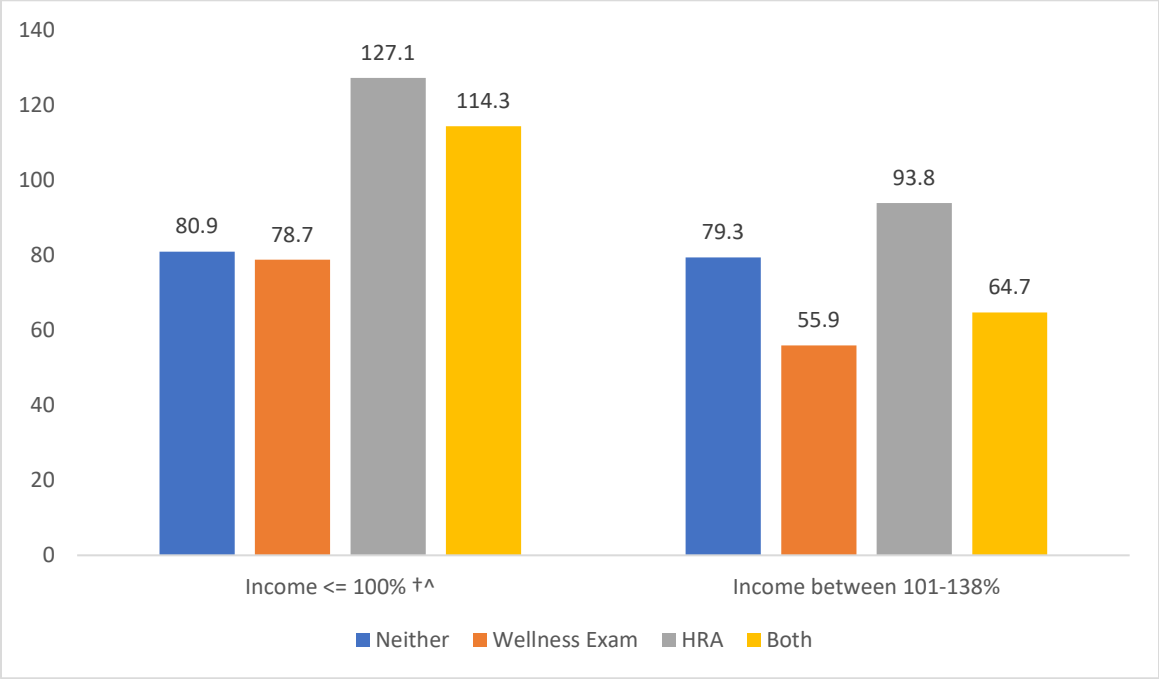


† Neither vs. wellness exam is not significant for either group

* Neither vs. heath risk assessment is significant at p<0.001 for low-income group only

^ Neither vs. both (wellness exam and health risk assessment) is significant at p<0.001 for low-income group only

Figure 17. Annual Number of Hospital Readmissions per 1000 Hospitalized Members, by Income and Healthy Behavior Completion, 2014 - 2018



† Neither vs. wellness exam is not significant for either group

* Neither vs. heath risk assessment is significant at p<0.001 for low-income group only

^ Neither vs. both (wellness exam and health risk assessment) is significant at p<0.001 for low-income group only

Methodology for Modeling Outcomes as a Function of Healthy Behavior Completion

Data Sources and Assignment of Medicaid Plan Members to Programs

Using the same data as described earlier in this report, and including two years of IowaCare (an earlier Medicaid waiver-based insurance program for individuals earning below 200% FPL) data (2012 & 2013) preceding implementation of the HBI program to establish baseline trends, we modeled the relationship between healthy behavior completion and outcomes within a difference-in-differences (DID) framework. We also used the same rolling cohort method, and the same method of identifying the completion of healthy behaviors.

Study Population and Comparison Group

The DID approach works by identifying a treatment group (exposed to the intervention of interest) and a control group (not exposed to the intervention of interest), and following them over a period of time both before and after the implementation of the intervention, which in this case is the introduction of the HBI Program. This method adjusts for baseline differences between the treatment and control groups, and then identifies any additional difference among the treatment group once the intervention has been implemented. This additional difference can then be attributed to the intervention itself.

Compared to our bivariate analyses, in which members could be in cohorts that spanned calendar years, the sample for our DID analyses was limited to members in cohorts with enrollment beginning in January of 2012, 2013, 2014, 2015, 2016, and 2017, and continuing through December of each of those years. This was essential to ensure that members did not span calendar years, since the intervention (introduction of the HBI Program) occurred on January 1, 2014. We also required members to be continuously enrolled for at least one year both pre- and post-implementation of the HBI Program.

For these analyses, we used a very conservative method of assigning members to the treatment group, which maximizes our likelihood of identifying a relationship between healthy behavior completion and our outcomes of interest. The **treatment group** consisted of members who were in IowaCare for at least one year during the pre-implementation period (2012 & 2013), were in the IHAWP for at least one year during the post-implementation period (2014 – 2017), and completed both a wellness exam and an HRA in each year they were in the data during the post-implementation period. The **control group** consisted of a similarly defined group of members who did not complete any healthy behaviors during the post-implementation period. We excluded individuals in IowaCare who reported an income above 138% of the federal poverty level, because these individuals would have transitioned to subsidized insurance through the health insurance exchange or another form of insurance, but would not have been eligible for IHAWP. We also excluded individuals who completed some of the healthy behaviors, but failed to complete both activities in all years that they were enrolled during the post-implementation period.

Multiple Regression Modeling

To isolate the effect of the intervention (completion of both HRA and wellness exam) among the treatment group, we used the following model:

$$Outcome_{it+1} = \alpha_0 + \beta_1 Group_i * Post_{2014} + \beta_2 Group_i + \beta_3 Post_{2014} + \beta_4 Group_i * Post_{2015-2018} + \beta_5 Post_{2015-2018} + \boldsymbol{x}'\beta_6 + u_{it}$$

Where $Post_{2014}$ is an indicator variable for observations after the program has taken effect (in 2014) but is considered a transitional implementation year and $Post_{2015-2018}$ is considered the post period following full implementation. We took this approach to account for issues with the fact that individuals could complete their activities at any time during the calendar year, so it is only beginning in January 2015 that we can be certain that all individuals in our treatment group have actually been fully exposed to the treatment. The term α_0 identifies an average individual constant term, and $Group_i$ is an indicator variable that captures whether the individual was in the treatment group. The two coefficients on the interaction terms $Group_i * Post_{2014}$ and $Group_i * Post_{2015-2018}$ are our primary parameters of interest, as they capture the change in the outcome among the treatment group after the treatment is implemented. In other words, this will demonstrate how outcomes changed for individuals who completed both a wellness exam and an HRA. In particular, the parameter β_4 is of greatest interest, since it captures the period once the program has been fully implemented and all individuals have been exposed to the treatment. We also control for a variety of covariates, X, including age, gender, race/ethnicity, rurality of residence (based on rural-urban continuum codes), number of changes in residence within the year, a categorical measure of income corresponding to the premium tiers of the HBI program, and a count of the number of conditions from a list of 24 commonly tracked chronic conditions for which a member has been diagnosed. All analyses were conducted as linear probability models or ordinary least squares regression models at the person-year level within the DID framework.

A critical assumption of the DID model is that the treatment and control groups experience similar, or parallel, trends in the period prior to the intervention. We conducted formal tests of this assumption and discovered that it was violated in the case of one outcome: having any preventive care visit. While we would ordinarily turn to propensity score matching to remedy this, doing so reduces sample size, which we wanted to avoid. Moreover, this occurred only for a single outcome and this outcome is potentially endogenous, because all individuals who completed treatment should, by definition, have had at least one preventive care visit.

In a series of sensitivity analyses, we modified our sample to include a partial treatment group. This group included individuals who had some exposure to the program, but failed to complete both activities in every year during which they were enrolled. This should begin to demonstrate the extent to which there is a "dose-response" relationship between completing HBP requirements and our health care utilization outcomes. To avoid confusion, these results appear in an appendix at the end of the document.

Results Demonstrating the Relationship Between Healthy Behavior Completion and Outcomes

Question 3 *Is engaging in behavior incentives associated with improved access to care and health outcomes?*

Measure 15 Adults' access to primary care

Our binary outcome was defined as whether or not a member had an ambulatory or preventive care visit. **Our DID model for ambulatory care visits (Table 5) indicated that completing both healthy behaviors in every year was not associated the likelihood of having an ambulatory care visit.** At baseline, the treatment group was 10.9 percentage points more likely than the control group to have an ambulatory care visit, and both groups were 11.4 percentage points more likely to have an ambulatory care visit in the 2014 post-period and 8.5 percentage points more likely to have an ambulatory care visit in the 2015 – 2018 post-period compared to the pre-period. Other factors in the model were also significant as shown in Table 5. Sensitivity analyses in Table A1 of the appendix find no differences depending on full versus partial treatment.

Table 5. Likelihood of an Ambulatory/Preventive Care Visit as a Function of Healthy Behavior Completion

	Coefficient	95% CI	
Post Period 2014	0.114***	0.097	0.132
Post Period 2015 - 2018	0.085***	0.068	0.101
Treatment Group	0.109***	0.089	0.129
Post Period 2014 * Treatment Group	0.006	-0.021	0.034
Post Period 2015 - 2018 * Treatment Group	0.001	-0.025	0.027
Age	-0.001***	-0.002	-0.001
Male	-0.076***	-0.087	-0.064
Black	0.037**	0.015	0.058
Hispanic	0.068***	0.038	0.099
Other Race	0.008	-0.027	0.043
Unknown Race	-0.012	-0.025	0.001
Metropolitan	0.036***	0.023	0.048
Nonmetropolitan Rural	0.005	-0.023	0.034
Number of Relocations	0.003	-0.002	0.007
Number of 24 Chronic Conditions	0.106***	0.103	0.109
Income between 51 - 100% FPL	0.014	-0.000	0.029
Income between 101 - 138% FPL	0.025*	0.004	0.046
Constant	0.592***	0.562	0.622

N = 16,629

* p<0.05, ** p<0.01, ***p<0.001

Measure 20 Comprehensive diabetes care: Hemoglobin A1c

Our binary outcome was defined as whether or not a member with type 1 or type 2 diabetes had Hemoglobin A1c testing. Table 6 provides the results of our DID model for hemoglobin A1c tests (limited to a sample of diabetics). **These results indicate that completing both healthy behaviors in every year is not associated with the probability of having a hemoglobin A1c test.** At baseline, there was no difference between the treatment and control groups in the likelihood of having hemoglobin A1c test, nor was there any association between the IHAWP and the likelihood of hemoglobin A1c testing. Other factors in the model were also significant as shown in Table 6. Sensitivity analyses in Table A2 of the appendix find no differences depending on full versus partial treatment.

Table 6. Likelihood of Hemoglobin A1c Testing in Diabetic Members as a Function of Healthy Behavior Completion

	Coefficient	95% CI	
Post Period 2014	-0.017	-0.058	0.024
Post Period 2015 - 2018	0.016	-0.019	0.050
Treatment Group	0.006	-0.040	0.052
Post Period 2014 * Treatment Group	0.058	-0.009	0.125
Post Period 2015 - 2018 * Treatment Group	0.008	-0.052	0.067
Age	0.001	-0.001	0.002
Male	-0.018	-0.043	0.007
Black	-0.038	-0.096	0.020
Hispanic	0.068***	0.031	0.105
Other Race	0.025	-0.048	0.099
Unknown Race	0.020	-0.009	0.049
Metropolitan	-0.001	-0.027	0.025
Nonmetropolitan Rural	0.001	-0.062	0.063
Number of Relocations	-0.001	-0.011	0.009
Number of 24 Chronic Conditions	0.016***	0.007	0.024
Income between 51 - 100% FPL	0.021	-0.010	0.052
Income between 101 - 138% FPL	0.007	-0.037	0.052
Constant	0.792***	0.702	0.882

N = 2,403

* p<0.05, ** p<0.01, ***p<0.001

Measure 21 Comprehensive diabetes care: LDL-C screening

Our binary outcome was defined as whether or not a member with type 1 or type 2 diabetes had LDL-C screening. **Our DID model for LDL tests (limited to a sample of diabetics) indicated that completing both healthy behaviors in every year was not associated with the probability of having an LDL test.** At baseline, the treatment and control group were similarly likely to have an LDL test. The IHAWP itself increased the likelihood of receiving an LDL test by nearly 22 percentage points in 2014 and by more than 24 percentage points thereafter. As seen in Table 7, other factors in the model were also significant in predicting rates of LDL-C screenings. Sensitivity analyses in Table A3 of the appendix find no differences depending on full versus partial treatment.

Table 7. Likelihood of LDL-C screenings in Diabetic Members as a Function of Healthy Behavior Completion

	Coefficient	95% CI	
Post Period 2014	0.219***	0.159	0.278
Post Period 2015 - 2018	0.241***	0.187	0.296
Treatment Group	0.051	-0.021	0.122
Post Period 2014 * Treatment Group	0.028	-0.078	0.134
Post Period 2015 - 2018 * Treatment Group	0.032	-0.061	0.124
Age	0.003**	0.001	0.006
Male	-0.023	-0.061	0.015
Black	-0.015	-0.094	0.064
Hispanic	0.042	-0.036	0.119
Other Race	0.099	-0.013	0.210
Unknown Race	0.003	-0.041	0.047
Metropolitan	0.111***	0.071	0.151
Nonmetropolitan Rural	-0.037	-0.139	0.065
Number of Relocations	0.008	-0.006	0.023
Number of 24 Chronic Conditions	0.030***	0.018	0.042
Income between 51 - 100% FPL	0.004	-0.045	0.054
Income between 101 - 138% FPL	-0.013	-0.083	0.058
Constant	0.084	-0.038	0.206

N = 2,403

* p<0.05, ** p<0.01, ***p<0.001

Measure 25a Emergency Department Use

We modeled ED use using two outcomes. Our binary outcome was defined as whether or not a member had any ED visits during the year, while our continuous outcome was defined as the number of ED visits per 1000 members. **Our DID model for ED visits indicated that completing both healthy behaviors in every year was associated with a 4.9 percentage point decrease in the likelihood of having an ED visit during the 2014 implementation period and a 4.1 percentage point decrease thereafter.** There were no significant differences between the treatment and control group at baseline, but the IHAWP was associated with an approximately 10-11 percentage point increase in the likelihood of having an ED visit. Several other factors in the model were also significant, as seen in Table 8. Sensitivity analyses in Table A4 of the appendix find no differences depending on full versus partial treatment.

Table 8. Likelihood of Having an ED Visit as a Function of Healthy Behavior Completion

	Coefficient	95% CI	
Post Period 2014	0.105***	0.086	0.125
Post Period 2015 - 2018	0.106***	0.087	0.125
Treatment Group	-0.013	-0.035	0.009
Post Period 2014 * Treatment Group	-0.049*	-0.088	-0.009
Post Period 2015 - 2018 * Treatment Group	-0.041*	-0.076	-0.006
Age	-0.005***	-0.005	-0.004
Male	-0.037***	-0.051	-0.024
Black	0.072***	0.045	0.100
Hispanic	0.064**	0.020	0.108
Other Race	-0.064***	-0.101	-0.028
Unknown Race	-0.030***	-0.045	-0.015
Metropolitan	0.059***	0.045	0.073
Nonmetropolitan Rural	-0.036*	-0.066	-0.005
Number of Relocations	0.006*	0.000	0.012
Number of 24 Chronic Conditions	0.068***	0.063	0.072
Income between 51 - 100% FPL	-0.022*	-0.040	-0.004
Income between 101 - 138% FPL	-0.052***	-0.077	-0.027
Constant	0.369***	0.336	0.402

N = 16,629

* p<0.05, ** p<0.01, ***p<0.001

Our DID model for annual ED visit volume indicated that completing both healthy behaviors in every year was associated with a decrease of nearly 252 ED visits per 1000 members during the 2014 implementation year and a decrease of 144 ED visits per 1000 members thereafter. While there were no significant differences between the treatment and control group at baseline, the IHAWP was associated with an increase of nearly 338 ED visits per 1000 members in 2014, and an increase of 227 ED visits per 1000 members thereafter. Several other factors in the model were also significant, as seen in Table 9. Sensitivity analyses in Table A5 of the appendix find that the reduction in ED visits is smaller and not statistically significant in individuals who only receive partial treatment.

Table 9. Annual Number of ED Visits Per 1000 Members as a Function of Healthy Behavior Completion

	Coefficient	95% CI	
Post Period 2014	337.658***	262.594	412.722
Post Period 2015 – 2018	227.245***	165.725	288.765
Treatment Group	-63.498	-138.539	11.542
Post Period 2014 * Treatment Group	-251.832***	-387.977	-115.687
Post Period 2015 - 2018 * Treatment Group	-144.325*	-257.077	-31.573
Age	-16.982***	-19.291	-14.673
Male	-118.161***	-164.015	-72.307
Black	238.350***	116.014	360.687
Hispanic	97.861	-27.916	223.639
Other Race	-139.687**	-244.442	-34.932
Unknown Race	-67.370**	-116.370	-18.371
Metropolitan	173.631***	128.795	218.466
Nonmetropolitan Rural	-79.076*	-157.024	-1.129
Number of Relocations	14.434	-8.824	37.692
Number of 24 Chronic Conditions	228.396***	203.540	253.251
Income between 51 - 100% FPL	-73.068*	-134.355	-11.781
Income between 101 - 138% FPL	-153.568***	-230.683	-76.453
Constant	935.722***	824.059	1,047.385

N = 16,629

* p<0.05, ** p<0.01, ***p<0.001

Measure 25b Non-emergent Emergency Department Use

Our binary outcome was defined as whether or not a member who had any ED visits during the year had at least one non-emergent ED visit. **Our DID model for non-emergent ED visits indicated that there was no relationship between completing both healthy behaviors in every year and the likelihood of having a non-emergent ED visit.** There were no significant differences between the treatment and control group at baseline, and the IHAWP was not associated with the likelihood of having a non-emergent ED visit. However, several other factors in the model were significant, as seen in Table 10. Sensitivity analyses in Table A6 of the appendix find no differences depending on full versus partial treatment.

Table 10. Likelihood of a Non-emergent ED Visit as a Function of Healthy Behavior Completion

	Coefficient	95% CI	
Post Period 2014	0.021	-0.003	0.044
Post Period 2015 – 2018	0.023	-0.001	0.048
Treatment Group	0.001	-0.033	0.035
Post Period 2014 * Treatment Group	-0.005	-0.056	0.047
Post Period 2015 - 2018 * Treatment Group	0.006	-0.041	0.052
Age	-0.002***	-0.003	-0.002
Male	-0.024**	-0.042	-0.007
Black	0.006	-0.021	0.033
Hispanic	-0.005	-0.053	0.044
Other Race	0.051**	0.014	0.088
Unknown Race	0.005	-0.016	0.026
Metropolitan	0.013	-0.007	0.032
Nonmetropolitan Rural	-0.012	-0.066	0.042
Number of Relocations	0.003	-0.002	0.009
Number of 24 Chronic Conditions	-0.015***	-0.020	-0.010
Income between 51 - 100% FPL	0.010	-0.011	0.031
Income between 101 - 138% FPL	0.017	-0.014	0.048
Constant	1.022***	0.982	1.062

N = 2,403

* p<0.05, ** p<0.01, ***p<0.001

Measure 26 Follow-up ED visits

Our binary outcome was defined as whether or not a member who had any ED visits during the year had a return ED visit within the first 30 days after an index ED visit. **Our DID model for return ED visits indicated that after an 8.4 percentage point decrease during the 2014 implementation year, there was no relationship between completing both healthy behaviors in every year and the likelihood of a having a return ED visit within 30 days.** There were no significant baseline differences between the treatment and control groups, but the Medicaid expansion was associated with a 4.3 percentage point increase in the likelihood of having a 30-day return ED visit in 2014 although the association was no longer significant beginning in 2015. Other significant factors in the model are shown in Table 11. Sensitivity analyses in Table A7 of the appendix find that there is no association between receipt of partial treatment and the likelihood of 30-day return ED visits.

Table 11. Likelihood of a Return ED Visit Within 30 Days as a Function of Healthy Behavior Completion

	Coefficient	95% CI	
Post Period 2014	0.043*	0.009	0.077
Post Period 2015 – 2018	0.007	-0.025	0.040
Treatment Group	-0.011	-0.054	0.032
Post Period 2014 * Treatment Group	-0.084*	-0.150	-0.019
Post Period 2015 - 2018 * Treatment Group	-0.018	-0.078	0.043
Age	-0.004***	-0.005	-0.003
Male	-0.013	-0.037	0.010
Black	0.024	-0.017	0.065
Hispanic	0.015	-0.051	0.081
Other Race	0.016	-0.061	0.093
Unknown Race	-0.029*	-0.056	-0.002
Metropolitan	0.048***	0.023	0.072
Nonmetropolitan Rural	-0.004	-0.069	0.061
Number of Relocations	0.004	-0.005	0.012
Number of 24 Chronic Conditions	0.040***	0.033	0.047
Income between 51 - 100% FPL	-0.021	-0.052	0.009
Income between 101 - 138% FPL	-0.024	-0.070	0.022
Constant	0.286***	0.228	0.345

N = 2,403

* p<0.05, ** p<0.01, ***p<0.001

Measure 30 Inpatient utilization-general hospital/acute care

We measured hospitalizations using both a binary outcome, which we defined as whether or not a member was hospitalized during the year, and a continuous measure of the volume of hospitalizations per 1000 members. **Our DID model indicated that completing both healthy behaviors every year was associated with a 1.9 percentage point decrease in a member's likelihood of ever being hospitalized in 2014, but this association was no longer significant beginning in 2015.** Members in the treatment group were 1.3 percentage points less likely to be hospitalized than the control group at baseline, but the IHAWP was not associated with the likelihood of being hospitalized. Other factors in the model were also significant, are shown in Table 12. Sensitivity analyses in Table A8 of the appendix find that there is no association between receipt of partial treatment and the likelihood of hospitalization.

Table 12. Likelihood of Any Hospitalization as a Function of Healthy Behavior Completion

	Coefficient	95% CI	
Post Period 2014	0.003	-0.006	0.012
Post Period 2015 – 2018	0.002	-0.007	0.011
Treatment Group	-0.013**	-0.022	-0.003
Post Period 2014 * Treatment Group	-0.019*	-0.036	-0.001
Post Period 2015 - 2018 * Treatment Group	-0.009	-0.025	0.008
Age	-0.000	-0.000	0.000
Male	0.014***	0.007	0.020
Black	0.007	-0.005	0.019
Hispanic	-0.007	-0.027	0.014
Other Race	0.001	-0.015	0.016
Unknown Race	-0.001	-0.008	0.007
Metropolitan	-0.001	-0.008	0.006
Nonmetropolitan Rural	-0.003	-0.019	0.013
Number of Relocations	-0.000	-0.003	0.002
Number of 24 Chronic Conditions	0.039***	0.036	0.042
Income between 51 - 100% FPL	-0.006	-0.014	0.002
Income between 101 - 138% FPL	-0.023***	-0.033	-0.013
Constant	-0.003	-0.017	0.011

N = 16,629

* p<0.05, ** p<0.01, ***p<0.001

Our DID model indicated that completing both healthy behaviors every year was associated with a decrease of nearly 25 hospitalizations per 1000 members in 2014, although this association was no longer significant beginning in 2015. Members in the treatment group had approximately 20 fewer hospitalizations per 1000 members than the control group at baseline, but the IHAWP was not associated with the volume of hospitalizations per 1000 members. Other factors in the model were also significant, are shown in Table 13. Sensitivity analyses in Table A9 of the appendix find that there is no association between receipt of partial treatment and the volume of hospitalizations per 1000 members.

Table 13. Annual Number of Hospitalizations per 1000 Members as a Function of Healthy Behavior Completion

	Coefficient	95% CI	
Post Period 2014	6.861	-6.700	20.422
Post Period 2015 - 2018	10.313	-4.201	24.826
Treatment Group	-20.341***	-31.886	-8.796
Post Period 2014 * Treatment Group	-24.648*	-49.184	-0.113
Post Period 2015 - 2018 * Treatment Group	-13.721	-38.921	11.479
Age	-0.525*	-1.006	-0.044
Male	21.264***	11.474	31.054
Black	6.516	-10.906	23.938
Hispanic	-6.254	-40.627	28.120
Other Race	-4.087	-22.537	14.362
Unknown Race	0.991	-10.199	12.182
Metropolitan	-2.221	-12.683	8.241
Nonmetropolitan Rural	-11.241	-30.794	8.312
Number of Relocations	-0.421	-4.953	4.111
Number of 24 Chronic Conditions	55.370***	49.846	60.894
Income between 51 - 100% FPL	-13.075*	-24.411	-1.738
Income between 101 - 138% FPL	-32.497***	-45.688	-19.305
Constant	2.364	-19.897	24.624

N = 16,629

* p<0.05, ** p<0.01, ***p<0.001

Measure 31 Plan "all cause" hospital readmissions

Among members with at least one hospitalization, we measured hospital readmissions for any diagnosis using both a binary outcome, which we defined as whether or not a member was hospitalized within 30-days following a prior hospitalization during the year, and a continuous measure of the volume of 30-day readmissions per 1000 hospitalized members. **Our DID model indicated that there was no relationship between completing both healthy behaviors in every year and the likelihood of having at least one hospital readmission during the year.** Neither was there any baseline difference between the treatment and control groups, nor any significant trend between the pre-period and post-period attributable to the IHAWP. Only gender, other race, and the number of chronic conditions were significant predictors in this DID model, as shown in Table 14. Sensitivity analyses in Table A10 of the appendix find no differences depending on full versus partial treatment.

Table 14. Likelihood of Any Hospital Readmission as a Function of Healthy Behavior Completion

	Coefficient	95% CI	
Post Period 2014	0.042	-0.014	0.098
Post Period 2015 - 2018	0.011	-0.039	0.061
Treatment Group	-0.009	-0.072	0.053
Post Period 2014 * Treatment Group	-0.003	-0.124	0.118
Post Period 2015 - 2018 * Treatment Group	0.050	-0.048	0.149
Age	-0.001	-0.003	0.002
Male	0.041*	0.003	0.079
Black	0.027	-0.050	0.104
Hispanic	-0.004	-0.113	0.105
Other Race	-0.073***	-0.113	-0.034
Unknown Race	0.024	-0.025	0.072
Metropolitan	0.008	-0.033	0.050
Nonmetropolitan Rural	-0.020	-0.092	0.051
Number of Relocations	-0.009	-0.020	0.002
Number of 24 Chronic Conditions	0.019***	0.010	0.028
Income between 51 - 100% FPL	-0.002	-0.055	0.052
Income between 101 - 138% FPL	-0.022	-0.109	0.065
Constant	-0.006	-0.123	0.110

N = 805

* p<0.05, ** p<0.01, ***p<0.001

Our DID model indicated that there was no relationship between completing both healthy behaviors in every year and the volume of hospital readmissions per 1000 hospitalized members during the year. Neither was there any baseline difference between the treatment and control groups, nor any significant trend between the pre-period and post-period attributable to the IHAWP. Again, only gender, other race, and the number of chronic conditions were significant predictors in this DID model, as shown in Table 15. Sensitivity analyses in Table A11 of the appendix find no differences depending on full versus partial treatment.

Table 15. Annual Number of Hospital Readmissions per 1000 Hospitalized Members as a Function of Healthy Behavior Completion

	Coefficient	95% CI	
Post Period 2014	59.447	-24.272	143.165
Post Period 2015 - 2018	10.430	-61.173	82.034
Treatment Group	-9.708	-83.154	63.738
Post Period 2014 * Treatment Group	5.600	-175.346	186.546
Post Period 2015 - 2018 * Treatment Group	63.212	-54.081	180.504
Age	-3.171	-7.253	0.911
Male	59.545*	10.725	108.364
Black	21.410	-77.327	120.146
Hispanic	-17.136	-131.361	97.090
Other Race	-91.877**	-148.030	-35.725
Unknown Race	25.815	-42.701	94.332
Metropolitan	21.854	-35.144	78.852
Nonmetropolitan Rural	-32.757	-112.539	47.024
Number of Relocations	-0.136	-28.224	27.951
Number of 24 Chronic Conditions	27.362***	14.589	40.136
Income between 51 - 100% FPL	-18.924	-76.496	38.648
Income between 101 - 138% FPL	-40.700	-131.209	49.808
Constant	85.795	-102.047	273.637

N = 805

* p<0.05, ** p<0.01, ***p<0.001

Limitations

The quantitative analyses are limited in three ways. First, the definition of our sample and the treatment variable, while necessary to cleanly model the relationship between the Healthy Behaviors Program and our outcomes of interest using a quasi-experimental method, result in dropping a number of member-year observations. In turn, this raises the possibility that our results are not generalizable to other IHAWP members, to say nothing of Medicaid members more generally. Despite employing rigorous analytic strategies to combat them, our regression models may be limited by unobserved factors that differ between individuals, which may bias our results. However, the direction and magnitude of any such bias cannot be well predicted. Finally, administrative data are collected for billing and tracking purposes and may not always accurately reflect the service provided.

Conclusions

The HBI program is designed to encourage enrollees to take an active part in maintaining their health and to promote accountability among enrollees. In the current report, we use five years of data to assess healthy behavior completion rates, determine which members are most likely to complete the healthy behaviors, and evaluate the extent to which completing both healthy behaviors is associated with improvements in health care outcomes.

Overall, we see that the completion rate of both healthy behaviors—the wellness exam and HRA—averaged just 11 – 18% across all five years, and never exceeded 32% in any given year. This suggests that a substantial proportion of members, depending on income, is subject to paying a monthly premium for Medicaid coverage. We also observe strikingly different trends over time according to members' income level. In the lower-income group that includes some individuals (50% FPL and below) who are exempt from premiums and other individuals (51 – 100% FPL) who are subject to $5 monthly premiums but not subject to disenrollment, we see a steady decline in the completion of both healthy behavior requirements. By contrast, in the higher-income group that is subject to a higher $10 monthly premium as well as disenrollment for non-payment, we see a steady increase in the completion of both healthy behavior requirements. While this does seem to suggest that members are responsive to the disincentives being placed on them, we would strongly caution against interpreting these results as evidence of the need to increase premiums or pursue a policy of disenrollment at lower income levels, because even among the more compliant group, compliance remains below 25% of members, which is required to avoid paying a monthly premium in the following year or facing disenrollment for non-payment.

We also find that certain member characteristics are associated with the likelihood of completing both healthy behaviors. Specifically, members who are younger, male, non-white, and/or live in a rural area are less likely to complete both healthy behaviors and more likely to owe a monthly premium or face disenrollment. This raises concerns that these differences in compliance with the HBI requirements may result in disparities in insurance coverage by age, gender, race, and geography within an already vulnerable group of individuals eligible for Medicaid. We find that these results are not influenced by whether a person's income places them in the lower-income or higher-income group. These results have remained consistent with our earlier findings going back to 2015, suggesting that these results are relatively stable over time and need to be carefully considered going forward.

Finally, our evaluation of the relationship between completion of both healthy behaviors and health care outcomes finds some meaningful results. While the bivariate analyses demonstrate numerous statistically significant—and desirable—associations between healthy behavior completion and health care outcomes, none of those results control for potentially confounding variables. For that reason, the most empirically robust results come from our difference-in-differences models. These models allow us to limit our sample to individuals who were continuously enrolled in IowaCare for at least 12 months prior to the IHAWP in 2014 and remained continuously enrolled for at least 12 months following the expansion. Among that sample, these models then allow us to compare the treatment group (i.e., those who completed both healthy behaviors in every year they are in our data from 2014 through 2018) with a control group that completed none of the

healthy behaviors during the study period. Thus, we can isolate the contribution of completing healthy behaviors separately from other aspects of implementing IHAWP, which might include access to a wider range of providers and other factors.

Based on these results, we find that completing both healthy behaviors each year is associated with a few potentially desirable outcomes. These include: a decreased likelihood among all members of having an ED visit, as well a decrease in the volume of ED visits per 1000 members in all years following the implementation, as well as a decrease in hospitalizations and 30-day return ED visits in 2014 only.

While this decrease in ED use is potentially encouraging, when placed in context with our other results, the narrative becomes less clear. For instance, we observe no relationship between healthy behavior completion and the likelihood that members with an ED visit have a non-emergent ED visit. This would suggest that healthy behavior completion may be reducing ED visits, but among those who still use the ED, it is not necessarily changing the reasons for which they use ED, which still include potentially avoidable visits. Among the group that is no longer visiting the ED at all, this may or may not be a welcome change, depending on whether that ED care was replaced by care in a primary care setting (desirable) or simply foregone (undesirable). Further evaluation work will be required to investigate this relationship at the individual member level.

Finally, we observed only a limited association between healthy behavior completion and the likelihood or volume of hospitalizations, and we observed no association with readmissions. This suggests several possibilities: first, the HBI activities may be insufficient to have a noticeable and/or lasting impact on these more serious and costly health outcomes; second, it may take longer than 5 years for the benefit of the HBI to accrue; or third, individuals may churn on and off of Medicaid in ways that make it difficult to observe improvements (i.e., they may no longer be enrolled in Medicaid during the time when they avoid a hospitalization).

Appendix

This appendix contains the results of several sensitivity analyses that include an expanded sample with a group that completed some of the HBP requirements but did not complete all of the HBP requirements in all years. This allows us to examine the extent to which there is a "dose-response" relationship between completing HBP requirements and our health care utilization outcomes of interest.

Table A1. Likelihood of an Ambulatory/Preventive Care Visit as a Function of Healthy Behavior Completion

	Coefficient	95% CI	
Post Period 2014	0.119***	0.102	0.136
Post Period 2015-2018	0.095***	0.078	0.111
Full Treatment	0.114***	0.094	0.134
Partial Treatment	0.098***	0.080	0.117
Post Period 2014 * Full Treatment	0.010	-0.018	0.037
Post Period 2015-2018 * Full Treatment	0.003	-0.023	0.029
Post Period 2014 * Partial Treatment	0.007	-0.019	0.033
Post Period 2015-2018 * Partial Treatment	-0.003	-0.027	0.020
Age	-0.001***	-0.001	-0.001
Male	-0.064***	-0.073	-0.054
Black	0.024**	0.006	0.042
Hispanic	0.054***	0.029	0.080
Other Race	0.022	-0.005	0.049
Unknown Race	-0.012*	-0.022	-0.002
Metropolitan	0.037***	0.027	0.046
Nonmetropolitan Rural	0.003	-0.019	0.025
Number of Relocations	0.003	-0.000	0.007
Number of 24 Chronic Conditions	0.092***	0.090	0.095
Income between 51 - 100% FPL	0.013*	0.002	0.025
Income between 101 - 138% FPL	0.034***	0.017	0.050
Constant	0.581***	0.556	0.606

N = 24,162

* p<0.05, ** p<0.01, ***p<0.001

Table A2. Likelihood of Hemoglobin A1c Testing in Diabetic Members as a Function of Healthy Behavior Completion

	Coefficient	95% CI	
Post Period 2014	-0.016	-0.057	0.024
Post Period 2015-2018	0.017	-0.017	0.052
Full Treatment	0.010	-0.036	0.055
Partial Treatment	0.055**	0.019	0.091
Post Period 2014 * Full Treatment	0.058	-0.009	0.125
Post Period 2015-2018 * Full Treatment	0.009	-0.050	0.068
Post Period 2014 * Partial Treatment	0.033	-0.022	0.087
Post Period 2015-2018 * Partial Treatment	-0.042	-0.089	0.005
Age	0.000	-0.001	0.002
Male	-0.004	-0.023	0.015
Black	-0.014	-0.057	0.029
Hispanic	0.073***	0.046	0.101
Other Race	0.046	-0.001	0.092
Unknown Race	0.023*	0.002	0.045
Metropolitan	0.013	-0.007	0.033
Nonmetropolitan Rural	0.017	-0.029	0.063
Number of Relocations	0.000	-0.008	0.008
Number of 24 Chronic Conditions	0.014***	0.008	0.021
Income between 51 - 100% FPL	0.017	-0.006	0.041
Income between 101 - 138% FPL	0.002	-0.035	0.038
Constant	0.793***	0.722	0.864

N = 3,672

* $p<0.05$, ** $p<0.01$, ***$p<0.001$

Table A3. Likelihood of LDL-C screenings in Diabetic Members as a Function of Healthy Behavior Completion

	Coefficient	95% CI	
Post Period 2014	0.218***	0.159	0.276
Post Period 2015-2018	0.239***	0.185	0.293
Full Treatment	0.055	-0.016	0.126
Partial Treatment	0.034	-0.029	0.097
Post Period 2014 * Full Treatment	0.028	-0.077	0.134
Post Period 2015-2018 * Full Treatment	0.027	-0.066	0.119
Post Period 2014 * Partial Treatment	0.087	-0.008	0.181
Post Period 2015-2018 * Partial Treatment	0.001	-0.080	0.082
Age	0.003**	0.001	0.004
Male	-0.013	-0.044	0.017
Black	-0.010	-0.074	0.054
Hispanic	0.040	-0.025	0.105
Other Race	0.118**	0.038	0.198
Unknown Race	0.007	-0.028	0.042
Metropolitan	0.117***	0.085	0.149
Nonmetropolitan Rural	-0.022	-0.101	0.057
Number of Relocations	0.007	-0.005	0.020
Number of 24 Chronic Conditions	0.033***	0.023	0.042
Income between 51 - 100% FPL	0.021	-0.018	0.060
Income between 101 - 138% FPL	0.034	-0.022	0.091
Constant	0.099	-0.002	0.200

N = 3,672

* $p<0.05$, ** $p<0.01$, ***$p<0.001$

Table A4. Likelihood of Having an ED Visit as a Function of Healthy Behavior Completion

	Coefficient	95% CI	
Post Period 2014	0.107***	0.088	0.127
Post Period 2015-2018	0.109***	0.090	0.128
Full Treatment	-0.013	-0.034	0.009
Partial Treatment	-0.029**	-0.048	-0.011
Post Period 2014 * Full Treatment	-0.048*	-0.088	-0.008
Post Period 2015-2018 * Full Treatment	-0.042*	-0.076	-0.007
Post Period 2014 * Partial Treatment	-0.044*	-0.079	-0.010
Post Period 2015-2018 * Partial Treatment	-0.047**	-0.075	-0.019
Age	-0.005***	-0.005	-0.004
Male	-0.038***	-0.049	-0.027
Black	0.071***	0.047	0.094
Hispanic	0.056**	0.018	0.093
Other Race	-0.061***	-0.091	-0.031
Unknown Race	-0.037***	-0.049	-0.024
Metropolitan	0.054***	0.042	0.066
Nonmetropolitan Rural	-0.017	-0.042	0.008
Number of Relocations	0.005*	0.000	0.010
Number of 24 Chronic Conditions	0.063***	0.060	0.067
Income between 51 - 100% FPL	-0.017*	-0.032	-0.002
Income between 101 - 138% FPL	-0.039***	-0.060	-0.018
Constant	0.369***	0.341	0.398

N = 24,162

* $p<0.05$, ** $p<0.01$, ***$p<0.001$

Table A5. Annual Number of ED Visits Per 1000 Members as a Function of Healthy Behavior Completion

	Coefficient	95% CI	
Post Period 2014	341.847***	266.034	417.659
Post Period 2015-2018	233.952***	171.603	296.301
Full Treatment	-57.714	-133.265	17.837
Partial Treatment	-120.298***	-165.898	-74.697
Post Period 2014 * Full Treatment	-250.467***	-386.142	-114.792
Post Period 2015-2018 * Full Treatment	-144.187*	-256.492	-31.882
Post Period 2014 * Partial Treatment	-107.832	-238.975	23.311
Post Period 2015-2018 * Partial Treatment	-62.235	-153.377	28.907
Age	-17.319***	-19.290	-15.348
Male	-108.608***	-148.262	-68.953
Black	193.285***	97.756	288.814
Hispanic	54.029	-46.931	154.990
Other Race	-125.008**	-217.748	-32.269
Unknown Race	-97.966***	-139.012	-56.921
Metropolitan	116.716***	75.685	157.748
Nonmetropolitan Rural	-89.344**	-152.415	-26.273
Number of Relocations	11.889	-6.969	30.746
Number of 24 Chronic Conditions	223.775***	199.044	248.507
Income between 51 - 100% FPL	-81.378**	-129.872	-32.884
Income between 101 - 138% FPL	-129.971***	-192.848	-67.094
Constant	996.811***	901.647	1,091.975

N = 24,162

* $p<0.05$, ** $p<0.01$, ***$p<0.001$

Table A6. Likelihood of a Non-emergent ED Visit as a Function of Healthy Behavior Completion

	Coefficient	95% CI	
Post Period 2014	0.018	-0.006	0.042
Post Period 2015-2018	0.018	-0.006	0.042
Full Treatment	0.001	-0.033	0.035
Partial Treatment	-0.002	-0.033	0.029
Post Period 2014 * Full Treatment	-0.006	-0.057	0.046
Post Period 2015-2018 * Full Treatment	0.008	-0.039	0.054
Post Period 2014 * Partial Treatment	0.002	-0.044	0.047
Post Period 2015-2018 * Partial Treatment	0.031	-0.008	0.070
Age	-0.003***	-0.003	-0.002
Male	-0.023**	-0.038	-0.009
Black	0.001	-0.023	0.025
Hispanic	-0.006	-0.049	0.037
Other Race	0.046**	0.013	0.079
Unknown Race	-0.006	-0.024	0.011
Metropolitan	0.002	-0.014	0.017
Nonmetropolitan Rural	-0.010	-0.052	0.031
Number of Relocations	0.003	-0.002	0.008
Number of 24 Chronic Conditions	-0.011***	-0.015	-0.007
Income between 51 - 100% FPL	-0.001	-0.019	0.017
Income between 101 - 138% FPL	0.012	-0.014	0.038
Constant	1.038***	1.003	1.073

N = 7,029

* $p<0.05$, ** $p<0.01$, ***$p<0.001$

Table A7. Likelihood of a Return ED Visit Within 30 Days as a Function of Healthy Behavior Completion

	Coefficient	95% CI	
Post Period 2014	0.044*	0.010	0.078
Post Period 2015-2018	0.011	-0.021	0.043
Full Treatment	-0.010	-0.053	0.033
Partial Treatment	-0.042*	-0.080	-0.004
Post Period 2014 * Full Treatment	-0.085*	-0.150	-0.019
Post Period 2015-2018 * Full Treatment	-0.018	-0.078	0.043
Post Period 2014 * Partial Treatment	0.001	-0.060	0.061
Post Period 2015-2018 * Partial Treatment	0.027	-0.024	0.078
Age	-0.004***	-0.005	-0.003
Male	-0.013	-0.033	0.006
Black	0.002	-0.034	0.037
Hispanic	-0.007	-0.063	0.050
Other Race	-0.015	-0.077	0.048
Unknown Race	-0.044***	-0.067	-0.022
Metropolitan	0.042***	0.022	0.063
Nonmetropolitan Rural	-0.020	-0.070	0.031
Number of Relocations	0.003	-0.005	0.010
Number of 24 Chronic Conditions	0.036***	0.031	0.042
Income between 51 - 100% FPL	-0.017	-0.042	0.008
Income between 101 - 138% FPL	-0.031	-0.069	0.006
Constant	0.315***	0.264	0.367

N = 7,029

* $p<0.05$, ** $p<0.01$, ***$p<0.001$

Table A8. Likelihood of Any Hospitalization as a Function of Healthy Behavior Completion

	Coefficient	95% CI	
Post Period 2014	0.003	-0.006	0.012
Post Period 2015-2018	0.003	-0.006	0.012
Full Treatment	-0.013**	-0.022	-0.003
Partial Treatment	-0.013**	-0.021	-0.005
Post Period 2014 * Full Treatment	-0.018*	-0.036	-0.001
Post Period 2015-2018 * Full Treatment	-0.009	-0.026	0.008
Post Period 2014 * Partial Treatment	-0.007	-0.022	0.009
Post Period 2015-2018 * Partial Treatment	-0.003	-0.016	0.011
Age	-0.000	-0.000	0.000
Male	0.012***	0.006	0.017
Black	0.006	-0.005	0.016
Hispanic	-0.006	-0.023	0.011
Other Race	0.002	-0.011	0.015
Unknown Race	-0.001	-0.007	0.005
Metropolitan	-0.003	-0.009	0.002
Nonmetropolitan Rural	-0.002	-0.015	0.011
Number of Relocations	0.000	-0.002	0.003
Number of 24 Chronic Conditions	0.038***	0.035	0.040
Income between 51 - 100% FPL	-0.006	-0.013	0.001
Income between 101 - 138% FPL	-0.019***	-0.027	-0.011
Constant	-0.001	-0.013	0.011

N = 24,162

* $p<0.05$, ** $p<0.01$, ***$p<0.001$

Table A9. Annual Number of Hospitalizations per 1000 Members as a Function of Healthy Behavior Completion

	Coefficient	95% CI	
Post Period 2014	5.732	-8.011	19.475
Post Period 2015-2018	8.271	-6.737	23.279
Full Treatment	-20.406***	-31.942	-8.870
Partial Treatment	-13.543*	-26.118	-0.968
Post Period 2014 * Full Treatment	-25.174*	-49.756	-0.591
Post Period 2015-2018 * Full Treatment	-13.874	-39.008	11.259
Post Period 2014 * Partial Treatment	-17.217	-41.810	7.375
Post Period 2015-2018 * Partial Treatment	-8.692	-32.610	15.227
Age	-0.706**	-1.225	-0.187
Male	21.998***	13.044	30.952
Black	7.431	-9.921	24.784
Hispanic	-9.543	-37.299	18.214
Other Race	-3.066	-17.877	11.745
Unknown Race	-3.668	-13.006	5.670
Metropolitan	-6.765	-16.084	2.554
Nonmetropolitan Rural	-13.284	-29.802	3.233
Number of Relocations	-0.300	-4.070	3.470
Number of 24 Chronic Conditions	58.665***	52.030	65.301
Income between 51 - 100% FPL	-15.800**	-25.595	-6.005
Income between 101 - 138% FPL	-30.877***	-41.993	-19.761
Constant	10.769	-11.991	33.529

N = 24,162

* $p<0.05$, ** $p<0.01$, ***$p<0.001$

Table A10. Likelihood of Any Hospital Readmission as a Function of Healthy Behavior Completion

	Coefficient	95% CI	
Post Period 2014	0.042	-0.014	0.098
Post Period 2015-2018	0.010	-0.040	0.060
Full Treatment	-0.006	-0.069	0.057
Partial Treatment	0.053	-0.022	0.129
Post Period 2014 * Full Treatment	-0.006	-0.126	0.115
Post Period 2015-2018 * Full Treatment	0.053	-0.045	0.151
Post Period 2014 * Partial Treatment	-0.094	-0.197	0.008
Post Period 2015-2018 * Partial Treatment	-0.041	-0.132	0.051
Age	-0.001	-0.003	0.001
Male	0.045**	0.013	0.077
Black	0.015	-0.050	0.080
Hispanic	0.007	-0.098	0.112
Other Race	-0.075***	-0.106	-0.044
Unknown Race	0.017	-0.022	0.056
Metropolitan	0.006	-0.029	0.041
Nonmetropolitan Rural	0.009	-0.063	0.080
Number of Relocations	-0.008	-0.018	0.003
Number of 24 Chronic Conditions	0.021***	0.013	0.030
Income between 51 - 100% FPL	-0.006	-0.049	0.036
Income between 101 - 138% FPL	-0.027	-0.090	0.037
Constant	0.010	-0.093	0.114

N = 1,188

* $p<0.05$, ** $p<0.01$, ***$p<0.001$

Table A11. Annual Number of Hospital Readmissions per 1000 Hospitalized Members as a Function of Healthy Behavior Completion

	Coefficient	95% CI	
Post Period 2014	63.691	-20.713	148.095
Post Period 2015-2018	-8.850	-82.927	65.227
Full Treatment	5.174	-70.880	81.227
Partial Treatment	60.062	-33.028	153.153
Post Period 2014 * Full Treatment	-15.784	-196.453	164.885
Post Period 2015-2018 * Full Treatment	69.528	-47.645	186.700
Post Period 2014 * Partial Treatment	-77.642	-253.709	98.426
Post Period 2015-2018 * Partial Treatment	-0.495	-128.149	127.160
Age	-5.117*	-9.176	-1.058
Male	68.818**	20.248	117.388
Black	1.874	-79.728	83.476
Hispanic	-13.691	-127.472	100.090
Other Race	-93.317***	-142.168	-44.465
Unknown Race	-2.676	-57.532	52.180
Metropolitan	8.227	-45.135	61.589
Nonmetropolitan Rural	-5.791	-85.518	73.937
Number of Relocations	-5.885	-26.951	15.181
Number of 24 Chronic Conditions	43.606***	23.806	63.406
Income between 51 - 100% FPL	-34.192	-84.412	16.029
Income between 101 - 138% FPL	-57.768	-128.199	12.663
Constant	137.831	-35.728	311.391

N = 1,188

* $p<0.05$, ** $p<0.01$, ***$p<0.001$