Iowa Medicaid Enterprise
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Dental Wellness Plan Healthy Behaviors

The Dental Wellness Plan (DWP) is the dental benefit offered to adult Medicaid Members.

The original DWP began in May 2014 and only included the Medicaid Expansion population. Beginning May 1, 2017, the State of Iowa proposed an amendment to the 1115 Waiver to include all Medicaid enrollees aged 19 and over. At this same time, the plan design was amended to include dental Healthy Behavior requirements including both of the following:

- Oral Health Risk Assessment
- Preventive Dental Service

Iowa felt strongly that including a Healthy Behavior component was important in the process of preventing disease and infections. Since not all adults are equally likely to develop oral health problems, a self-assessment as a Healthy Behavior brings awareness to any risk for oral disease (including the habits that attribute to the condition). In addition, receiving dental care is a first step in engaging in positive prevention so oral health diseases do not occur in the first place. The ultimate goal of Healthy Behaviors is to change member behavior in seeking urgent dental care and instead value routine dental care and prevention interventions to avoid emergencies.

Each enrollment period, if a member receives a preventive dental service and completes an oral health risk assessment, they are deemed compliant for completing Healthy Behaviors. If both Healthy Behaviors are not completed, the Member is subject to a monthly premium in their following enrollment period. Each Dental Plan Administrator, Delta Dental of Iowa (DDIA) or Managed Care of North America (MCNA), has their own self-risk assessment tool. Members can access the tool on their respective websites or call their customer service line to complete it over the phone. MCNA also allows members to mail or fax a paper copy. The preventive dental services that qualify as a Healthy Behavior includes the following:

- D0120 periodic oral evaluation – established patient
- D0140 limited oral evaluation – problem focused
- D0150 comprehensive oral evaluation – new or established patient
- D0180 comprehensive periodontal evaluation – new or established patient
- D0190 screening of a patient (allowed only for non-dentist providers)
- D1110 prophylaxis – adult
- D1206 topical application of fluoride varnish
- D4346 scaling in presence of generalized moderate or severe gingival inflammation, full mouth, after evaluation
- D4910 periodontal maintenance
- D0601 caries risk assessment and documentation, low risk
- D0602 caries risk assessment and documentation, moderate risk
- D0603 caries risk assessment and documentation, high risk

In development of the Dental Wellness Plan Healthy Behaviors program, the state intended alignment with the Wellness Plan protocol to maximize member and provider understanding and operational efficiencies. Therefore, the stakeholder engagement as described in the “Stakeholder Engagement in Protocol Development” was leveraged in finalization of this protocol.

As part of the Dental Wellness Plan design, members are encouraged to participate in Healthy Behaviors. Healthy Behaviors were 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.

Originally, the risk assessment was administered by providers. However, due to provider dissatisfaction on the amount of time to complete the risk assessment for minimal reimbursement, it switched to a member self-risk assessment. However, providers are still able to complete this on the member's behalf. The expectation is that the PAHP's collect the information and use it for direct outreach and education based on responses. The Dental Plan Administrators (DPAs) are responsible for member and provider education and outreach as it relates to Healthy Behaviors. The PAHPs used internal and external resources to develop the risk assessment tool. The tool gives members information about tooth caries risk, and individual risk for oral diseases, such as gum disease, and oral cancers along with actions members can take to reduce their risks. Providers may reimburse for completing the risk assessment tool.

The Iowa Medicaid Enterprise (IME) engages in continual quality improvement activities and identifies opportunities for programmatic improvements to the DWP. As such, as reflected in the list above, additional cleaning codes, fluoride varnish, risk assessment codes and oral health screenings completed by either dental hygienists or nurses in a public health setting are now eligible to meet the Healthy Behaviors requirement. The addition of prophylaxis (cleaning) codes as Healthy Behaviors had been requested by providers to truly reflect the DWP high risk population's needs and would ultimately help Members complete the Healthy Behavior requirement. In addition, due to the number of counties that qualify as Health Professional Shortage Areas (HPSA), allowing Iowa's strong public health infrastructure to provide preventive services to Members that cannot access care from a dentist would ease the stress of accessing care for the Healthy Behavior Requirement.

Healthy Behaviors are tracked by the Dental Plan Administrators (DPA) and IME. A monthly file exchange of completed Healthy Behaviors occurs on the last working day of the month. This file assures premiums are not charged to Members who have completed both Healthy Behaviors. The file also identifies which Healthy Behaviors a member has completed to allow the DPAs to conduct targeted outreach and education to members needing to complete a service prior to their enrollment period ending.

The Agency shall determine eligibility of patients to enroll in the DWP. The Agency shall periodically conduct a review of each enrollee's circumstances to establish the enrollees continued eligibility to participate in the DWP.

The Notice of Action (NOA) regarding eligibility decisions are mailed to beneficiaries at the time the determination is made. If the determination results in negative action, the NOA is mailed allowing for timely notice of at least ten calendar days. A NOA is also sent when the dental benefits are changed.

Dental providers are able to confirm a member's status through the IME Eligibility and Verification Information System (ELVS) line or access provider portals with a member's plan. Members are allowed to call and self-attest to completing the self-risk assessment. In addition, a member that pays for a service out of pocket by a non-network provider (no claims history would be on file) is allowed to self-attest to completing the preventive service as well.

Members who are at or below 50% of the Federal Poverty Level (FPL) will never be assessed a dental premium. Members above 50% of the FPL are given a 30 day grace period after the enrollment year to complete the Healthy Behaviors in order to avoid cost sharing. If members do not complete the Healthy Behaviors after the grace period has ended, they receive a premium statement for $3 in order to maintain comprehensive (full) dental benefits. This premium statement is mailed to the member's address on file and includes the option for a member to claim a financial hardship. If neither a payment nor hardship is received after 90 days, the member is moved from the full dental benefit package to a reduced (basic) benefit package. Once a member is moved to the basic benefit package, premium statements cease. Members have the ability in their current enrollment period to complete Healthy Behaviors for the following enrollment period to re-gain full dental benefits. Members are not allowed to "catch up" premium payments to get back to full benefits.

Members have the ability to appeal the move in benefit levels and request an appeal hearing through the state. Appeals are made directly to the Department of Human Services (DHS), not to the DPA, and may be made in person, by telephone or in writing. A member can complete an appeal form on the DHS website which is sent directly to the DHS Appeals Section at the following address:

Department of Human Services
Appeals Section
1305 E. Walnut Street, 5th Floor
Des Moines, IA 50319
Email: appeals@dhs.state.ia.us

Including copayments, all cost sharing will be subject to the 5 percent out-of-pocket maximum limit. When members approach their 5 percent limit, payment of copayments for nonemergency use of the emergency department will take precedence over payment of monthly contributions. Members will be permitted to request a reassessment of their 5 percent out-of-pocket maximum if they meet certain qualifying conditions including a change in income or adding or losing a dependent. All household cost sharing amounts paid to Iowa Medicaid will be included in determining if the participant has met their 5 percent out-of-pocket maximum. This will include consideration for any other cost sharing paid by the member's household for Iowa Medicaid programs and services.

System programming is underway to capture and track this process through eligibility, MMIS and the Managed Care Organization (MCO) systems. These system edits will be implemented in advance of post-PHE premium resumption. The actual tracking of cost sharing will not start until 12 months after the PHE ends, when premiums will begin to resume. When a change in income is reported, the 5% maximum will be systematically updated. The MMIS will issue a notice of action for the FFS members and the MCOs for the Iowa Health Link members, when the 5% cap has been met.

Certain populations are excluded from Healthy Behavior requirements (as outlined in the 1115 waiver). These members are identified in the Medicaid Management Information System (MMIS) by an assigned indicator and have remained consistent since implementation. The following DWP populations will not be charged premiums and (therefore) would not have their benefits limited to basic services in their second year of enrollment for failure to complete Healthy Behaviors:

- 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 services waiver enrollees.
- Individuals receiving hospice care.
- American Indians/Alaskan Natives (AI/AN) who are eligible to receive or have received an item or service furnished by an Indian health care provider or through referral under contract health services.
- Breast and cervical cancer treatment program enrollees.
- Medically frail enrollees (also referred to as medically exempt).
- Breast and cervical cancer treatment program enrollees
- Enrollees who attest financial hardship
- Enrollees under or equal to 50% FPL
- 19 – 20 year olds covered by EPSDT

Upon application, enrollees are screened for medially frail status as described at CFR § 440.315(f) and a retrospective process can be implemented to identify individuals who become medically frail post enrollment. This form that can be completed if a patient believes they meet the definition of medically frail is form. It can be submitted electronically to the IME but instructions for additional methods for submission (telephone, mail, email and fax) are also available.

The DPAs are responsible for member and provider education and outreach as it relates to Healthy Behaviors. Their systems must have the ability to track the results of the initial oral health screening, comprehensive oral health risk assessment, enrollee outcomes and to share information with the Member, his or her authorized representatives, and all relevant treatment providers, including (but not limited to) primary care providers and specialists. The DPA must submit to IME regular reporting regarding the selection criteria, strategies, and outcomes of education and outreach programs as prescribed in the monthly reporting template. Contractual Scope of Work language within respective contracts includes the following:

> *The Contractor shall manage population health by focusing on restoring basic functionality for all enrollees and improving the oral health of enrollees over time through education, enrollee engagement and community support by such means as, but not limited to:*
>
> *a. Increasing use of preventive services versus restorative services;*
> *b. Educate enrollees on appropriate utilization of preventive dental services to maintain oral health;*
> *c. Educate enrollee incentives of completing of healthy behaviors;*

d. Utilizing community resources and health and dental providers to educate enrollees of the importance of oral health care and treatment.

e. Promote completion of Healthy Behaviors:

i. Upon enrollment, educate members on the Healthy Behavior requirement by means other than referencing the member manual.

ii. Consider incentivizing members who complete Healthy Behaviors.

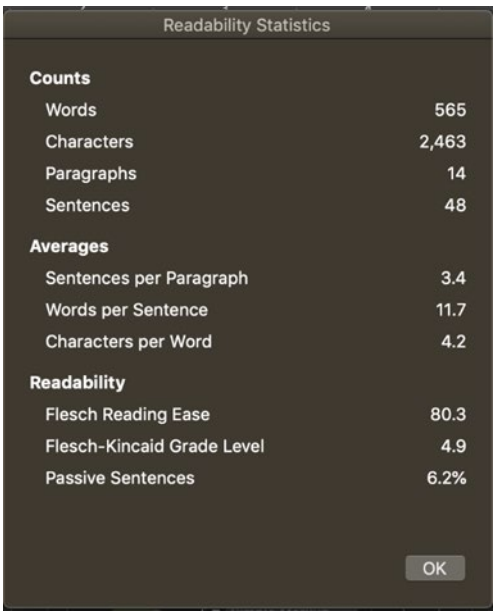
iii. Provide targeted outreach to members (prior to the end of their enrollment period) who have not fulfilled the Healthy Behavior requirements and assist them with completing requirements.

iv. Provide a targeted outreach to members on Basic benefits and educate them on how to earn back Full benefits.

Both DPAs notify members about DWP benefits by sending members assigned to them a new member packet upon enrollment which includes their dental cards and information about Healthy Behavior requirements. Additional outreach is completed based on monitoring of members who have not completed Healthy Behaviors. This outreach is traditionally completed by telephone or additional mailings. DDIA is also in the process of piloting a texting program to members. Both DBAs work to have a presence at meetings and events where members or stakeholders that work with the same population are at for opportunities to cross train or educate.

Per the PAHP contracts, all notices, information materials, and instructional materials related to enrollees and potential enrollees are written in a manner and format that may be easily understood and written at a maximum sixth grade reading level. Any information that includes the State's name and correspondence that may be sent to participants on behalf of the Agency must also be submitted by the Contractor to the Agency for review and approval. The Agency reserves the right to mandate that specific language be included in member communication materials.

The PAHP's provide the readability statistics with materials submitted for approval. Example:



Both the fee-for-service and MCO handbooks are available on the DHS website in English and Spanish. Translation services can be requested through Iowa Medicaid Member Services. Beneficiaries with low literacy or those who live in rural areas and have no or limited internet access can call the DHS Contact Center. Representatives can provide additional information, answer any questions and help complete an application for Medicaid over the phone.

Contractually, the PAHP's must make its written materials that are critical to obtaining services, including, at a minimum, provider directories, enrollee handbooks, appeal and grievance notices, and denial and termination notices available in the prevalent non-English languages in its particular service area.

In addition, the Contractor's written materials must:

- Include taglines in the prevalent non-English languages in the state, as well as large print, explaining the availability of written translation or oral interpretation to understand the information provided.
- Include taglines in the prevalent non-English languages in the state, as well as large print, explaining the availability of the toll-free and Teletypewriter Telephone/Text Telephone (TTY/TDY) telephone number of the Contractor's member/customer service unit.
- Make written materials for potential enrollees and enrollees available in alternative formats in an appropriate manner that takes into consideration the special needs of enrollees or potential enrollees with disabilities or limited English proficiency.
- Make written materials for potential enrollees and enrollees available through auxiliary aids and services in an appropriate manner that takes into consideration the special needs of enrollees or potential enrollees with disabilities or limited English proficiency.

Beneficiaries can report changes by phone, email, fax, or in person. These methods are included in Communication 233, Rights and Responsibilities, which is included in the application form. In accordance with federal regulations, 42 CFR 435.916(c), all beneficiaries or someone acting on the beneficiary's behalf must report any changes that affect eligibility.

Also, the form 'Ten-Day Report of Change for Medicaid/Hawki' is available on the DHS website as well as in the Self-Service Portal (SSP). This form also provides the methods for reporting changes. Contact information for the department is also available on the website.

For MAGI-related Medicaid, the client shall not be required to provide additional verification if attested income meets the Department's standards for 'reasonable compatibility'. If attested income does not meet the Department's standards for 'reasonable compatibility' or if the Department is not able to verify income through an Electronic Data Source, a written request will be sent for the additional information or verification. For non-MAGI-related Medicaid, when the Department is not able to verify income through an Electronic Data Source, the beneficiary must supply complete and accurate information. A written request will be sent in these scenarios.

The Premium Payment System (PPS) manages premium payments for the IHAWP including DWP premiums. This system receives invoices from the MMIS and generates statements for members based on what they owe (versus what they have paid). Statements are sent out monthly to members that have an amount owed greater than zero.

Members are able to remit payment in multiple ways. Monthly check payments or claimed hardships can be mailed to DHS via Wells Fargo PO Box. For members without a checking account, the IME also accepts money orders. In addition, IME can accept a hardship claim from a member over the phone. Members also have the option of using a web application called ClickPay to make payments from a checking account, which is administered through U.S. Bank.

The state monitors premiums and thresholds for modification and/or termination of the premium in event of unintended harm to beneficiaries in many ways. Iowa contracts with the University of Iowa Public Policy Center (PPC) to evaluate different aspects of Healthy Behaviors. This includes the following:

- Do Healthy Behaviors empower members to make healthy behavior changes (ie: preventive care vs. treatment)?
- Do Healthy Behaviors encourage members to take specific proactive steps in managing their own health and provide educational support?

The evaluation from the PPC provides information to DHS for consideration when making future policy decisions on future healthy behavior requirements and rewards.

Additionally, decision documents have been created to guide staff through the various scenarios. Since an unpaid medical premium can result in loss of benefits, the hierarchy is such that all payments go towards medical premiums first before being applied to dental. As long as members remain eligible for IHAWP benefits, they will have some level of dental coverage.

Below is an example for how payment would be applied if a member pays $50.00 and has $10.00 premiums for Medical and $3.00 premiums for Dental:

April Dental 3.00 Paid 5th	May Dental 3.00 Paid 6th	June Dental 3.00 Paid 7th	July Dental 3.00 Not paid, only 1 dollar remains, so would go to credit on account.	August Dental 3.00
	May Medical 10.00 Paid 1st	June Medical 10.00 Paid 2nd	July Medical 10.00 Paid 3rd	August Dental 10.00 Paid 4th

Most recently, Iowa formally discontinued the dental Healthy Behavior protocol for the Dental Wellness Plan (DWP) as described in the Iowa Wellness Plan Section 1115 Demonstration Waiver on July 1, 2023. Members enrolled in the DWP will no longer be required to complete two dental Healthy Behavior services annually or pay a monthly dental contribution to receive full dental coverage. This will ensure that members get the services they need at the time they need them. On the medical side, Healthy Behaviors remains and either a wellness exam or a preventive dental exam complies with fulfilling one of the requirements.