DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop: S2-25-26
Baltimore, Maryland 21244-1850

State Demonstrations Group

June 25, 2025

Rebecca Curtiss
Acting Director
Iowa Medicaid Enterprise
Iowa Department of Human Services
1305 E Walnut Street
Des Moines, Iowa 50319

Dear Acting Director Curtiss:

The Centers for Medicare & Medicaid Services (CMS) is updating the section 1115 demonstration monitoring approach to reduce state burden, promote effective and efficient information sharing, and enhance CMS's oversight of program integrity by reducing variation in information reported to CMS.

Federal section 1115 demonstration monitoring and evaluation requirements are set forth in section 1115(d)(2)(D)-(E) of the Social Security Act (the Act), in CMS regulations in 42 CFR 431.428 and 431.420, and in individual demonstration special terms and conditions (STCs). Monitoring provides insight into progress with initial and ongoing demonstration implementation and performance, which can detect risks and vulnerabilities to inform possible course corrections and identify best practices. Monitoring is a complementary effort to evaluation. Evaluation activities assess the demonstration's success in achieving its stated goals and objectives.

Key changes of this monitoring redesign initiative include introducing a structured template for monitoring reporting, updating the frequency and timing of submission of monitoring reports, and standardizing the cadence and content of the demonstration monitoring calls.

Updates to Demonstration Monitoring

Below are the updated aspects of demonstration monitoring for the Iowa Wellness Plan (Project Number 11-W-00289/7) demonstration.

Reporting Cadence and Due Date

CMS determined that, when combined with monitoring calls, an annual monitoring reporting cadence will generally be sufficient to monitor potential risks and vulnerabilities in demonstration implementation, performance, and progress toward stipulated goals. Thus, pursuant to CMS's authority under 42 CFR 431.420(b)(1) and 42 CFR 431.428, CMS is

updating the cadence for this demonstration to annual monitoring reporting (see also section 1115(d)(2)(D)-(E) of the Act). This transition to annual monitoring reporting is expected to alleviate administrative burden for both the state and CMS. In addition, CMS is extending the due date of the annual monitoring report from 90 days to 180 days after the end of each demonstration year to balance Medicaid claims completeness with the state's work to draft, review, and submit the report timely.

CMS might increase the frequency of monitoring reporting if CMS determines that doing so would be appropriate. The standard for determining the frequency of monitoring reporting will ultimately be included in each demonstration's STCs. CMS expects that this standard will permit CMS to make on-going determinations about reporting frequency under each demonstration by assessing the risk that the state might materially fail to comply with the terms of the approved demonstration during its implementation and/or the risk that the state might implement the demonstration in a manner unlikely to achieve the statutory purposes of Medicaid. *See* 42 CFR 431.420(d)(1)-(2).

The Iowa Wellness Plan demonstration will transition to annual monitoring reporting effective June 25, 2025. The next annual monitoring report will be due on January 27, 2026, which reflects the first business day following 180 calendar days after the end of the current demonstration year. The demonstration STCs will be updated in the next demonstration amendment or extension approval to reflect the new reporting cadence and due date.

Structured Monitoring Report Template

As noted in STC 41, "Monitoring Reports," monitoring reports "must follow the framework provided by CMS, which is subject to change as monitoring systems are developed/evolve, and be provided in a structured manner that supports federal tracking and analysis." Pursuant to that STC, CMS is introducing a structured monitoring report template to minimize variation in content of reports across states, which will facilitate drawing conclusions over time and across demonstrations with broadly similar section 1115 waivers or expenditure authorities. The structured reporting framework will also provide CMS and the state opportunities for more comprehensive and instructive engagement on the report's content to identify potential risks and vulnerabilities and associated mitigation efforts as well as best practices, thus strengthening the overall integrity of demonstration monitoring.

This structured template will include a set of base metrics for all demonstrations. For demonstrations with certain waiver and expenditure authorities, there are additional policy-specific metrics that will be collected through the structured reporting template.

CMS is also removing the requirement for a Monitoring Protocol deliverable, which has been required under certain types of section 1115 demonstration, including but not limited to Eligibility and Coverage demonstrations. Removal of the Monitoring Protocol requirement simplifies and streamlines demonstration monitoring activities for states and CMS.

Demonstration Monitoring Calls

As STC 44 "Monitoring Calls" describes, CMS may "convene periodic conference calls with the state," and the calls are intended "to discuss ongoing demonstration operation, to include (but not limited to) any significant actual or anticipated developments affecting the demonstration." Going forward, CMS envisions implementing a structured format for monitoring calls to provide consistency in content and frequency of demonstration monitoring calls across demonstrations. CMS also envisions convening quarterly monitoring calls with the state and will follow the structure and topics in the monitoring report template. We anticipate that standardizing the expectations for and content of the calls will result in more meaningful discussion and timely assessment of demonstration risks, vulnerabilities, and opportunities for intervention. The demonstration STCs will be updated in the next demonstration amendment or extension approval to reflect that monitoring calls will be held no less frequently than quarterly.

CMS will continue to be available for additional calls as necessary to provide technical assistance or to discuss demonstration applications, pending actions, or requests for changes to demonstrations. CMS recognizes that frequent and regular calls are appropriate for certain demonstrations and at specific points in a demonstration's lifecycle.

In the coming weeks, CMS will reach out to schedule a transition meeting to review templates and timelines outlined above. As noted above, the pertinent Iowa Wellness Plan section 1115 demonstration STCs will be updated in the next demonstration amendment or extension approval to reflect these updates.

If you have any questions regarding these updates, please contact Danielle Daly, Director of the Division of Demonstration Monitoring and Evaluation, at Danielle.Daly@cms.hhs.gov.

Sincerely,

[redacted]

Karen LLanos
Acting Director

Enclosure
cc: Lee Herko, State Monitoring Lead, Medicaid and CHIP Operations Group

CENTERS FOR MEDICARE & MEDICAID SERVICES

WAIVER AUTHORITY

NUMBER: **11-W-00289/7**

TITLE: **Iowa Wellness Plan Section 1115 Demonstration**

AWARDEE: **Iowa Department of Human Services**

All requirements of the Medicaid program expressed in law, regulation and policy statement, not expressly waived or identified as not applicable in accompanying expenditure authorities, shall apply to the demonstration project effective from January 1, 2020 through December 31, 2024.

In addition, these waivers may only be implemented consistent with the approved special terms and conditions (STCs).

Under the authority of section 1115(a)(1) of the Social Security Act (the Act), the following waivers of state plan requirements contained in section 1902 of the Act are granted subject to the STCs for the Iowa Wellness Plan section 1115 demonstration.

1. **Premiums** — **Section 1902(a)(14) insofar as it incorporates Section 1916**

   To the extent necessary to enable the state to charge premiums beyond applicable Medicaid limits to the Iowa Wellness Plan demonstration populations above 50 percent of the federal poverty level and to enable the state to charge premiums for all Dental Wellness Plan enrollees above 50 percent of the federal poverty level. Combined premiums and cost-sharing is subject to a quarterly aggregate cap of 5 percent of family income.

2. **Methods of Administration** — **Section 1902(a)(4) insofar as it incorporates 42 CFR 431.53**

   To the extent necessary to relieve the state of the responsibility to assure transportation to and from providers for individuals in the demonstration for the new adult group beneficiaries. Medically frail beneficiaries and those eligible for EPSDT services are exempt from this waiver of NEMT.

3. **Comparability** — **Section 1902(a)(17)**

   To the extent necessary to permit the state to provide reduced cost sharing for the newly eligible population through an $8 copay for non-emergency use of the emergency department.

This copay will not apply to other Medicaid populations; copays applied to other Medicaid populations will not be imposed on this population.

To the extent necessary to enable the state to vary dental benefits based on premium payment and engagement in healthy behaviors, as provided for in the STCs.

4. Proper and Efficient Administration **Section 1902(a)(17)**

To the extent necessary to permit the state to contract with a single dental benefit plan administrator to provide dental services to beneficiaries affected by the Iowa Wellness Plan section 1115 demonstration.

5. Freedom of Choice **Section 1902(a)(23)(A)**

To the extent necessary to permit the state to require enrollees to receive dental services through a carved-out contracted dental benefit with no access to other providers.

6. Amount, Duration and Scope of Services **Section 1902(a)(10)(B)**

To the extent necessary to enable the state to provide benefit packages to demonstration populations that differ from the state plan benefit package. To the extent necessary to enable the state to provide different dental benefits to Dental Wellness Plan enrollees subject to the requirements in the STCs.

7. Retroactive Eligibility and (a)(34) **Section 1902(a)(10)**

To the extent necessary to enable the state not to provide three months of retroactive eligibility for state plan populations. The waiver of retroactive eligibility does not apply to pregnant women (and during the 60-day period beginning on the last day of the pregnancy), infants under age 1, and (effective January 1, 2020) children under 19 years of age. The earliest that a retroactive eligibility period for children under age 19 will begin will be January 1, 2020, for an application filed on or after January 1, 2020.

The waiver of retroactive eligibility also does not apply to applicants who are eligible for nursing facility services based on level of care, who had been a resident of a nursing facility in any of the three months prior to an application, and who are otherwise eligible for Medicaid. For persons who are exempted from the waiver due to eligibility for nursing facility services, retroactive eligibility would be provided for any particular months in which the applicant was a nursing facility resident.

CENTERS FOR MEDICARE & MEDICAID SERVICES

SPECIAL TERMS AND CONDITIONS

NUMBER: **11-W-00289/7**

TITLE: **Iowa Wellness Plan**

AWARDEE: **Iowa Department of Human Services**

I. PREFACE

The following are the Special Terms and Conditions (STCs) for the Iowa Wellness Plan section 1115(f) Medicaid demonstration (hereinafter "demonstration") to enable Iowa to operate this demonstration. Pursuant to authority in section 1115 of the Act, the Centers for Medicare & Medicaid Services (CMS) has granted waivers of certain requirements under section 1902(a) of the Social Security Act (the Act). These STCs set forth in detail the nature, character and extent of federal involvement in the demonstration and the state's obligations to CMS during the life of the demonstration. Enrollment activities for the new adult group began on October 1, 2013 for the Iowa Wellness Plan with eligibility effective January 1, 2014. The demonstration is statewide and is approved through December 31, 2024.

The STCs have been arranged into the following subject areas:

I. Preface
II. Program Description and Objectives
III. General Program Requirements
IV. Populations Affected
V. Dental Delivery System
VI. Benefits
VII. Healthy Behaviors, Premiums, and Cost Sharing
VIII. Appeals
IX. General Reporting Requirements
X. Monitoring Calls and Discussions
XI. Evaluation of the Demonstration

II. PROGRAM DESCRIPTION ANDOBJECTIVES

The Iowa Wellness Plan (IWP) demonstration was first implemented on January 1, 2014, at the same time that Iowa's expansion of Medicaid to the new adult group took effect. The Iowa Wellness Plan (IWP) demonstration initially sought to promote responsible health care decisions among the ACA expansion population by coupling a monthly required financial contribution with an incentive to earn an exemption from the monthly contribution requirement by actively seeking preventive health services.

As initially approved, the demonstration also provided authority for a waiver of non-emergency medical transportation for the ACA expansion population. The NEMT waiver was scheduled to sunset on December 31, 2014, with the possibility of extending based on an evaluation of its impact on access to care. After reviewing initial data on the impact of the waiver on access, CMS approved an extension of the NEMT waiver through July 31, 2015. Thereafter, CMS and the state established criteria necessary for the state to continue the NEMT waiver beyond July 31, 2015. Specifically, the state agreed to compare survey responses of the persons affected by the waiver to survey responses of persons receiving "traditional" Medicaid benefits through the state plan. Iowa conducted the analysis and found that the survey responses of the two populations did not have statistically significant differences. In light of those results, CMS approved a second amendment through June 30, 2016. Based on the state's ongoing analysis and evaluation of the impact of the NEMT waiver on access to covered services, the waiver of NEMT was extended again, and is still part of the demonstration. According to the most current analysis, the Iowa Health and Wellness Plan Evaluation Interim Summative Report, April 2019, reported unmet need for transportation was not statistically different for Medicaid members (12 percent) and IWP members (11 percent). There was no statistical difference between Medicaid and IWP in reported worry about the cost of transportation with around 8 percent of each reporting that they worried "a great deal" about their ability to pay for the cost of transportation to or from a health care visit.

On May 1, 2014, CMS approved the state's request to amend the IWP demonstration to include a Dental Wellness Plan (DWP) component, which at that time provided tiered dental benefits, based on beneficiary completion of periodic exams, to the ACA expansion population. All dental benefits covered under the DWP were optional, not mandatory.

Currently, the demonstration still includes an incentive program intended to improve the use of preventive services and encourage health among the ACA expansion population. Under this program, beginning in year two of a beneficiary's enrollment, the state requires monthly premiums for beneficiaries in the ACA expansion population with household incomes above 50 percent up to and including 133 percent of the federal poverty level (FPL). However, beneficiaries with a premium requirement who complete a wellness exam and health risk assessment (HRA) will have their premium waived for the following benefit year. The premium amounts may not exceed $5 per month for non-exempt beneficiaries with household incomes above 50 percent up to and including 100 percent of the FPL, and $10 per month for non-exempt beneficiaries with household incomes over 100 percent up to and including 133 percent of the FPL. Exempt

beneficiaries include those who completed the wellness exam and HRA, beneficiaries who are medically frail, members of the Health Insurance Premium Payment (HIPP) population, and beneficiaries who self-attest to a financial hardship. IWP premiums are permitted in lieu of other cost sharing except for an $8 copay for non-emergency use of the emergency department. Beneficiaries subject to premiums are allowed a 90-day grace period to make payment. The nonpayment of these premiums will result in a collectible debt. Individuals with household income over 100 percent of the FPL will be disenrolled for nonpayment. Enrollees with household income at or under 100 percent of the FPL cannot be disenrolled for nonpayment of a premium, nor can an individual be denied an opportunity to re-enroll due to nonpayment of a premium. Persons who are disenrolled for nonpayment can reapply at any time; however, their outstanding premium payments will remain subject to recovery. Monthly premiums are subject to a quarterly aggregate cap of 5 percent of household income.

On February 23, 2016, CMS approved the State's request to implement a managed care delivery system for the medical and dental services affected by the IWP demonstration, concurrent with the §1915(b) High Quality Healthcare Initiative Waiver, effective April 1, 2016.

On November 23, 2016, CMS extended the demonstration for three years under section 1115(e) of the Act, through December 31, 2019. This initial extension was approved with no program modifications. Subsequently, the state submitted two amendment requests during the renewal period. The first amendment, approved by CMS on July 27, 2017, modified the Dental Wellness Plan (DWP) component of the demonstration based on analysis of independent evaluation findings and stakeholder feedback. Through this amendment, the state implemented an integrated dental program for all Medicaid enrollees aged 19 and over, including the new adult group (ACA expansion population), parent and other caretaker relatives, and mandatory aged, blind, and disabled individuals. The tiered benefit structure was removed, and instead, the state established an incentive structure to encourage uptake of preventive dental services. Enrollees with household income above 50 percent of the FPL are required to contribute financially toward their dental health care costs through $3 monthly premium contributions in order to maintain comprehensive dental benefits. Dental premiums are waived in the first year of the individual's enrollment. Dental premiums will continue to be waived in subsequent years if enrollees complete an oral health risk assessment and obtain a preventive dental service in the prior year. Failure to make monthly dental premium payments results in the enrollee being eligible for only a basic dental services package for the remainder of the benefit year, but beneficiaries will not be disenrolled for failure to pay premiums and the past due amounts. The following eligibility groups are exempt from Dental Wellness Plan premiums, and will not have their benefits reduced in their second year of enrollment, notwithstanding any failure to complete state-designated healthy behaviors (i) pregnant women; (ii) individuals whose medical assistance for services furnished in an institution is reduced by amounts reflecting available income other than required for personal needs; (iii) 1915(c) waiver enrollees; (iv) individuals receiving hospice care; (v) American Indians/ Alaska 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; (vi) breast and cervical

cancer treatment program enrollees; and (vii) medically frail enrollees (referred to as medically exempt in Iowa). Additionally, persons who self-attest to financial hardship or who are exempt as described in 42 CFR 447.56 will have no dental premium obligation. The program thus creates incentives for enrollees to appropriately utilize preventive dental services, maintain oral health, and prevent oral disease. This program is also intended to create incentives for members to establish a dental home, because it encourages the receipt of preventive dental services. As was the case before this amendment, all dental benefits covered under the DWP are optional, not mandatory.

On August 2, 2017, Iowa, as directed by its legislature, submitted a request to amend the demonstration to waive retroactive eligibility for all Medicaid beneficiaries. On October 26, 2017, CMS approved the state's amendment request for a waiver of retroactive eligibility for all Medicaid beneficiaries except for pregnant women (and during the 60-day period beginning on the last day of the pregnancy), and infants under one year of age. Under the currently approved demonstration, unless an exemption applies, an applicant's coverage would begin on the first day of the month in which the application is submitted, or as otherwise allowed under the state plan.

On June 20, 2019, Iowa submitted a renewal application under section 1115(f) for a five-year extension, and requested one change to the existing terms and conditions. In accordance with Iowa Senate File 2418 (2018), the state requested to exempt applicants from the waiver of retroactive eligibility who are eligible for both Medicaid, and nursing facility services based on level of care, and who had been a resident of a nursing facility in any of the three months prior to submitting an application. For persons who are exempted from the waiver of retroactive eligibility due to eligibility for nursing facility services, retroactive eligibility is, and would continue to be, provided for those particular months in which the applicant was a nursing facility resident. The state already applies this exemption, for applications filed on or after July 1, 2018.

CMS approved the 1115(f) extension on November 15, 2019, including the change requested by Iowa to the retroactive eligibility waiver. In extending the approval period, CMS also updated the waiver of retroactive eligibility to exempt children under 19 years of age. The earliest that a retroactive eligibility period for children under age 19 will begin will be January 1, 2020, for an application filed on or after January 1, 2020.

In an abundance of caution, CMS also updated the waiver of retroactive eligibility to include a waiver of section 1902(a)(10) of the Act, to the extent that section 1902(a)(10) imposes a requirement of retroactive eligibility. CMS has also updated the monitoring and evaluation sections of the STCs to align those sections with CMS' current approach to monitoring and evaluation for section 1115 demonstrations, and to specify that CMS has the authority to require the state to submit a corrective action plan if monitoring or evaluation data indicate that demonstration features are not likely to assist in promoting the objectives of Medicaid. The STCs further specify that any such corrective action plan, submitted by the state, could include a temporary suspension of implementation of demonstration programs, in circumstances where data indicate substantial, sustained directional change, inconsistent with state targets (such as substantial, sustained trends indicating increases in disenrollment, difficulty accessing services, provider uncompensated care costs, or unpaid medical bills). These updates will better aid the

state in measuring and tracking the demonstration's impact on Iowans affected by it, and give CMS additional tools to protect beneficiaries if necessary. CMS would further have the ability to suspend implementation of the demonstration should corrective actions not effectively resolve these concerns in a timely manner.

Consistent with sections 1115(f)(6) and 1915(h) of the Act, CMS approved a 5-year extension approval period because the demonstration (specifically, the DWP component) provides medical assistance to beneficiaries dually eligible for Medicare and Medicaid.

On February 25, 2021, Iowa submitted an amendment to the Iowa Wellness Plan to provide dental benefits to children through Prepaid Ambulatory Health Plans (PAHPs). The amendment sought to allow the state to better coordinate dental care for children, helping to promote oral health in an accessible and cost-effective manner. There are no proposed changes to children's dental benefits, they will remain exempt from the incentive structure required for adult enrollees in the Dental Wellness Plan (DWP), and all enrollees under 21 years of age will continue to be eligible for medically necessary services in accordance with federal early and periodic screening, diagnostic and treatment (EPSDT) requirements.

III. GENERAL PROGRAM REQUIREMENTS

1. **Compliance with Federal Non-Discrimination Laws.** The state must comply with all applicable federal civil rights laws relating to non-discrimination in services and benefits in its programs and activities. These include, but are not limited to, the Americans with Disabilities Act of 1990 (ADA), title VI of the Civil Rights Act of 1964, section 504 of the Rehabilitation Act of 1973 (Section 504), the Age Discrimination Act of 1975, and section 1557 of the Patient Protection and Affordable Care Act (ACA).

2. **Compliance with Medicaid and CHIP Law, Regulation, and Policy.** All requirements of the Medicaid and CHIP programs expressed in federal law, regulation, and written policy not expressly waived or identified as not applicable in the waiver document (of which these terms and conditions are part), apply to the demonstration.

3. **Changes in Medicaid and CHIP Law, Regulation, and Policy.** The state must, within the timeframes specified in federal law, regulation, or written policy, come into compliance with any changes in law, regulation, or policy affecting the Medicaid or CHIP programs that occur during this demonstration approval period, unless the provision being changed is explicitly waived or identified as not applicable. In addition, CMS reserves the right to amend the STCs to reflect such changes and/or changes of an operational nature without requiring the state to submit an amendment to the demonstration under STC 7. CMS will notify the state 30 business days in advance of the expected approval date of the amended STCs to allow the state to provide comment. Changes will be considered in force upon issuance of the approval letter by CMS. The state must accept the changes in writing.

4. **Impact on Demonstration of Changes in Federal Law, Regulation, and Policy.**
   If mandated changes in the federal law require state legislation, unless otherwise prescribed by the terms of the federal law, the changes must take effect on the day such state legislation becomes effective, or on the last day such legislation was required to be in effect under the law, whichever is sooner.

5. **State Plan Amendments.** The State will not be required to submit title XIX or title XXI state plan amendments (SPAs) for changes affecting any populations made eligible solely through the demonstration. If a population eligible through the Medicaid or CHIP state plan is affected by a change to the demonstration, a conforming amendment to the appropriate state plan is required, except as otherwise noted in these STCs. In all such cases, the Medicaid and CHIP state plans govern.

6. **Changes Subject to the Amendment Process.** Changes related to eligibility, enrollment, benefits, delivery systems, cost sharing, sources of non-federal share of funding, budget neutrality, and other comparable program elements must be submitted to CMS as amendments to the demonstration. All amendment requests are subject to approval at the discretion of the Secretary in accordance with section 1115 of the Act. The state must not implement changes to these elements without prior approval by CMS either through an approved amendment to the Medicaid or CHIP state plan or amendment to the demonstration. Amendments to the demonstration are not retroactive and no FFP of any kind, including for administrative or medical assistance expenditures, will be available under changes to the demonstration that have not been approved through the amendment process set forth in STC 7 below, except as provided in STC 3.

7. **Amendment Process.** Requests to amend the demonstration must be submitted to CMS for approval no later than 120 days prior to the planned date of implementation of the change and may not be implemented until approved. CMS reserves the right to deny or delay approval of a demonstration amendment based on non-compliance with these STCs, including, but not limited to, failure by the state to submit required reports and other deliverables in a timely fashion according to the deadlines specified therein. Amendment requests must include, but are not limited to, the following:

   a. An explanation of the public process used by the state consistent with the requirements of STC 12. Such explanation must include a summary of any public feedback received and identification of how this feedback was addressed by the state in the final amendment request submitted to CMS;

   b. A detailed description of the amendment, including impact on beneficiaries, with sufficient supporting documentation;

c. A data analysis which identifies the specific "with waiver" impact of the proposed amendment on the current budget neutrality agreement. Such analysis must include current total computable "with waiver" and "without waiver" status on both a summary and detailed level through the current approval period using the most recent actual expenditures, as well as summary and detailed projections of the change in the "with waiver" expenditure total as a result of the proposed amendment, which isolates (by Eligibility Group) the impact of the amendment;

d. An up-to-date CHIP allotment worksheet, if necessary;

e. The state must provide updates to existing demonstration reporting and quality and evaluation plans. This includes description of how the evaluation design and annual progress reports will be modified to incorporate the amendment provisions as well as the oversight monitoring and measurement of the provisions.

8. **Extension of the Demonstration.** States that intend to request an extension of the demonstration must submit an application to CMS from the Governor of the state in accordance with the requirements of 42 CFR § 431.412(c). States that do not intend to request an extension of the demonstration beyond the period authorized in these STCs must submit a phase-out plan consistent with the requirements of STC 9.

9. **Demonstration Phase-Out.** The state must only suspend or terminate this demonstration in whole, or in part, consistent with the following requirements.

a. Notification of Suspension or Termination: The state must promptly notify CMS in writing of the reason(s) for the suspension or termination, together with the effective date and a transition and phase-out plan. The state must submit a notification letter and a draft transition and phase-out plan to CMS no less than six months before the effective date of the demonstration's suspension or termination. Prior to submitting the draft transition and phase-out plan to CMS, the state must publish on its website the draft transition and phase-out plan for a 30-day public comment period. In addition, the state must conduct tribal consultation in accordance with STC 12, if applicable. Once the 30-day public comment period has ended, the state must provide a summary of the issues raised by the public during the comment period and how the state considered the comments received when developing the revised transition and phase-out plan.

b. Transition and Phase-Out Plan Requirements: The state must include, at a minimum, in its phase-out plan the process by which it will notify affected beneficiaries, the content of said notices (including information on the beneficiary's appeal rights), the process by which the state will conduct administrative reviews of Medicaid or CHIP eligibility prior to the termination of the demonstration for the affected beneficiaries, and ensure ongoing coverage for eligible beneficiaries, as well as any community outreach activities the state will undertake to notify affected beneficiaries, including community resources that

are available.

c. Transition and Phase Out Plan Approval: The state must obtain CMS approval of the transition and phase-out plan prior to the implementation of transition and phase-out activities. Implementation of transition and phase-out activities must be no sooner than 14 calendar days after CMS approval of the transition and phase-out plan.

d. Transition and Phase-out Procedures: The state must comply with applicable notice requirements found in 42 CFR, part 431 subpart E, including sections 431.206, 431.210, and 431.213. In addition, the state must assure all applicable and hearing rights are afforded to beneficiaries in the demonstration as outlined in 42 CFR, part 431 subpart E, including §§ 431.220 and 431.221. If a beneficiary in the demonstration requests a hearing before the date of action, the state must maintain benefits as required in 42 CFR 431.230. In addition, the state must conduct administrative renewals for all affected beneficiaries in order to determine if they qualify for Medicaid or CHIP eligibility under a different eligibility category prior to termination, as discussed in the October 1, 2010 State Health Official letter #10-008 and as required under 42 CFR 435.916(f)(1). For individuals determined ineligible for Medicaid, the state must determine potential eligibility for other insurance affordability programs and comply with the procedures set forth in 42 CFR 435.1200(e).

e. Exemption from Public Notice Procedures, 42 CFR 431.416(g). CMS may expedite the federal and state public notice requirements under circumstances described in 42 CFR 431.416(g).

f. Enrollment Limitation during Demonstration Phase-Out. If the state elects to suspend, terminate, or not extend this demonstration, during the last six months of the demonstration, enrollment of new individuals into the demonstration must be suspended. The limitation of enrollment into the demonstration does not impact the state's obligation to determine Medicaid eligibility in accordance with the approved Medicaid state plan.

g. Federal Financial Participation (FFP). If the project is terminated or any relevant waivers are suspended by the state, FFP must be limited to normal closeout costs associated with the termination or expiration of the demonstration, including services, continued benefits as a result of beneficiaries' appeals, and administrative costs of disenrolling beneficiaries.

10. **Withdrawal of Waiver or Expenditure Authority.** CMS reserves the right to withdraw waivers and/or expenditure authorities at any time it determines that continuing the waivers or expenditure authorities would no longer be in the public interest or promote the objectives of title XIX. CMS will promptly notify the state in writing of the determination and the reasons for the withdrawal, together with the effective date, and must afford the state an opportunity to request a hearing to

challenge CMS' determination prior to the effective date. If a waiver or expenditure authority is withdrawn, FFP is limited to normal closeout costs associated with terminating the waiver or expenditure authorities, including services, continued benefits as a result of beneficiary appeals, and administrative costs of disenrolling participants.

11. **Adequacy of Infrastructure.** The State will ensure the availability of adequate resources for implementation and monitoring of the demonstration, including education, outreach, and enrollment; maintaining eligibility systems; compliance with cost sharing requirements; and reporting on financial and other demonstration components.

12. **Public Notice, Tribal Consultation, and Consultation with Interested Parties.** The state must comply with the state notice procedures as required in 42 CFR §431.408 prior to submitting an application to extend the demonstration. For applications to amend the demonstration, the state must comply with the state notice procedures set forth in 59 Fed. Reg. 49249 (September 27, 1994) prior to submitting such request. The state must also comply with the public notice procedures set forth in 42 CFR § 447.205 for changes in statewide methods and standards for setting payment rates.

    The state must also comply with tribal and Indian Health Program/Urban Indian Organization consultation requirements at section 1902(a)(73) of the Act, 42 CFR §431.408(b), State Medicaid Director Letter #01-024, or as contained in the state's approved Medicaid state plan, when any program changes to the demonstration, either through amendment as set out in STC 7 or extension, are proposed by the state.

13. **Federal Financial Participation (FFP).** No federal matching funds for state expenditures under this demonstration, including for administrative and medical assistance expenditures, will be available until the effective date identified in the demonstration approval letter, or if later, as expressly stated within these STCs.

14. **Administrative Authority.** When there are multiple entities involved in the administration of the demonstration, the Single State Medicaid Agency must maintain authority, accountability, and oversight of the program. The State Medicaid Agency must exercise oversight of all delegated functions to operating agencies, managed care organizations (MCOs), and any other contracted entities. The Single State Medicaid Agency is responsible for the content and oversight of the quality strategies for the demonstration.

15. **Common Rule Exemption.** The state must ensure that the only involvement of human subjects in research activities that may be authorized and/or required by this demonstration is for projects which are conducted by or subject to the approval of CMS, and that are designed to study, evaluate, or otherwise examine the Medicaid or CHIP program—including public benefit or service programs, procedures for

obtaining Medicaid or CHIP benefits or services, possible changes in or alternatives to Medicaid or CHIP programs or procedures, or possible changes in methods or levels of payment for Medicaid benefits or services. The Secretary has determined that this demonstration as represented in these approved STCs meets the requirements for exemption from the human subject research provisions of the Common Rule set forth in 45 CFR 46.104(b)(5).

IV. POPULATIONS AFFECTED

16. **Waiver of Retroactive Eligibility Population.** The waiver of retroactive eligibility applies to individuals who are eligible for Medicaid under the state plan (including all modified adjusted gross income (MAGI) and Non-MAGI related groups), with certain exceptions described below.

    a. The state assures that it will provide outreach and education about how to apply for and receive Medicaid coverage to the public and to Medicaid providers, particularly those who serve vulnerable populations that may be impacted by the retroactive eligibility waiver and those disenrolled for nonpayment of premiums. The waiver of retroactive eligibility does not apply to pregnant women (and during the 60 day period beginning on the last day of the pregnancy), infants under one year of age, or children under nineteen years of age. The earliest that a retroactive eligibility period for children under age 19 will begin will be January 1, 2020, for an application filed on or after January 1, 2020.
    b. The waiver of retroactive eligibility also does not apply to applicants who are eligible for nursing facility services based on level of care, who had been a resident of a nursing facility in any of the three months prior to an application, and who are otherwise eligible for Medicaid. For individuals exempted from the retroactive eligibility waiver on the basis of nursing facility eligibility, retroactive eligibility would be provided for those particular months in which the applicant was a nursing facility resident.

17. **Iowa Wellness Plan Population.** The Iowa Wellness Plan premium incentive program intended to improve the use of preventive services and encourage health is targeted for individuals who are eligible in the new adult group under the state plan that is described in 1902(a)(10)(A)(i)(VIII) of the Act, and 42 CFR 435.119, and includes those persons up to and including 133 percent of the FPL.

18. **Dental Wellness Plan Population.** The Dental Wellness Plan (DWP) is targeted to all Medicaid populations identified in Table 1 below:

Table 1: Dental Wellness Plan eligible populations

Eligibility Group Name	Social Security Act and CFR Citations	Income Level
New Adult Group	1902(a)(10)(A)(i)(VIII) 42 CFR. 435.119	

<table>
<tr><td></td><td></td><td><table><tr><td>Household Size</td><td>Monthly Income Limit</td></tr></table></td></tr>
<tr><td>Parents and Other Caretaker Relatives</td><td>1902(a)(10)(A)(i)(I)
1931(b) and (d) 42 CFR 435.110</td><td><table><tr><td>1</td><td>$447</td></tr><tr><td>2</td><td>$716</td></tr><tr><td>3</td><td>$872</td></tr><tr><td>4</td><td>$1,033</td></tr><tr><td>5</td><td>$1,177</td></tr><tr><td>6</td><td>$1,330</td></tr><tr><td>7</td><td>$1,481</td></tr><tr><td>8</td><td>$1,633</td></tr><tr><td>9</td><td>$1,784</td></tr><tr><td>10</td><td>$1,950</td></tr></table></td></tr>
<tr><td>Transitional Medical Assistance</td><td>408(a)(11)(A)
1931(c)(2)
1925
1902(a)(52)</td><td>First 6 months: N/A
Additional 6 months:
0-185% FPL</td></tr>
<tr><td>Pregnant Women</td><td>1902(a)(10(A)(i)(III) and (IV)
1902(a)(10)(A)(ii)(I), (IV) and (IX)
1920
43 CFR 435.116</td><td>0-375% FPL</td></tr>
<tr><td>Mandatory Aged, Blind and Disabled Individuals</td><td>42 CFR 435.120 through
42 CFR 435.138</td><td>SSI Limit</td></tr>
<tr><td>Optional Eligibility for Individuals who Meet Income & Resource of Cash Assistance Programs</td><td>1902(a)(10)(A)(ii)(I)
42 CFR 435.210</td><td>SSI Limit</td></tr>
<tr><td>Optional Eligibility for Individuals who would be Eligible for Cash Assistance if they Were not in Medical Institutions</td><td>1902(a)(10)(A)(ii)(IV)
42 CFR 435.211</td><td>SSI FBR</td></tr>
<tr><td>Institutionalized Individuals</td><td>1902(a)(10)(A)(ii)(V)</td><td>300% SSI FBR</td></tr>
<tr><td>Medicaid for Employed People</td><td>1902(a)(10)(A)(ii)(XIII)</td><td>250% FPL</td></tr>
<tr><td>Former Foster Care Children up to Age 26</td><td>1902(a)(10)(A)(i)(IX)
42 CFR 435.150</td><td>N/A</td></tr>
<tr><td>Independent Foster Care Adolescents</td><td>1902(a)(10)(A)(ii)(XVII)</td><td>254% FPL</td></tr>
</table>

Reasonable Classifications of Children	42 CFR 435.222	N/A
§1915(c) HCBS Physical Disability	1902(a)(10)(A)(ii)(VI) 42 CFR 435.217	300% SSI FBR
§1915(c) HCBS Health and Disability Waiver	1902(a)(10)(A)(ii)(VI) 42 CFR 435.217	300% SSI FBR
§1915(c) HCBS Elderly Waiver	1902(a)(10)(A)(ii)(VI) 42 CFR 435.217	300% SSI FBR
§1915(c) HCBS Intellectual Disability Waiver	1902(a)(10)(A)(ii)(VI) 42 CFR 435.217	300% SSI FBR
§1915(c) HCBS AIDS Waiver	1902(a)(10)(A)(ii)(VI) 42 CFR 435.217	300% SSI FBR
§1915(c) HCBS Brain Injury Waiver	1902(a)(10)(A)(ii)(VI) 42 CFR 435.217	300% SSI FBR
Breast & Cervical Cancer Treatment Program	1902(a)(10)(A)(ii)(XVIII)	N/A
Deemed Newborn Children	42 CFR §435.117	N/A
Infants and Children under Age 19	42 CFR §435.118	Infants under 1: 375% FPL Age 1 -5: 167% FPL Age 6-18: 167% FPL
Children with Adoption Assistance, Foster Care, or Guardianship Care Under Title IV-E	42 CFR §435.145 1902(a)(10)(A)(i)(l) 473(b)(3)	N/A
Children with Non IV-E Adoption Assistance	42 CFR §435.277 1902(a)(10)(A)(ii)(VIII)	N/A
Family Opportunity Act Children with Disabilities	1902(a)(10)(ii)(XIX)	300% FPL
§1915(c) Children's Mental Health Waiver	1902(a)(10)(A)(ii)(VI) 42 CFR §435.217	300% SSI FBR

V. DENTAL DELIVERY SYSTEM

19. Overview. The Iowa Wellness Plan will provide dental services through a managed care delivery system known as a Prepaid Ambulatory Health Plan(PAHP).

20. Managed Care Requirements. The state must comply with the managed

care regulations published at 42 CFR 438, except as waived herein. Capitation rates shall be developed and certified as actuarially sound, in accordance with 42 CFR 438.4. The certification shall identify historical utilization of services that are the same as outlined in the corresponding Alternative Benefit Plan and used in the rate development process.

21. **Managed Care Contracts.** No FFP is available for activities covered under contracts and/or modifications to existing contracts that are subject to 42 CFR 438 requirements prior to CMS approval of this demonstration authority as well as such contracts and/or contract amendments. The state shall submit any supporting documentation deemed necessary by CMS. The state must provide CMS with a minimum of 60 days to review and approve changes. CMS reserves the right, as a corrective action, to withhold FFP (either partial or full) for the demonstration, until the contract compliance requirement is met.

22. **Public Contracts**. Payments under contracts with public agencies, that are not competitively bid in a process involving multiple bidders, shall not exceed the documented costs incurred in furnishing covered services to eligible individuals (or a reasonable estimate with an adjustment factor no greater than the annual change in the consumer price index).

23. **Managed Care Dental Benefit Package.** Individuals enrolled in the Iowa Wellness Plan will receive from the managed care program the benefits as identified in Section VI of the STCs. Covered dental benefits should be delivered and coordinated in an integrated fashion.

24. **Enrollment Requirements.** The state may require any of the populations identified in Section IV to enroll in PAHPs pursuant to 42 CFR 438.

25. **Network Requirements**. The state must ensure the delivery of all covered dental benefits, including high quality care. Services must be delivered in a culturally competent manner, and the PAHP network must be sufficient to provide access to covered services to the low- income population. The following requirements must be included in the state's PAHP contracts:

    a. **Special Health Care Needs.** Enrollees with special health care needs must have direct access to a specialist, as appropriate for the individual's health care condition, as specified in 42 CFR 438.208(c)(4).

    b. **Out of Network Requirements.** The PAHP must provide demonstration populations with all demonstration program benefits under their contract and as described within these STCs and must allow access to non-network

providers when services cannot be provided consistent with the timeliness standards required by the state.

26. Demonstrating Network Adequacy. Annually, the PAHP must provide adequate assurances that it has sufficient capacity to serve the expected enrollment in its service area and offers an adequate range of providers necessary to provide covered services for the anticipated number of enrollees in the service area.

a. The state must verify these assurances by reviewing demographic, utilization and enrollment data for enrollees in the demonstration as well as:
   i. The number and types of dentists and dental specialty providers available to provide covered services to the demonstration population;
   ii. The number of network providers accepting the new demonstration population; and
   iii. The geographic location of providers and demonstration populations, as shown through GeoAccess or similar software.

b. The state must submit the documentation required in subparagraphs i – iii above to CMS with initial PAHP contract submission as well as at each contract renewal or renegotiation, or at any time that there is a significant impact to the PAHP's operation, including service area expansion or reduction and population expansion.

VI. BENEFITS

27. Iowa Wellness Plan Benefits. Individuals in the IWP populations described in STC 17 will receive benefits described in the Iowa Wellness Plan alternative benefit plan (ABP).

28. Dental Wellness Plan Benefits.

a. **Benefits in First Year of Enrollment**. Individuals enrolled in the Dental Wellness Plan will receive all available dental benefits described in the state plan or alternative benefit plan, as applicable.

b. **Benefit Requirements After First Year of Enrollment**. Individuals enrolled in the Dental Wellness Plan may continue to receive all benefits described in the state plan or the alternative benefit plan, as applicable, subject to the requirements set forth below.

   i. **Dental Premium.** Beneficiaries will be required to pay a monthly dental premium starting in year 2 of enrollment in the demonstration to maintain full dental benefits, as specified in STC 30.
   ii. **Healthy Behaviors.** Beneficiaries will not be charged a monthly dental premium if they complete state-designated healthy behaviors

in the prior year of enrollment.

iii. **Penalty.** Beneficiaries who do not make a premium payment or complete healthy behaviors will receive basic dental benefits as outlined in the state plan and alternative benefits plan.

iv. **Appeal Rights.** Beneficiaries will be able to challenge any denial in whole or in part, limited authorization of service, termination of a previously authorized service, or failure of a plan to act within the required timeframe as described in Section VII of the STCs.

c. **Dental Appointments.** The state must take action to assist beneficiaries in accessing services if they report to the state, in a timely manner, that they were not able to secure a dental appointment through a PAHP. The state must provide member hotline assistance to individuals seeking dental care who were unable to secure an appointment with a dental provider.

d. **EPSDT.** All beneficiaries under 21 years of age will continue to be eligible for medically necessary dental services in accordance with federal EPSDT requirements.

29. Non-Emergency Medical Transportation (NEMT). Individuals in the new adult group shall not receive any benefit in the form of an administrative activity or service to assure non-emergency transportation to and from providers. Medically frail beneficiaries and those eligible for EPSDT services are exempt from this waiver.

VII. HEALTHY BEHAVIORS, PREMIUMS AND COSTSHARING

30. Iowa Wellness Plan and Dental Wellness Plan Premiums. The premiums and cost-sharing features of the demonstration are designed to incentivize the uptake of preventive services, which could improve beneficiary health and thereby reduce the costs of providing coverage, thus improving the financial sustainability of Iowa's Medicaid program. The state has the authority to charge premiums in accordance with the CMS approved protocols described in STC 34, which are binding upon the state**.** The state may request changes to the approved protocols; any changes must be accepted by CMS. Any change will require advance notice to members. All modifications to the premium policies must be captured through the immediate next Annual Monitoring Report.

a. No premium will be charged for the first year of enrollment in the Iowa Wellness Plan or the Dental Wellness Plan.

b. All premiums permitted by this paragraph are subject to the exemptions and waivers described in STC 31.

c. Monthly premium amounts for the Iowa Wellness Plan may not exceed $5/month for nonexempt households with income above 50 percent up to and

including 100 percent of the FPL and $10/month for nonexempt households with income over 100 percent up to and including 133 percent of the FPL. Monthly premium amounts for the Dental Wellness Plan may not exceed $3/month for nonexempt households with income above 50 percent of the FPL. Combined premiums and cost-sharing is subject to a quarterly aggregate cap of 5 percent of household income.

d. Enrollees in the Iowa Wellness Plan and the Dental Wellness Plan will be allowed a 90-day premium grace period.

e. Iowa Wellness Plan enrollees with income up to and including 100 percent FPL and all Dental Wellness Plan beneficiaries may not be disenrolled for nonpayment of a premium, nor can an individual be denied an opportunity to re-enroll due to nonpayment of a premium.

f. Individuals with income over 100 percent of the FPL may be disenrolled from the IWP for nonpayment. Persons disenrolled for nonpayment can reapply at any time; however, their outstanding premium payments will remain subject to recovery.

g. After the 90 day grace period, unpaid Iowa Wellness Plan and Dental Wellness Plan premiums may be considered a collectible debt owed to the State of Iowa and, at state option, subject to collection by the state, with the following exception:

h. If, at the member's next annual renewal date, the member does not apply for renewed eligibility, and the member has no claims for services delivered after the month of the last premium payment, unpaid premiums shall not be considered a collectible debt by the state.

i. Enrollees with a premium requirement who complete state-designated healthy behaviors will have their premium waived for the following benefit year.

31. Premium Exemptions.

a. **Iowa Wellness Plan**. Enrollees will be exempt from a monthly contribution obligation under the following conditions:

i. For all individuals enrolled in the Iowa Wellness Plan, premiums are waived in the first year of the individual's enrollment. Premiums will continue to be waived in subsequent years if enrollees complete healthy behaviors in their prior annual period, as outlined in the state's approved Healthy Behavior Incentive Protocol.

ii. Premiums may only be assessed on non-exempt individuals as described in 42 CFR 447.56.

iii. Medically frail and members in the HIPP population are not subject to premiums.

iv. All individuals who self-attest to a financial hardship will have no premium obligation. The opportunity to self-attest will be made available with each invoice.

b. **Dental Wellness Plan.** Enrollees will be exempt from a monthly contribution obligation for dental benefits under the following conditions:

i. For all individuals enrolled in the Dental Wellness Plan, premiums are waived in the first year of the individual's enrollment. Premiums will continue to be waived in subsequent years if enrollees complete healthy behaviors in the prior year.

ii. Premiums may only be assessed on non-exempt individuals as described in 42 CFR 447.56.

iii. The following eligibility groups will be exempt from Dental Wellness Plan premiums, and will not have their benefits reduced in their second year of enrollment, notwithstanding any failure to complete state-designated healthy behaviors as described in STC 33 (i) pregnant women; (ii) individuals whose medical assistance for services furnished in an institution is reduced by amounts reflecting available income other than required for personal needs; (iii) 1915(c) waiver enrollees; (iv) individuals receiving hospice care; (v) American Indians/Alaska 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; (vi) breast and cervical cancer treatment program enrollees; and (vii) medically frail enrollees (referred to as medically exempt in Iowa) ; (viii) Deemed Newborn Children (ix) Infants and Children under Age 19; (x) Children with Adoption Assistance, Foster Care, or Guardianship Care Under Title IV-E; (xi) Children with Non IV-E Adoption Assistance; (xii) Family Opportunity Act Children with Disabilities; (xiii) §1915(c) Children's Mental Health Waiver; and (ix) 19 and 20 year olds eligible for EPSDT services.

iv. All individuals who self-attest to a financial hardship will have no dental premium obligation. The opportunity to self-attest will be made available with each invoice.

32. Copayment for non-emergency use of the emergency department. Individuals in the IWP populations described in STC 17 are subject to premiums in lieu of other cost sharing except that the state may impose a copayment for non-emergency use of the emergency room consistent with its approved state plan and with all federal requirements that are set forth in statute, regulation and policies, including exemptions from cost-sharing set forth in 42 CFR 447.56.

33. Healthy Behaviors.

a. **Iowa Wellness Plan.** The state has the authority to implement the Healthy Behaviors component pursuant to the CMS approved protocols described in STC 34. Enrollees who do not complete required healthy behaviors will be required to pay their monthly premiums beginning in the next enrollment year.

i. **General Description.** All individuals subject to premiums who are enrolled in the Iowa Wellness Plan will have premiums waived during the 1st year of enrollment and will be eligible to receive a waiver of monthly premium contributions required in the 2nd year of enrollment if enrollees complete healthy behaviors during the first year. For each subsequent year, nonexempt enrollees will have the opportunity to complete healthy behaviors to continue to waive financial contributions, i.e. healthy behaviors performed in year 2 of enrollment will be permitted to waive premiums for year 3.

ii. **Healthy Behaviors.** The conditions to be met by a nonexempt individual in year 1 of enrollment as a condition for not being liable for monthly contributions in year 2 are completing a health risk assessment and wellness exam (annual exam). A health risk assessment is considered part of the individual's medical record and is afforded all associated privacy and confidentiality protections afforded to such documents by federal and state law, regulations, and policy. The state must provide outreach and education to beneficiaries to inform them of the incentives that can be used to avoid premiums and the consequences of nonpayment of those premiums if due.

iii. **Grace Period.** Nonexempt individuals will be given a 30-day healthy behavior grace period. If the individual completes the required healthy behaviors in the first 30 days of a year when premiums are due, no premiums will be due for the remainder of the year.

b. **Dental Wellness Plan.** Members who complete dental healthy behaviors each year of enrollment will continue to receive full dental benefits without ever being subject to monthly dental premiums.

i. General Description. All individuals in the Dental Wellness Plan who are subject to premiums will have premiums waived in year 1 of enrollment and will be eligible to receive a waiver of monthly premium contributions required in year 2 of enrollment to maintain full dental benefits if enrollees complete dental healthy behaviors during year 1 of enrollment. For each subsequent year, nonexempt enrollees will have the opportunity to complete dental healthy

behaviors to continue to waive financial contributions (e.g. healthy behaviors performed in year 2 will be permitted to waive premiums for year 3).

ii. Healthy behaviors. The conditions to be met by a nonexempt individual in year 1 of enrollment as a condition of maintaining full dental benefits without liability for monthly premium contributions in year 2 are completing an oral health risk assessment and preventive dental service. The state must provide outreach and education to beneficiaries to inform them of the incentives that can be used to avoid premiums and the consequences of nonpayment of those premiums if due. Additionally, any future changes to state-designated healthy behaviors will be thoroughly communicated to enrollees in order to provide thorough opportunity for enrollees to maintain full dental benefits without liability for monthly contributions. Self-assessments submitted are considered part of the individual's medical record and afforded all associated privacy and confidentiality protections afforded to such documents by federal and state law, regulations, and policy.

34. Iowa Wellness Plan Healthy Behaviors and Premiums Protocols. The state has the authority to implement the Healthy Behaviors and Premiums component in accordance with the CMS approved protocol, which is binding upon the state**.** The state may request changes to the approved Healthy Behaviors and Premiums Protocols; any changes must be accepted by CMS. Any change will require advance notice to members. All modifications to the Healthy Behaviors and Premiums Protocols must be captured through the immediate next Annual Monitoring Report.

The state's approved Healthy Behaviors and Premiums Protocols detail**:**

a. The purpose and objectives of the Healthy Behaviors Incentive program.
b. The methodology for obtaining, and content of, the health risk assessment used to identify unhealthy behaviors such as alcohol abuse, substance use disorders, tobacco use, obesity, and deficiencies in immunization status.
c. The criteria to be met for completing a wellness exam.
d. The process by which an enrollee is deemed compliant with healthy behaviors in year 1.
e. A list of stakeholders consulted in the development of the protocol.
f. A description of how healthy behaviors will be tracked and monitored at the enrollee and provider levels, including standards of accountability for providers.
g. A description of how the state will notify and educate enrollees about the Healthy Behaviors Incentives program.

In addition, the approved protocol delineates:

a. The process by which the state will identify individuals who are exempt from the premium requirements.
b. The notices beneficiaries will receive regarding premiums and/or Healthy Behaviors and the schedule for such notices.
c. The process by which beneficiaries will be able to remit payment, including ways individuals who cannot pay by check will be accommodated.
d. The process by which the state will collect past due premiums.
e. The approved protocol also describes criteria by which the state will monitor premiums and thresholds for modification and/or termination of premium collection in the event of unintended harm to beneficiaries.
f. The state's approved Future Year Healthy Behaviors Incentives Protocol describes the following Healthy Behaviors Incentive Programstandards:
    i. A description of any provisions that will be provided to assist enrollees in addressing unhealthy behaviors identified through the health risk assessment.
    ii. A description of selected healthy behaviors to be met by an individual in year 1 (or subsequent years) in order to be deemed compliant with healthy behaviors resulting in a waiver of monthly contributions in year 2 (or subsequent years).

Iowa will further evaluate, define and refine healthy behavior requirements for subsequent years of the demonstration. Iowa must obtain CMS approval before the state can introduce new requirements to enrollees.

VIII. APPEALS

35. Beneficiary safeguards of appeal rights will be provided by the state, including fair hearing rights. No waiver will be granted related to appeals. The state must ensure compliance with all federal and state requirements related to beneficiary appeal rights. Pursuant to the Intergovernmental Cooperation Act of 1968, the state may submit a State Plan Amendment delegating certain responsibilities to the Iowa Insurance Division or another state agency. Dental services appeals are governed by the contract between the state and the dental Prepaid Ambulatory Health Plans (PAHPs).

IX. GENERAL REPORTING REQUIREMENTS

36. Deferral for Failure to Submit Timely Demonstration Deliverables. CMS may issue deferrals in accordance with 42 CFR part 430 subpart C, in the amount of $5,000,000 per deliverable (federal share) when items required by these STCs (e.g., required data elements, analyses, reports, design documents, presentations, and other items specified in these STCs) (hereafter singly or collectively referred to as "deliverable(s)") are not submitted timely to CMS or are found to not be consistent with the requirements approved by CMS. A deferral shall not exceed the value of the federal amount for the current demonstration period. The state does not relinquish its rights provided under 42 CFR part 430 subpart C to challenge any CMS finding that the state materially failed to comply with the terms of this agreement.

The following process will be used: 1) Thirty (30) days after the deliverable was due if the state has not submitted a written request to CMS for approval of an extension as described in subsection (b) below; or 2) Thirty days after CMS has notified the state in writing that the deliverable was not accepted for being inconsistent with the requirements of this agreement and the information needed to bring the deliverable into alignment with CMS requirements:

a. CMS will issue a written notification to the state providing advance notification of a pending deferral for late or non-compliant submissions of required deliverable(s).

b. For each deliverable, the state may submit to CMS a written request for an extension to submit the required deliverable that includes a supporting rationale for the cause(s) of the delay and the state's anticipated date of submission. Should CMS agree to the state's request, a corresponding extension of the deferral process can be provided. CMS may agree to a corrective action as an interim step before applying the deferral, if corrective action is proposed in the state's written extension request.

c. If CMS agrees to an interim corrective process in accordance with subsection (b), and the state fails to comply with the corrective action steps or still fails to submit the overdue deliverable(s) that meets the terms of this agreement, CMS may proceed with the issuance of a deferral against the next Quarterly Statement of Expenditures reported in Medicaid Budget and Expenditure System/State Children's Health Insurance Program Budget and Expenditure System (MBES/CBES) following a written deferral notification to the state.

d. If the CMS deferral process has been initiated for state non-compliance with the terms of this agreement for submitting deliverable(s), and the state submits the overdue deliverable(s), and such deliverable(s) are accepted by CMS as meeting the standards outlined in these STCs, the deferral(s) will be released.

e. As the purpose of a section 1115 demonstration is to test new methods of operation or service delivery, a state's failure to submit all required reports, evaluations and other deliverables will be considered by CMS in reviewing any application for an extension, amendment, or for a new demonstration.

37. Submission of Post-Approval Deliverables. The state must submit all deliverables as stipulated by CMS and within the timeframes outlined within these STCs.

38. Compliance with Federal Systems Updates. As federal systems continue to evolve and incorporate additional 1115 waiver reporting and analytics functions, the state will work with CMS to:

a. Revise the reporting templates and submission processes to accommodate timely compliance with the requirements of the new systems;
b. Ensure all 1115, Transformed Medicaid Statistical Information System (T-MSIS), and other data elements that have been agreed to for reporting and analytics are provided by the state; and
c. Submit deliverables to the appropriate system as directed by CMS.

39. Implementation Plan. The state must submit an Implementation Plan to CMS no later than 90 calendar days after the effective date of the demonstration. The Implementation Plan must cover at least the key policies being tested under this demonstration, including premiums and the waiver of retroactive eligibility. The state must include premiums in the implementation plan only to the extent it needs to provide information in addition to the information already included in the approved Healthy Behaviors and Premiums Protocols. Once determined complete by CMS, the Implementation Plan will be incorporated into the STCs, as Attachment B. At a minimum, the Implementation Plan must include definitions and parameters of key policies, and describe the state's strategic approach to implementing the policies, including timelines for meeting milestones associated with these key policies. Other topics to be discussed in the Implementation Plan include application assistance, reporting, and processing; notices; coordinated agency responsibilities; coordination with other insurance affordability programs; appeals; renewals; coordination with other state agencies; beneficiary protections; and outreach.

40. Monitoring Protocol. The state must submit to CMS a Monitoring Protocol no later than 150 calendar days after the effective date of the demonstration. Once approved, the Monitoring Protocol will be incorporated into the STCs, as Attachment C.

At a minimum, the Monitoring Protocol will affirm the state's commitment to conduct quarterly and annual monitoring in accordance with CMS' template. Any proposed deviations from CMS' template should be documented in the Monitoring Protocol. The Monitoring Protocol will describe the quantitative and qualitative elements on which the state will report through quarterly and annual monitoring reports. For quantitative metrics (e.g., performance metrics as described in STC 41b below), CMS will provide the state with a set of required metrics, and technical specifications for data collection and analysis covering the key policies being tested under this demonstration, including but not limited to premiums, incentives for healthy behaviors, and waiver of retroactive eligibility. The state is also expected to describe its plans for capturing data and information pertaining to the NEMT waiver policy, including but not limited to data and other information about beneficiary understanding of and experience with transportation in accessing covered services, particularly services that beneficiaries must obtain to avoid premiums. The Monitoring Protocol will specify the methods of data collection and timeframes for reporting on the state's progress as part of the quarterly and annual monitoring reports. For the qualitative elements (e.g., operational updates as described in STC 41a below), CMS will provide the state

with guidance on narrative and descriptive information which will supplement the quantitative metrics on key aspects of the demonstration policies. The quantitative and qualitative elements will comprise the state's quarterly and annual monitoring reports.

41. **Monitoring Reports.** The state must submit three (3) Quarterly Reports and one (1) Annual Report each DY. The fourth quarter information that would ordinarily be provided in a separate report should be reported as distinct information within the Annual Report. The Quarterly Reports are due no later than sixty (60) calendar days following the end of each demonstration quarter. The Annual Report (including the fourth-quarter information) is due no later than ninety (90) calendar days following the end of the DY. The reports will include all required elements as per 42 CFR 431.428, and should not direct readers to links outside the report. Additional links not referenced in the document may be listed in a Reference/Bibliography section. The Monitoring Reports must follow the framework provided by CMS, which is subject to change as monitoring systems are developed/evolve, and be provided in a structured manner that supports federal tracking and analysis.
    a. Operational Updates - Per 42 CFR 431.428, the Monitoring Reports must document any policy or administrative difficulties in operating the demonstration. The reports shall provide sufficient information to document key challenges, underlying causes of challenges, how challenges are being addressed, as well as key achievements and to what conditions and efforts successes can be attributed. The discussion should also include any issues or complaints identified by beneficiaries; lawsuits or legal actions; unusual or unanticipated trends; legislative updates; and descriptions of any public forums held. The Monitoring Report should also include a summary of all public comments received through post-award public forums regarding the progress of the demonstration.

    Performance Metrics - Per 42 CFR 431.428, the Monitoring Reports must document the impact of the demonstration in providing insurance coverage to beneficiaries and the uninsured population, as well as outcomes of care, quality and cost of care, and access to care. The performance metrics will provide data to demonstrate how the state is progressing towards meeting the demonstration goals for the following key policies under this demonstration, including premiums, incentives for healthy behaviors, and the waiver of retroactive eligibility. For premiums, this will also include metrics related to premium payment/non-payment, such as individuals subject to premium requirements, individuals whose premiums have been waived due to compliance with healthy behaviors, individuals exempt due to hardship, individuals with overdue premiums, information about the state's collectionactivities, and individuals over 100 percent up to and including 133 percent of the FPL who are disenrolled due to premium non-payment. The state will report applicable monitoring metrics to cover the waiver of retroactive eligibility policy, including "unpaid medical bills", using information found on the beneficiary

enrollment application.

The required monitoring and performance metrics must be included in the Monitoring Reports, and will follow the framework provided by CMS to support federal tracking and analysis.

The state is also expected to provide information regarding the NEMT waiver about beneficiary understanding of and experience with transportation in accessing covered services, particularly services that beneficiaries must obtain to avoid premiums. In addition, the state must provide metrics pertaining to access to care generally.

b. Financial Reporting Requirements - Per 42 CFR 431.428, the Monitoring Reports must document the financial performance of the demonstration. The state must report quarterly and annual expenditures associated with the populations affected by this demonstration on the Form CMS-64. Administrative costs for this demonstration should be reported separately on the CMS-64.

c. Evaluation Activities and Interim Findings - Per 42 CFR 431.428, the Monitoring Reports must document any results of the demonstration to date per the evaluation hypotheses. Additionally, the state shall include a summary of the progress of evaluation activities, including key milestones accomplished, as well as challenges encountered and how they were addressed.

42. Corrective Action Plan Related to Monitoring. If monitoring indicates that demonstration features are not likely to assist in promoting the objectives of Medicaid, CMS reserves the right to require the state to submit a corrective action plan to CMS for approval. A state corrective action plan could include a temporary suspension of implementation of demonstration programs, in circumstances where monitoring data indicate substantial sustained directional change, inconsistent with state targets (such as substantial, sustained trends indicating increases in disenrollment, difficulty accessing services, or unpaid medical bills). A corrective action plan may be an interim step to withdrawing waivers or expenditure authorities, as outlined in STC 10. CMS will withdraw an authority, as described in STC 10, when metrics indicate substantial, sustained directional change, inconsistent with state targets, and the state has not implemented corrective action. CMS would further have the ability to suspend implementation of the demonstration should corrective actions not effectively resolve these concerns in a timely manner.

43. Close Out Report. Within 120 calendar days after the expiration of the demonstration, the state must submit a draft Close-Out Report to CMS for comments.

a. The draft report must comply with the most current guidance from CMS.
b. The state will present to and participate in a discussion with CMS on the Close-Out Report.
c. The state must take into consideration CMS' comments for incorporation into the final Close-Out Report.

d. The final Close-Out Report is due to CMS no later than thirty (30) calendar days after receipt of CMS' comments.
e. A delay in submitting the draft or final version of the Close-Out Report may subject the state to penalties described in STC 36.

X. MONITORING CALLS AND DISCUSSIONS

44. Monitoring Calls. CMS will convene periodic conference calls with the state.
a. The purpose of these calls is to discuss ongoing demonstration operation, to include (but not limited to), any significant actual or anticipated developments affecting the demonstration. Examples include implementation activities, trends in reported data on metrics and associated mid-course adjustments, budget neutrality, and progress on evaluation activities.
b. CMS will provide updates on any pending actions, as well as federal policies and issues that may affect any aspect of the demonstration.
c. The state and CMS will jointly develop the agenda for the calls.

45. Post Award Forum. Pursuant to 42 CFR 431.420(c), One year from the last post award forum the state shall afford the public with an opportunity to provide meaningful comment on the progress of the demonstration. At least thirty (30) days prior to the date of the planned public forum, the state must publish the date, time and location of the forum in a prominent location on its website. The state must also post the most recent annual report on its website with the public forum announcement. Pursuant to 42 CFR 431.420(c), the state must include a summary of the comments in the Monitoring Report associated with the quarter in which the forum was held, as well as in its compiled Annual Report.

XI. EVALUATION OF THE DEMONSTRATION

46. Cooperation with Federal Evaluators. As required under 42 CFR 431.420(f), the state shall cooperate fully and timely with CMS and its contractors in any federal evaluation of the demonstration or any component of the demonstration. This includes, but is not limited to: commenting on design and other federal evaluation documents; providing data and analytic files to CMS; entering into a data use agreement that explains how the data and data files will be exchanged; and providing a technical point of contact to support specification of the data and files to be disclosed, as well as relevant data dictionaries and record layouts. The state shall include in its contracts with entities that collect, produce or maintain data and files for the demonstration, that they make data available for the federal evaluation as is required under 42 CFR 431.420(f) to support federal evaluation. The state may claim administrative match for these activities. Failure to comply with this STC may result in a deferral being issued as outlined in STC 36.

47. Independent Evaluator. Upon approval of the demonstration, the state must arrange with an independent party to conduct an evaluation of the demonstration to ensure that the necessary data is collected at the level of detail needed to study the

effectiveness of the demonstration, as will be delineated in the approved evaluation design (see STC 48). The state must require the independent party to sign an agreement that the independent party will conduct the demonstration evaluation in an independent manner in accordance with the CMS-approved Evaluation Design. When conducting analyses and developing the evaluation reports, every effort should be made to follow the approved methodology. However, the state may request, and CMS may agree to, changes in the methodology in appropriate circumstances.

48. **Draft Evaluation Design.** The state must submit, for CMS comment and approval, a draft Evaluation Design, no later than 180 calendar days after the effective date of the demonstration.

    Any modifications to an existing approved Evaluation Design will not affect previously established requirements and timelines for report submission for the demonstration, if applicable. The draft Evaluation Design must be developed in accordance with the following CMS guidance (including but not limited to):

    a. Attachment D (Developing the Evaluation Design) of these STCs.
    b. All applicable evaluation design guidance, including guidance on premiums and waivers of retroactive eligibility.
    c. Any applicable CMS technical assistance on applying robust evaluation approaches, including establishing appropriate comparison groups and assuring causal inferences in demonstration evaluations.

    49. Evaluation Design Approval and Updates. The state must submit a revised draft Evaluation Design within sixty (60) calendar days after receipt of CMS' comments. Upon CMS approval of the draft Evaluation Design, the document will be included as Attachment F to these STCs. Per 42 CFR 431.424(c), the state will publish the approved Evaluation Design within thirty (30) days of CMS approval. The state must implement the evaluation design and submit a description of its evaluation implementation progress in each of the Monitoring Reports. Once CMS approves the evaluation design, if the state wishes to make changes, the state must submit a revised evaluation design to CMS for approval.

50. **Evaluation Questions and Hypotheses.** Consistent with Attachments D and E (Developing the Evaluation Design and Preparing the Evaluation Report) of these STCs, the evaluation documents must include a discussion of the evaluation questions and hypotheses that the state intends to test. The evaluation must outline and address well-crafted hypotheses and research questions for all key demonstration policy components covering applicable demonstration populations that support understanding the demonstration's impact and its effectiveness in achieving the goals. The evaluation must assess the impact of the demonstration on beneficiary coverage, access to and quality of care, and health outcomes. Each demonstration component should have at least one evaluation question and hypothesis. In addition, CMS's expectations for evaluating waivers pertaining to premiums, NEMT and retroactive eligibility, and for other eligibility and coverage policies, are more extensive as

follows. Hypotheses for healthy behavior incentives and premiums must relate to (but are not limited to) the following areas: beneficiary understanding of and experience with premiums as an incentive, the interface between incentives to seek out preventive care and premiums, and consequences of these demonstration policies, including non-compliance with premiums and healthy behavior requirements, on coverage (including employer-sponsored health insurance and no coverage for those who separate from the demonstration) and health outcomes. Hypotheses for the waiver of retroactive eligibility must relate to (but are not limited to) the following outcomes: likelihood of enrollment and enrollment continuity; likelihood that beneficiaries will apply for Medicaid when they believe they meet the criteria for Medicaid; enrollment when people are healthy, or as soon as possible after meeting eligibility criteria; and health status (as a result of greater enrollment continuity). Hypotheses to evaluate the NEMT waiver policy must include (but are not limited to): effects on access to covered services, including access to the services that beneficiaries must obtain to avoid premiums. The state must also investigate cost outcomes for the demonstration as a whole, including but not limited to: administrative costs of demonstration implementation and operation, Medicaid health service expenditures, and provider uncompensated costs. In addition, the state must use results of hypothesis tests and cost analyses to assess demonstration effects on Medicaid program sustainability.

The hypothesis testing should include, where possible, assessment of both process and outcome measures. Proposed measures should be selected from nationally-recognized sources and national measures sets, where possible. Measures sets could include CMS's Core Set of Health Care Quality Measures for Children in Medicaid and CHIP, Consumer Assessment of Health Care Providers and Systems (CAHPS), the Initial Core Set of Health Care Quality Measures for Medicaid-Eligible Adults and/or measures endorsed by National Quality Forum (NQF).

51. **Evaluation Budget.** A budget for the evaluation shall be provided with the draft Evaluation Design. It will include the total estimated cost, as well as a breakdown of estimated staff, administrative and other costs for all aspects of the evaluation such as any survey and measurement development, quantitative and qualitative data collection and cleaning, analyses and report generation. A justification of the costs may be required by CMS if the estimates provided do not appear to sufficiently cover the costs of the design or if CMS finds that the design is not sufficiently developed, or if the estimates appear to be excessive.

52. **Interim Evaluation Report.** The state must submit an Interim Evaluation Report for the completed years of the demonstration, and for each subsequent extension of the demonstration, as outlined in 42 CFR 431.412(c)(2)(vi). When submitting an application for extension, the Evaluation Report should be posted to the state's website with the application for public comment.
    a. The Interim Evaluation Report will discuss evaluation progress and present findings to date as per the approved evaluation design.
    b. For demonstration authority that expires prior to the overall demonstration's

expiration date, the Interim Evaluation Report must include an evaluation of the authority as approved by CMS.

c. If the state is seeking to extend the demonstration, the draft Interim Evaluation Report is due when the application for extension is submitted. If the state would make changes to the demonstration in its application for extension, the report should include how the evaluation design would be adapted to accommodate the proposed policy changes. If the state is not requesting an extension for a demonstration, an Interim Evaluation report is due one (1) year prior to the end of the demonstration (i.e., by December 31, 2023). For demonstration phase outs prior to the expiration of the approval period, the draft Interim Evaluation Report is due to CMS on the date that will be specified in the notice of termination or suspension.
d. The state must submit the revised Interim Evaluation Report sixty (60) calendar days after receiving CMS's comments on the draft Interim Evaluation Report Once approved by CMS, the state must post the final Interim Evaluation Report to the state's website within thirty (30) calendar days of approval by CMS.
e. The Interim Evaluation Report must comply with Attachment E (Preparing the Evaluation Report) of these STCs.

53. Summative Evaluation Report. The draft Summative Evaluation Report must be developed in accordance with Attachment E (Preparing the Evaluation Report) of these STCs. The state must submit a draft Summative Evaluation Report for the demonstration's current approval period within 18 months of the end of the approval period represented by these STCs. The Summative Evaluation Report must include the information in the approved Evaluation Design.

a. Unless otherwise agreed upon in writing by CMS, the state must submit a revised Summative Evaluation Report within sixty (60) calendar days of receiving comments from CMS on the draft.
b. Upon approval from CMS, the final Summative Evaluation Report must be posted to the state's Medicaid website within thirty (30) calendar days of approval by CMS.

54. Corrective Action Plan Related to Evaluation. If evaluation findings indicate that demonstration features are not likely to assist in promoting the objectives of Medicaid, CMS reserves the right to require the state to submit a corrective action plan to CMS for approval. A state corrective action plan could include a temporary suspension of implementation of demonstration programs, in circumstances where evaluation findings indicate substantial, sustained directional change inconsistent with state targets (such as substantial, sustained trends indicating increases in disenrollment, difficulty accessing services or unpaid medical bills). A corrective action plan may be an interim step to withdrawing waivers or expenditure authorities, as outlined in STC 10. CMS would further have the ability to suspend implementation of the demonstration should corrective actions not effectively resolve these concerns in a timely manner.

55. **State Presentations for CMS**. CMS reserves the right to request that the state present and participate in a discussion with CMS on the Evaluation Design, the interim evaluation, and/or the summative evaluation.

56. **Public Access**. The state shall post the final documents (e.g., Monitoring Reports, Close Out Report, approved Evaluation Design, Interim Evaluation Report, and Summative Evaluation Report) on the state's Medicaid website within 30 calendar days of approval by CMS.

57. **Additional Publications and Presentations.** For a period of twelve (12) months following CMS approval of the final reports, CMS will be notified prior to presentation of these reports or their findings, including in related publications (including, for example, journal articles), by the state, contractor, or any other third party directly connected to the demonstration over which the state has control. Prior to release of these reports, articles or other publications, CMS will be provided a copy including any associated press materials. CMS will be given ten (10) business days to review and comment on publications before they are released. CMS may choose to decline to comment or review some or all of these notifications and reviews. This requirement does not apply to the release or presentation of these materials to state or local government officials.

58. **Schedule of Demonstration Period Deliverables**

Schedule of Deliverables for the Demonstration Period		
Date	**Deliverable**	**STC**
30 calendar days after approval date-	State acceptance of demonstration Waivers, STCs, and Expenditure Authorities	Approval letter
90 calendar days after the effective date- **March 31, 2020**	Implementation Plan	STC 39
150 calendar days effective date- **May 30, 2020**	Monitoring Protocol	STC 40
180 calendar days after effective date- **June 29, 2020.**	Draft Evaluation Design	STC 48
60 days after receipt of CMS comments	Revised Draft Evaluation Design	STC 49
30 calendar days after CMS Approval	Approved Evaluation Design published to state's website	STC 49
With extension application or by	Draft Interim Evaluation Report	STC 52 c

December 31, 2023, whichever is earlier		
60 days after receipt of CMS comments	Revised Interim Evaluation Report	STC 52 d
Within 18 months after **December 31, 2024**	Draft Summative Evaluation Report	STC 53
60 calendar days after receipt of CMS comments	Revised Summative Evaluation Report	STC 53
Monthly Deliverables	Monitoring Call	STC 44
Quarterly monitoring reports due 60 calendar days after end of each quarter, except 4th quarter	Quarterly Monitoring Reports (Dates for 1st year only) 1st Report Due - May 30, 2020 2nd Report Due - August 29, 2020 3rd Report Due - November 29, 2020	STC 41
Annual Deliverables - (90) calendar days following the end of the DY (4th quarter)	Annual Monitoring Reports (Date for 1st year only) 1st Report Due- March 31, 2021	STC 41

Attachment A
Healthy Behaviors and Premiums Protocols

Section 1115 Eligibility and Coverage Demonstration Implementation Plan: Healthy Behaviors Program Protocol for the Iowa Wellness Plan

Overview: Iowa's Healthy Behaviors Program is designed to influence how consumers interact with their health care system, emphasizing primary care access and utilization. The Healthy Behaviors Program is designed to reward members through encouraging completion of healthy behaviors by rewarding them with waiver of contributions (premiums) in subsequent enrollment periods.

Stakeholder Engagement in Protocol Development

Iowa began engaging stakeholder input for the Iowa Health and Wellness Plan by holding public hearings and education sessions prior to implementation. Each hearing included initial details regarding the Healthy Behaviors Program, with the specific activities added into the discussion once finalized. Two public hearings were held in July 2013. Thereafter, another six public hearings were held statewide in conjunction with the State Innovation Model grant outreach. Each session was attended by a variety of community members, providers and stakeholder organizations.

Iowa has also undertaken an extensive and comprehensive stakeholder approach as part of the State Innovation Model (SIM) Design Grant project in the summer and fall of 2013. A broad spectrum of stakeholders were involved, including providers, payers, physicians, practitioners, managed care organizations, and state agencies like Iowa Department of Public Health and Iowa Department on Aging.

Iowa also sought consumer input through two specific Consumer Focused workgroups and a series of public meetings called Listening Sessions. One workgroup was tasked with identifying goals and approaches to engaging members in their own health care and encouraging them to be active participants in becoming healthier. All workgroups discussed the importance of member engagement strategies and specifically the Healthy Behaviors Program for the Iowa Health and Wellness Program.

The SIM stakeholder process, a list of stakeholder participants, meeting agendas, meeting minutes, workgroup summaries and the State Healthcare Innovation Plan are all available at: https://dhs.iowa.gov/ime/about/initiatives/newSIMhome.

Iowa also sought input from the Patient-Centered Health Advisory Council and presented the 2014 Healthy Behavior Program for Iowa Health and Wellness Plan at the November 15, 2013 meeting.

Additional stakeholder feedback has been received throughout the fall of 2013 with a variety of organizations. A special meeting of the Medical Assistance Advisory Council (MAAC) was held on August 15, 2013. This session focused on details on the Iowa Health and Wellness Plan, and included a discussion on the Healthy Behavior programs. On November 21, 2013, the Healthy Behaviors were again discussed with the full MAAC membership. The meeting was open to the public. The Healthy

Behaviors, including member outreach and education, was a key topic of the MAAC Executive Committee meeting in April 2014, and the full council meeting in May 2014.

Other key stakeholder organizations have held meetings on the Iowa Health and Wellness Plan, all meetings including discussion of the Healthy Behaviors Program. Some of the organizations include:

- Iowa Hospital Association
- Iowa Mental Health Planning Council
- Epilepsy Foundation
- Coalition for Family and Children's Services
- Iowa Behavioral Health Association
- Iowa Primary Care Association
- Visiting Nurse Services of Iowa
- Iowa Safety Net Providers
- Iowa State Association of Counties
- Susan G. Komen Foundation, Iowa Chapter
- Family Development and Self Sufficiency Program
- Iowa Rural Health Association
- AmeriCorps

Further, Iowa accepted written comments from the Child and Family Policy Center. Specifically related to the HRA requirement, the IME decided to use the HYH tool after meeting with various stakeholders including the following:

- Coventry Health Care of Iowa November 26,2013
- CoOportunity Health December 5, 2013
- University of Iowa Public Policy Center December 6, 2013
- The University of Iowa Alliance December 17, 2013
- UnityPoint Health December 19, 2013
- Meridian Health Plan December 19, 2013
- Treo Solutions December 24, 2013

From the stakeholders who are provider entities, the IME learned that, if the entity uses an HRA, it is to gauge their members' health status and to subsequently implement incentives to encourage healthier behaviors with the long-term goal of reducing health care costs.

The University of Iowa Public Policy Center provided HRA research consistent with the information presented by the provider entities. The research showed that HRA are helpful to engage patients in their care and help primary care practices and patients work in close cooperation. Additionally, the IME found that HRAs have been widely used in employer sponsored plan for a number of years as a means to control costs.

Contribution Waiver for Healthy Behaviors Program

Iowa has designated completion of a Health Risk Assessment (HRA) and a wellness exam as the healthy behaviors that will qualify members for waiver of their contributions in their subsequent enrollment period. There are no contributions charged for the first year of enrollment.

Healthy Behavior 1: Completion of a HRA

In an effort to improve patient outcomes and engage members in their health care, the Managed Care Organizations (MCOs) have developed HRAs. The HRAs include questions regarding hospital visits, chronic diseases, and social determinants of health. The HRA can be completed by mail, fax, online, or by phone to the MCO. The MCOs are required to conduct a comprehensive assessment if a special health care need is identified in the HRA. The MCOs help the member set up appointments with a primary care provider if needed.

Healthy Behavior 2: Completion of a Wellness Exam

Members are encouraged to complete an annual preventive wellness exam or a dental exam as part of an emphasis on pro-active healthcare management. Wellness exam have been defined by the following codes:

New Patient CPT Codes		Established Patient CPT Codes	
99385	18-39 years of age	99395	18-39 years of age
99386	40-64 years of age	99396	40-64 years of age

Dental examination codes that can also meet the requirements of a wellness exam are:

Code	Description
D0120	Periodic Oral Evaluation
D0140	Limited Oral Examination
D0150	Comprehensive Oral Examination
D0180	Comprehensive Periodontal Exam

As mentioned above, IME will ensure members who have completed their healthy behaviors are not charged contributions in their second year of enrollment. IME receives files from the MCOs to update the IME system that the healthy behaviors have been completed and this will be reported through the Quarterly Progress reports. Members will be given their first enrollment year and an additional 30-day grace period to qualify to have their contributions waived in their subsequent enrollment year. During this grace period, members will also be given the opportunity to self-report completion of the wellness exam.

Beneficiaries who are exempt from premiums are those who are medically exempt, Alaska Native/American Indian, and those in Health Insurance Premium Payment (HIPP). Women who are pregnant at the time of application or at the time of redetermination are placed in the Mothers and Children category for Medicaid. If a woman becomes pregnant while on the IWP and notifies the state of her pregnancy has

a choice of IWP or Medicaid. If a pregnant woman remains on IWP, the state has identified that pregnant women are not being excluded for premiums. The state will be updating programming to correct this.

If the member indicates on the application that they are American Indian/Alaska native, this then triggers the enrollment system to exclude them from premium payments. The member may also call in to member services to notify us of their race. Providers can also call in and share this information.

System programming in underway to capture and track when beneficiaries have reached the premiums aggregate cap (quarterly aggregate cap of 5 percent of household income) through the claim and contribution system. The system will provide reports on a monthly basis to identify when the 5% cap has been met. Should the programming not be in production when the waiver for collecting contributions expires at the end of the public health emergency, a manual backup plan is being outlined.

Premium/Contribution Protocols

During their first year of eligibility, all members will be exempt from any contribution payments. This will permit the member the opportunity to 1) gain an understanding of the Healthy Behaviors Program and 2) to complete those Healthy Behaviors that will qualify the member for contribution waiver in the second year of eligibility. In each enrollment year that the member completes the Healthy Behaviors, the member will qualify to have their contributions waived in the subsequent year.

Regardless of whether they complete their Healthy Behaviors, the following members will be exempt from contribution payments:

- Persons with income at or below 50 percent the Federal Poverty Level (FPL)
- Persons with a Medically Exempt (Medically Frail) status
- American Indians/Alaska Natives
- Health Insurance Premium Payment (HIPP) enrollees

Members who do not complete their Healthy Behaviors during the first year of enrollment will be subject to the contribution payments in their second year of enrollment. Contributions will be charged as follows:

- Persons with income >50–100 percent of the FPL = $5 monthly contribution
- Persons with income from >100-133 percent of FPL = $10 monthly contribution

The IME will give members a 30 day grace period after their enrollment year to complete their Healthy Behaviors and qualify for contribution waiver. After that time, if the member has not qualified for contribution waiver, the IME will begin sending monthly billing statements including a hardship exemption request form. The billing statement will be mailed to the member prior to the first day of the month in which the contribution is due. Members will have until the last day of the contribution month to either mail in their contribution or request a hardship exemption for the month. Members may pay by check,

money order or online through the IME Click Pay site. Directions of where to mail the contribution, how to request a hardship exemption, and who to call with questions will be clearly detailed on the billing statement. A hardship exemption can be requested by checking the hardship exemption on the billing statement or by calling the IME. No documentation is needed to claim a hardship exemption. Unpaid contributions will be reflected on the member's next monthly billing statement.

For individuals at or below 100% FPL, unpaid contributions will not, however, result in termination from the Iowa Wellness Plan.

For members with income over 100% FPL, if a member fails to pay any monthly contributions after a 90 day grace period, the IME will terminate the member's enrollment status. The member's outstanding contribution will be considered a collectible debt and subject to recovery. A member whose benefits are terminated for nonpayment of monthly contributions must reapply for Medicaid coverage. The IME will permit the member to reapply at any time, however, the member's outstanding contribution payments will remain subject to recovery.

After the 90 day grace period, unpaid premiums may be considered a collectible debt owed to the State of Iowa and, at state option, subject to collection by the state, with the following exception: If, at the member's next annual renewal date, the member does not apply for renewed eligibility, and the member has no claims for services delivered after the month of the last premium payment, unpaid premiums shall not be considered a collectible debt by the state.

Year Two and Subsequent Years

If the member completed the healthy behaviors listed above, then the contribution is waived for the second year. The member must complete the healthy behaviors in year two and subsequent years to have the contribution waived in the next enrollment year.

Systems Monitoring

Information collected on the HRA assess a member's physical, behavioral, social, functional, and psychological status and needs. It determines the need for care coordination, behavioral health services, or any other health or community services. The HRA complies with the NCQA standards for health risk screenings.

If the HRA identifies a special health care need is identified the member is referred to non-waiver case management. The member is then assessed using a complex care/comprehensive care assessment. Case management is explained to the member and those who consent are place in the case management program.

The IME Medicaid Management Information System (MMIS) has been coded to detect all persons who are mandatorily exempt. The MMIS is also coded to capture those members who complete both a wellness exam and an HRA during a twelve month period of continuous enrollment in the IWP. Ensuring a member has twelve months of continuous enrollment prior to being subject to monthly

contributions will avoid any unintended harm to the member if the member's coverage options change periodically (aka churn). For example, there may be situations wherein the member loses IWP eligibility if they become eligible for another Medicaid program, gain access to employer sponsored insurance (ESI), or their economic situation improves such that they can access insurance through the Health Insurance Marketplace. If the member churns back to the IWP, the MMIS system will detect that the member had a break in coverage and has not had twelve months of continuous coverage in the IWP and will therefore not be subject to monthly contributions. Essentially, a break in the member's coverage will begin a new twelve month period during which the member will be exempt from contributions. See the examples below:

Example: Member A

- 01.01.19 enrolled in IWP
- 07.01.19 gains access to ESI and is disenrolled from IWP
- 09.01.19 loses access to ESI, applies for Medicaid and is determined eligible for IWP.

Member A did not have 12 months of continuous IWP eligibility. Member A will be exempt from monthly contributions during his enrollment period that begins 09.01.19. Member A will have 12 full months to complete a wellness exam and HRA to continue to be exempt from monthly contributions in the next enrollment year.

Example: Member B

- 01.01.18 enrolled in IWP
- 12.31.18 Member B does not complete healthy behaviors; at re-enrollment she is determined eligible for Mothers and Children (MAC) program
- 01.01.19 – 12.31.19 Member B has MAC coverage
- 01.01.20 Re-enrollment determines Member B is eligible IWP.

Although Member B had 12 months of IWP coverage, there has been a 12 month break in that coverage. Member B will be exempt from monthly contributions and have 12 full months to complete a wellness exam and HRA to continue to be exempt from monthly contributions in the next enrollment year.

Information collected on the HRA assess a member's physical, behavioral, social, functional, and psychological status and needs. It determines the need for care coordination, behavioral health services, or any other health or community services. The HRA complies with the NCQA standards for health risk screenings.

If the HRA identifies a special health care need is identified the member is referred to non-waiver case management. The member is then assessed using a complex

care/comprehensive care assessment. Case management is explained to the member and those who consent are place in the case management program.

Managed Care Organizations (MCOs) are provided flexibility in methods for monitoring healthy behaviors at the provider level, including standards of accountability for providers. For example, one MCO provides access to completed HRA data via its provider portal and providers are educated on their accountability for accessing this assessment and working to improve these unhealthy behaviors during their annual wellness exam and any follow up visits as necessary. Additionally, many providers are engaged in value-based contracts which incentivize quality performance through meeting established metrics around HEDIS data, which focuses heavily on preventive care for members in alignment with the Healthy Behavior requirements.

Medically Exempt

Individuals who otherwise qualify for IWP but who need specialized medical services due to complex medical conditions or mental, physical or developmental disorders will be eligible for more comprehensive coverage through Iowa's traditional Medicaid program. This is referred to as being Medically Exempt.

Iowa uses the term 'Medically Exempt' to define the Federal definition of 'Medically Frail'. 'Medically Frail' includes: individuals with disabling mental disorders (including adults with serious mental illness), individuals with chronic substance use disorders, individuals with serious and complex medical conditions, individuals with a physical, intellectual or developmental disability that significantly impairs their ability to perform 1 or more activities of daily living, or individuals with a disability determination based on Social Security criteria.

Members or their providers can complete a survey either by phone, fax or mail for the IME to determine if the member meets the definition of Medically Exempt. If the member is Medically Exempt, the member will have the full Medicaid benefits the next month after determination. More information and the survey instrument can be found at: https://dhs.iowa.gov/sites/default/files/Medically%20Exempt%20Toolkit.pdf?012220201532.

Once a member becomes Medically Exempt, the member remains Medically Exempt for life for purposes of exemption from premium requirements and enrollment in State Plan benefits.

Debt Collection

The IME has initiated a debt collection process. The state has a premium payment system that tracks all invoices, payments and non-payments. When an IWP member's premium becomes ninety (90) days past due and the amount owed is $50 or greater, the debt collection is sent to the Iowa Department of Revenue (IDR). IDR then attempts to collect the amount using various methods such as establishing a repayment plan or taking monies from a tax refund. This debt is not reported to credit agencies.

Disenrollment

Before an IWP is disenrolled, the members have received invoice statements that state they may be disenrolled if the contribution is not paid for 90 days. Each invoice includes the months for which the member owes a contribution.

As occurs for all Medicaid eligibility terminations, prior to disenrolling an individual for premium non-payment, the eligibility system conducts an automated determination to confirm whether the individual is eligible for another Medicaid category.

When an IWP member is disenrolled from IWP, the member can reapply for IWP at any time. If the member reapplies in the month of the disenrollment and is eligible for the plan, there would not be a gap in coverage. If the member reapplies after the month of disenrollment and is found eligible for the plan, enrollment would begin the month of the application date.

Appeal Process

A member can appeal the disenrollment from IWP when the contribution is 90 days past due, the amount of the contribution or benefits. The appeal process is the same for IWP as it is for Medicaid. During the appeal process, a member can continue benefits while awaiting the outcome of the appeal. If the member loses the appeal, the member will be responsible for any claims or capitation payments made during that time.

The Quarterly Progress Reports will detail the number and types of appeal received during the reporting quarter.

Communication

Communication about IWP can begin before a person becomes eligible for IWP. The Department's website has a page about IWP at https://dhs.iowa.gov/IHAWP. The page includes information about:

- Who qualifies
- Benefits
- Health Plans
- Healthy Behaviors
- How to Apply
- Find a Provider
- Resources
- Frequently Asked Questions
- Rights and Responsibilities

All mailings are distributed state wide and are available on the Department's website. The website page also tells current members how to make their contribution online or the address to send the payment if they choose not to pay online.

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.

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. Details about the Iowa Wellness Plan are included in both the IA Health Link Member Handbook and the Fee-for-Service Member Handbook. These details include an overview of the program, covered benefits, Healthy Behaviors requirements and information about monthly contributions.

Both the IA Health Link and Fee-for-Service member handbooks are available on the DHS website in both English and Spanish. Should a member need information in another language, they can use the state's Interpreter Services by calling Iowa Medicaid Member Services.

A flyer with information about how to access the member handbook is included in the welcome packet that is mailed to new Medicaid enrollees.

The IME utilizes computer software to determine the reading level of all communication sent to members.

If the member has not completed the healthy behavior activities two months prior to the end of the member's first enrollment period, the MCOs send a notice to the member about completing these healthy behaviors. The notice is member specific, telling the member which or both healthy behaviors still need to be met to qualify for the exemption of contributions.

IWP members in their second and subsequent years who did not complete the healthy behaviors during the prior enrollment period are sent an invoice on the first of each month. The invoice tells them when their contribution is due, how to pay the contribution either online or by mail, how to claim a financial hardship and the consequences for not paying the contribution each month.

New information about IWP is communicated through the Department's website, Medicaid e-news, newsletters and direct letters to IWP members.

Beneficiaries are notified by mail of any changes in requirements. For example, if the payment amount is recalculated, the beneficiary will receive a payment statement indicating the new payment amount. If other changes occur, the MCOs and the state work together to provide communication to beneficiaries.

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.

At any time, a potential member or an eligible member can call or email Medicaid Member Services to get answers to their questions or help to solve any issues with IWP.

The MCOs are required in their contract with the IME to have member and provider incentives in place to increase quality outcomes, encourage utilization of health services and healthy behaviors. The IME is collaborating with the MCOs to further address communication about the completion of healthy behaviors through providers and members.

Attachment B
Implementation Plan

Section 1115 Eligibility and Coverage Demonstration Implementation Plan: Retroactive Eligibility Waivers

Overview: The implementation plan documents the state's approach to implementing eligibility and coverage policies. It also helps establish what information the state will report in its quarterly and annual monitoring reports. The implementation plan does not usurp or replace standard CMS approval processes, such as advance-planning documents, verification plans, or state plan amendments.

This template covers the retroactive eligibility waivers. It has three sections. Section 1 is the uniform title page. Section 2 contains implementation questions that states should answer. These questions are organized around two reporting topics:

1. Retroactive eligibility and demonstration requirements
2. Develop comprehensive communications strategy

State may submit additional supporting documents in Section 3.

1. Title page for the state's eligibility and coverage demonstration or eligibility and coverage policy components of the broader demonstration

The state should complete this title page at the beginning of a demonstration and submit it as the title page of all monitoring reports. The content of this transmittal table should stay consistent over time.

This template only includes the retroactive eligibility waivers policy.

State	*Iowa*
Demonstration name	*Iowa Wellness Plan*
Approval date for demonstration	*Current: 11/15/2019* *Original: 12/10/2013*
Approval period for retroactive eligibility waiver	*01/01/2020 – 12/31/2024*
Approval date for retroactive eligibility waiver, if different from above	*10/27/2017*
Implementation date for retroactive eligibility waiver	*11/01/2017*

2. Required implementation information

Answer the following questions about the implementation of the retroactive eligibility policy. The state should respond to each prompt listed in the tables. Note any actions that involve coordination or input from other organizations (government or nongovernment entities). Place "NA" in the summary cell if a prompt does not pertain to the state's demonstration. Answers are meant to provide details beyond the information provided in the state's special terms and conditions. Answers should be concise but provide enough information to fully answer the question.

This template only includes the retroactive eligibility waivers policy.

Prompts	Required key points	CMS comments	State response
RW.Mod_1. Retroactive eligibility and demonstration requirements			
Intent: To describe how the state determines eligibility for and exemptions from the retroactive eligibility policy.			
1.1 Describe how the state will define exempt populations, including: a) Pregnant women b) Infants under age 1 c) Nursing facility residents d) Beneficiaries with disabilities e) Other (by specific exempt status)	☒ A) States must exempt pregnant women. The state clearly defines requirements, including whether women in the post-partum period are exempt, if enrollment is not based on the pregnant women's group.	No comments for the state.	*a) Pregnancy – as indicated on the application, renewal form or reported change. Iowa exempts women in the post-partum period.* *Iowa has exempted this population from the retroactive eligibility policy since November 1, 2017.*
	☒ A) State attests that it is exempting infants under age 1	No comments for the state.	*b) Infants under age 1 – based on Date of Birth of the member at the time of application, renewal form or reported change.* *Iowa has exempted this population from the retroactive eligibility policy since November 1, 2017.*

Prompts	Required key points	CMS comments	State response
	☒ A) For states that are exempting nursing facility residents, the state clearly defines: ☒ Resident status requirements ☒ Nursing facility requirements ☐ B) The state is not exempting nursing facility residents	No comments for the state.	*c) Nursing facility residents – based on the living arrangements of the individual as indicated on the application, renewal form or reported change.* *Iowa has exempted this population from the retroactive eligibility policy since July 1, 2018.*
	☐ A) For states that are exempting beneficiaries with disabilities, the state clearly defines the requirements to meet the exemption ☒ B) The state is not exempting beneficiaries with disabilities	No comments for the state.	*d) Beneficiaries with disabilities – Not Applicable*
	☒ A) For other exempt populations, the state clearly defines each exempt population and requirements ☐ B) The state is not exempting any other populations	No comments for the state.	*f) Other (by specific exempt status) Children under age 19 years old - based on Date of Birth of the member at the time of application, renewal form or reported change.* *Iowa has exempted this population from the retroactive eligibility policy since January 1, 2020.*

Prompts	Required key points	CMS comments	State response
1.2 Describe when the state will waive retroactive eligibility (for example, will the state only waive it at application?). Provide additional details, beyond what is in STCs, about how the state will implement this policy, including whether the state will waive the full retroactive eligibility period.	☒ A) The state clearly describes: ☒ If it will waive retroactive eligibility at: ☒ Application ☐ Renewal for beneficiaries whose coverage is terminated for failure to respond but who return documentation within the 90-day reconsideration period ☒ The period for which the state is waiving retroactive eligibility (that is, if the waiver will reduce retroactive eligibility to a set number of days before the date of the application, rather than eliminating it altogether)	No comments for the state.	*Iowa has opted to waive retroactive eligibility at application only. Up to 3 months of retroactive coverage is available to populations exempt from the retroactive eligibility policy.* *Iowa maintains applying the 90 day reasonable opportunity period as a separate and distinct policy applicable to the renewal process.*

Prompts	Required key points	CMS comments	State response
1.3 Describe the state's process for identifying and exempting beneficiaries from the retroactive eligibility waiver.	☒ A) For the exempt populations described in 1.1, the state clearly describes: ☒ Procedures it will use to identify beneficiaries who are exempt from retroactive eligibility waivers, including through application questions or post-enrollment follow-up ☒ How the state will notify applicants/beneficiaries that they may be eligible for retroactive coverage and can declare unpaid medical expenses from the past three months ☒ Systems changes the state has implemented or plans to implement to exempt beneficiaries from retroactive eligibility waivers	No comments for the state.	*The Medicaid application and the renewal form requires the member to provide information used to identify the exempt criteria. In addition, the member may report a change that would meet the exemption criteria.* *Declaring the need for retroactive coverage is a standard question on the application and renewal forms.* *Eligibility systems have coding edits in place to recognize whether a person meets the exemption criteria to be granted retroactive coverage.*

Prompts	Required key points	CMS comments	State response
1.4 Describe planned modifications to Medicaid applications to reflect the retroactive eligibility waiver, including changes to any application questions.	☒ A) The state clearly describes planned modifications to Medicaid applications to reflect that individuals may no longer be determined retroactively eligible ☐ B) The state is not planning any modifications to its Medicaid applications	No comments for the state.	*Due to previous CMS approvals to waive retroactive eligibility, the application language has been modified to address the availability of retroactive coverage. Current application language:* *"Do you need help paying for medical bills from the last three calendar months? If you answer yes and you fall into a category that allows for retroactive approval, we will determine if you are eligible for coverage during those months."*
1.5 Describe any modifications to the appeals processes for beneficiaries subject to the retroactive eligibility policy.	☐ A) The state clearly describes: ☐ Modifications to the appeals process for beneficiaries, including modifications to internal processes or changes from a beneficiary perspective ☐ Systems changes that the state has implemented or plans to implement to track retroactive eligibility-specific appeals (optional) ☒ B) The state is not modifying its appeals processes for beneficiaries subject to the retroactive eligibility policy	No comments for the state.	

Prompts	Required key points	CMS comments	State response
1.6 Describe how the state will track the number of beneficiaries who indicated that they had unpaid medical bills at the time of application (if applicable).	Tracking beneficiaries who indicated that they had unpaid medical bills at the time of application may be important for the state's monitoring report. ☒ A) The state clearly describes: ☒ Processes for capturing and reporting the number of beneficiaries who had unpaid medical bills at the time of application ☒ General approach for assessing whether the state will have required data ☐ If known, potential trouble spots or issues the state may encounter when capturing or reporting data ☒ What system(s) the state will use to track these data ☐ Systems changes the state has implemented or plans to implement to track the number of beneficiaries (optional)	Specific to tracking the number of beneficiaries who indicated that they had unpaid medical bills at the time of application and were not granted retroactive coverage, is the state aware of any potential trouble spots or issues the state may encounter when capturing or reporting data?	*Current functionality of the eligibility systems allows for identifying the number of individuals granted retroactive coverage. Both eligibility systems have a field specific to retroactive coverage that requires entry at the time of the eligibility determination when retroactive coverage is granted.* *Response to CMS comments: current functionality of the eligibility systems does not allow for the identifying or reporting of individuals who were not granted retroactive coverage. Eligibility staff are trained to recognize which individuals may qualify for retroactive coverage and only consider retroactive eligibility for those specific populations.*

1.7 Describe how the state will track the number of beneficiaries who had a coverage gap at renewal or the number of beneficiaries who had a coverage gap at renewal and had claims denied (if applicable).	Tracking beneficiaries who had a coverage gap at renewal and/or the number of beneficiaries who had a coverage gap at renewal and had claims denied may be important for the state's monitoring report. ☐ A) The state clearly describes: ☐ Processes for capturing and reporting the number of beneficiaries with a coverage gap at renewal ☐ Processes for capturing and reporting the number of denied claims for beneficiaries with a coverage gap at renewal ☐ General approach for assessing whether the state will have required data ☐ If known, potential trouble spots or issues the state may encounter when capturing or reporting data ☐ What system(s) the state will use to track these data ☐ Systems changes the state has implemented or plans to implement to track the number of beneficiaries	No comments for the state. (The key points for this prompt are not required since the prompt does not apply to the state's demonstration.)	*Not applicable. Iowa maintains applying the 90 day reasonable opportunity period as a separate and distinct policy applicable to the renewal process which will eliminate the possibility of coverage gaps at the time of renewal.* *Iowa has opted to waive retroactive eligibility at application only.*

RW.Mod_2. Develop comprehensive communications strategy			
Intent: To describe how the state will communicate the retroactive eligibility policy and procedures to internal and external stakeholders (beneficiaries and partners), as necessary.			
2.1 Describe the state's plan to communicate to current beneficiaries and new applicants about the retroactive eligibility policy. Include details such as how often the state plans to communicate with beneficiaries through what modes of communication, what information will be distributed using formal notices, and how the state will ensure that materials or communications are accessible to beneficiaries.	☒ A) The state clearly describes: ☒ The state's plan to communicate to current beneficiaries about this policy ☒ The state's plan to communicate to new beneficiaries about this policy ☒ How often the state plans to communicate with beneficiaries about this policy ☐ The modes of communication through which the state will reach beneficiaries about this policy ☐ What information will be communicated to beneficiaries using formal notices ☐ How the state will ensure that materials or communications are accessible to beneficiaries, such as those who have limited English proficiency, have low	Please describe how the state will ensure that materials or communications are accessible to beneficiaries with low literacy or those who live in rural areas and have no or limited internet access.	*As part of the implementation process of waiving retroactive eligibility, the Department provided information to beneficiaries and applicants in the June 2017, October 2017, January 2018, and February 2018 editions of the monthly Iowa Medicaid newsletter. This newsletter is emailed to 6,000 individuals and posted on the DHS website.* *With the amendment to the demonstration to exempt nursing facility residents from the retroactive eligibility policy, the Department provided information to beneficiaries and applicants in the September 2018 edition of the Iowa Medicaid newsletter.* *With the most recent amendment to the demonstration to exempt children under age 19 years old from the retroactive eligibility policy, the Department provided information to beneficiaries and applicants in the March 2020 edition of the Iowa Medicaid newsletter.* *The Department is also working on adding information regarding retroactive eligibility coverage to both the managed care and fee-for-service member*

	literacy, or live in rural areas ☐ How the documents will be translated (e.g., third party translation services, in-house, etc.), and into what languages ☐ That notices are provided in a manner consistent with 42 CFR 431.206, 431.210-214, 435.905, and 435.917		*handbooks. It is anticipated the updated handbooks will be available in March. Both handbooks are available on the DHS website in English and Spanish. Translation services can be requested through Iowa Medicaid Member Services.* *Response to CMS comments: 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. In addition, eligibility staff can provide details on which individuals may qualify for retroactive coverage.*

2.2 Describe the state's plans to communicate the retroactive eligibility policy to partner organizations, including managed care organizations, and community organizations.	☒ A) The state clearly describes: ☒ Which partner organizations it plans to actively communicate with throughout the demonstration ☒ All forms of communication that it plans to use to engage partner organizations ☒ What modes of communication it plans to use to keep partner organizations informed and engaged ☐ How often the state plans to communicate with partner organizations	No comments for the state	*As part of the implementation process of waiving retroactive eligibility, the Department issued Information Letters (IL) in June 2017 and October 2017.* *With the amendment to the demonstration to exempt nursing facility residents from the retroactive eligibility policy, the Department issued an IL in September 2018.* *With the most recent amendment to the demonstration to exempt children under age 19 years old from the retroactive eligibility policy, the Department issued an IL in January 2020.* *IL are distributed by email to providers, are shared with both Managed Care Organizations, and are posted on the DHS website. IL are published in English and translation services can be requested through Iowa Medicaid Provider Services.*

2.3 Describe the state's plans to communicate the retroactive eligibility policy to providers.	☒ A) The state clearly describes: ☒ All forms of communication that it plans to use to engage providers ☒ What modes of communication it plans to use to keep providers informed and engaged ☐ How often the state plans to communicate with providers	No comment for the state.	*As part of the implementation process of waiving retroactive eligibility, the Department issued Information Letters (IL) in June 2017 and October 2017.* *With the amendment to the demonstration to exempt nursing facility residents from the retroactive eligibility policy, the Department issued an IL in September 2018.* *With the most recent amendment to the demonstration to exempt children under age 19 years old from the retroactive eligibility policy, the Department issued an IL in January 2020.* *IL are distributed by email to providers, are shared with both Managed Care Organizations, and are posted on the DHS website. IL are published in English and translation services can be requested through Iowa Medicaid Provider Services.*

3. Relevant documents

Please provide any additional documentation or information that the state deems relevant to successful execution of the implementation plan. This information is not meant as a substitute for the information provided in response to the prompts outlined in Section 2. Instead, material submitted as attachments should support those responses.

Attachments:

Application for Health Coverage and Help Paying Costs, revised 10/2019

Medicaid/Hawki Review, revised 10/2019

Informational Letter 1808, published 6/2017

Informational Letter 1841, published 10/2017

Informational Letter 1847, published 10/2017

Information Letter 1955, published 9/2018

Information Letter 2085, published 1/2020

Medicaid E-News Volume 2 Issue 10, published 6/2017

Medicaid E-News Volume 2 Issue 17, published 10/2017

Medicaid E-News Volume 3 Issue 2, published 1/2018

Medicaid E-News Volume 3 Issue 3, published 2/2018

Medicaid E-News Volume 3 Issue 26, published 9/2018

Attachment C: Monitoring Protocol

Overview: The Medicaid Section 1115 Eligibility and Coverage Demonstrations Monitoring Protocol contains information on the following policies:[1]

1. Premiums or account payments (PR)
2. Health behavior incentives (HB)
3. Community engagement (CE)
4. Retroactive eligibility waivers (RW)
5. Non-eligibility periods (NEP)

Each state with an approved eligibility and coverage demonstration will receive a customized version of the Monitoring Protocol Template that includes each eligibility and coverage policy in its demonstration and the sections applicable for the demonstration overall. If the eligibility and coverage policies are part of a broader section 1115 demonstration, the state should report on the entire demonstration in the sections that apply to all eligibility and coverage demonstrations. In those situations, CMS will work with the state to ensure there is no duplication in the reporting requirements for different policy components of the demonstration. For more information, the state should contact the section 1115 eligibility and coverage demonstration monitoring and evaluation mailbox (1115MonitoringandEvaluation@cms.hhs.gov), copying the state's CMS demonstration team on the message.

[1] For other eligibility and coverage policies, such as non-emergency medical transportation and marketplace-focused premium assistance, see general guidance for monitoring and evaluation available on Medicaid.gov.

1. Title page for the state's eligibility and coverage demonstrations or eligibility and coverage policy components of the broader demonstration

The state should complete this title page as part of its eligibility and coverage monitoring protocol.

This section collects information on the state's section 1115 demonstration overall, followed by information for each eligibility and coverage policy. This form should be submitted as the title page for all eligibility and coverage monitoring reports. The content of this table should stay consistent over time. Definitions for certain rows are provided below the table.

Overall section 1115 demonstration	
State	*Iowa.*
Demonstration name	*Iowa Wellness Plan*
Approval period for section 1115 demonstration	*01/01/2020 – 12/31/2024*
Premiums or account payments	
Premiums or account payments start date[a]	*01/01/2020*
Implementation date if different from premiums or account payments start date[b]	Click here to enter text.
Health behavior incentives	
Health behavior incentives start date	*01/01/2020*
Implementation date, if different from health behavior incentives start date	Click here to enter text.
Retroactive eligibility waiver	
Retroactive eligibility waiver start date	*01/01/2020*
Implementation date, if different from retroactive eligibility waiver start date	Click here to enter text.

[a] **Start date:** For monitoring purposes, CMS defines the start date of the demonstration as the "effective date" listed in the state's STCs at time of eligibility and coverage demonstration approval. For example, if the state's STCs at the time of eligibility and coverage demonstration approval note that the demonstration is effective January 1, 2020 – December 31, 2025, the state should consider January 1, 2020 to be the start date of the demonstration. Note that the effective date of the eligibility and coverage demonstration may differ from the date CMS approved the demonstration.

[b] **Implementation date of policy:** The date the state implemented each eligibility and coverage policy in its demonstration.

2. Acknowledgement of narrative reporting requirements

☒ The state has reviewed the narrative questions in Sections 3, 4, and 5 of the Monitoring Report Template provided by the CMS demonstration team and understands the expectations for quarterly and annual monitoring reports. The state will report the requested narrative information in quarterly and annual monitoring reports (no modifications).

3. Acknowledgement of budget neutrality reporting requirements

☐ The state has reviewed the Budget Neutrality Workbook provided by the CMS demonstration team and understands the expectations for quarterly and annual monitoring reports. The state will provide the requested budget neutrality information (no modifications).

4. Retrospective reporting

The state is not expected to submit metrics data until after protocol approval, to ensure that data reflects the monitoring plans agreed upon by CMS and the state. Prior to protocol approval, the state should submit quarterly and annual monitoring reports with narrative updates on implementation progress and other information that may be applicable, according to the requirements in its STCs.

If a state's monitoring protocol is approved after one or more of its initial quarterly monitoring report submissions, it should report data to CMS retrospectively, for any prior quarters of the section 1115 eligibility and coverage demonstration that precede the monitoring protocol approval date. The state is expected to submit retrospective metrics data—provided there is adequate time for preparation of these data—in its second monitoring report submission that contains metrics.

The retrospective report for a state with a first eligibility and coverage demonstration year of less than 12 months, should include data for any baseline period quarters preceding the demonstration, as described in Part A of the state's monitoring protocol. (See Appendix B of the instructions for further guidance determining baseline periods for first eligibility and coverage demonstration years that are less than 12 months.) If a state needs additional time for preparation of these data, it should propose an alternative plan (i.e., specify the monitoring report that would capture the data) for reporting retrospectively on its section 1115 eligibility and coverage demonstration.

In the monitoring report submission containing retrospective metrics data, the state should also provide a general assessment of metrics trends from the start of its demonstration through the end of the current reporting period. The state should report this information in Part B of its monitoring report submission (Table 3: Narrative information on implementation, by eligibility and coverage policy). This general assessment is not intended to be a comprehensive description of every trend observed in metrics data. Unlike other monitoring report submissions, for

instance, the state is not required to describe all metrics changes (+ or -) greater than 2 percent for retrospective reporting periods. Rather, the assessment is an opportunity for the state to provide context on its retrospective metrics data and to support CMS's review and interpretation of these data. For example, consider a state that submits data showing a decrease in beneficiaries who did not complete renewal and were disenrolled from Medicaid (metric AD_19) over the course of the retrospective reporting period. The state could highlight this change and specify that during this period the state conducted additional outreach to beneficiaries about the renewal process. For further information on how to compile and submit a retrospective report, the state should review Section B of the Monitoring Report Instructions document.

☒ The state will report retrospectively for any quarters prior to monitoring protocol approval as described above, in the state's second monitoring report submission that contains metrics after protocol approval.

☐ The state proposes an alternative plan to report retrospectively for any quarters prior to monitoring protocol approval: *Insert narrative description of proposed alternative plan for retrospective reporting. The state should provide justification for its proposed alternative plan.*

5. Eligibility and coverage demonstration metrics and narrative information

The state should review the guidance in Appendix A of the Monitoring Protocol Instructions in order to attest that it will follow CMS's guidance on reporting metrics and narrative information, or propose any deviations. The state should complete Table A below to reflect its proposed reporting schedule for the duration of its section 1115 eligibility and coverage demonstration approval period. This table includes a column for each eligibility and coverage policy in the demonstration. For each eligibility and coverage policy, add details in the corresponding column to indicate the policy demonstration year and quarter for each quarterly monitoring report. Metrics that apply to all eligibility and coverage demonstrations (AD) are expected to be reported starting with the first reporting quarter for the section 1115 eligibility and coverage demonstration, even if it is prior to the implementation of any eligibility and coverage policies. The state is encouraged to discuss with CMS any potential exceptions from this by contacting its CMS demonstration team. The text in the table is an example of how to complete these columns to indicate the measurement period and reporting schedule as it pertains to each eligibility and coverage policy when the policies are being implemented on different time frames. (See detailed table notes for assumptions regarding the demonstration in this example.)

☐ The state has completed the table below according to the guidance in Appendix A of the Monitoring Protocol Instructions and attests to reporting metrics and narrative information in its quarterly and annual monitoring reports according as described.

☐ The state has reviewed Appendix A of the Monitoring Protocol Instructions and completed the table below with the following deviations: *Insert narrative description of proposed changes to reporting. State should provide justification for any proposed deviation.*

Table A. State reporting in quarterly and annual monitoring reports, with example text
Below the table, there are notes that are specific to the example schedule provided. The state should remove any table notes not specific to its reporting schedule.

Dates of reporting quarter	AD DY	PR DY	HB DY	RW DY	Report due (per STCs schedule)[b]	Measurement period associated with eligibility and coverage information in report, by reporting category
01/01/2020-03/31/2020	DY1Q1	DY1Q1	DY1Q1	DY1Q1	05/29/2020	• Narrative information: AD, PR, and RW DY1Q1 • Monthly and quarterly metrics, no lag: AD, PR, and RW DY1Q1 • Quarterly metrics, 90 day lag: None • Annual metrics that are quality of care and health outcomes metrics: None • Other annual metrics: None
04/01/2020 – 06/30/2020	DY1Q2	DY1Q2	DY1Q2	DY1Q2	08/29/2020	• Narrative information AD, PR, & RW DY1Q2 • Monthly and quarterly metrics, no lag: AD, RW & PR DY1Q2 • Quarterly metrics, 90 day lag: AD & HB DY1Q1 • Annual metrics that are quality of care and health outcomes metrics: None • Other annual metrics None

Dates of reporting quarter	AD DY	PR DY	HB DY	RW DY	Report due (per STCs schedule)[b]	Measurement period associated with eligibility and coverage information in report, by reporting category
07/01/2020 – 09/30/2020	DY1Q3	DY1Q3	DY1Q3	DY1Q3	11/29/2020	• Narrative information: AD, PR, & RW DY1Q3 • Monthly and quarterly metrics, no lag: AD, RW & PR DY1Q3 • Quarterly metrics, 90 day lag: AD & HB DY1Q2 • Annual metrics that are quality of care and health outcomes metrics: None • Other annual metrics: None
10/01/2020 – 12/31/2020	DY1Q4	DY1Q4	DY1Q4	DY1Q4	03/31/2021	• Narrative information: AD, PR, & RW DY1Q4 • Monthly and quarterly metrics, no lag: AD, RW & PR DY1Q4 • Quarterly metrics, 90 day lag: AD & HB DY1Q3 • Annual metrics that are quality of care and health outcomes metrics: None • Other annual metrics: AD DY1 (calculated for DY1)
01/01/2021 – 03/31/2021	DY2Q1	DY2Q1	DY2Q1	DY2Q1	05/30/2021	• Narrative information: AD, PR, RW & HB DY2Q1 • Monthly and quarterly metrics, no lag: AD & PR DY2Q1

Dates of reporting quarter	AD DY	PR DY	HB DY	RW DY	Report due (per STCs schedule)[b]	Measurement period associated with eligibility and coverage information in report, by reporting category
						• Quarterly metrics, 90 day lag: AD & HB DY1Q4 • Annual metrics that are quality of care and health outcomes metrics: None • Other annual metrics: None
04/01/2021 – 06/30/2021	DY2Q2	DY2Q2	DY2Q2	DY2Q2	08/29/2021	• Narrative information: AD, PR, & HB DY2Q2 • Monthly and quarterly metrics, no lag: AD & PR DY2Q2 • Quarterly metrics, 90 day lag: AD & HB DY2Q1 • Annual metrics that are quality of care and health outcomes metrics: AD DY1 (calculated for CY 2019)[c] • Other annual metrics: None

PR = premiums or account payments; HB = health behavior incentives; CE = community engagement; RW = retroactive eligibility waiver; AD = any demonstration

Medicaid Section 1115 Eligibility and Coverage Demonstrations Monitoring Protocol (Version 3.0)

Overview: The Monitoring Protocol for the section 1115 eligibility and coverage demonstrations consists of a Monitoring Protocol Workbook (Part A) and a Monitoring Protocol Template (Part B). Each state with an approved eligibility and coverage policy in its section 1115 demonstration shall complete only one Monitoring Protocol Workbook (Part A) that encompasses all eligibility and coverage policies approved in its demonstration as well as the demonstration overall, in accordance with the demonstration's special terms and conditions (STC). This state-specific Part A Workbook reflects the composition of the eligibility and coverage policies in the state's demonstration. For more information and any questions, the state should contact the CMS section 1115 demonstration team.

Notes for Iowa Wellness Plan Demonstration

- *At CMS's request, the state of Iowa should use the eligibility and coverage monitoring tools to also report on its Dental Wellness Plan (DWP) component. Iowa should complete the "DWP planned metrics" and "DWP planned subpop" tabs using the standard instructions for the eligibility and coverage demonstration monitoring tools. CMS will provide technical specifications for the state-specific DWP metrics.*

Eligibility and Coverage (EandC)

Note: PRA Disclosure Statement to be added here

Medicaid Section 1115 Eligibility and Coverage Demonstrations Monitoring Protocol (Part A) - Planned metrics (AD) (Version 3.0)
State Iowa
Demonstration Name Iowa Wellness Plan

Table: Eligibility and Coverage Demonstration Planned Metrics - Any Demonstration (AD)

Standard information on CMS-provided metrics										Baseline, annual goals, and demonstration target			Alignment with CMS-provided technical specifications manual		Phased-in metrics reporting		
#	Metric name	Metric description	Reporting topic[a]	Data source	Calculation lag	Measurement period	Reporting frequency	Reporting priority	State will report (Y/N/n.a.)	Baseline reporting period (MM/DD/YYYY - MM/DD/YYYY)	Annual goal	Overall demonstration target	Attest that planned reporting matches the CMS-provided technical specifications manual (Y/N)	Explanation of any deviations from the CMS-provided technical specifications manual (different data sources or state-specific definitions, policies, codes, target populations, etc.), or other considerations[bc]	State plans to phase in reporting (Y/N)	EandC monitoring report in which metric will be phased in (Format DY#Q#; e.g., DY1Q3)	Explanation of any plans to phase in reporting over time
AD_38A	Medical Assistance with Smoking and Tobacco Use Cessation (MSC-AD) [NCQA; NQF #0027; Medicaid Adult Core Set; Adjusted HEDIS measure]	This metric consists of the following components; each assesses different facets of providing medical assistance with smoking and tobacco use cessation: • Advising smokers and tobacco users to quit • Discussing cessation medications • Discussing cessation strategies	1.1.8 Quality of care and health outcomes	Consumer Assessment of Healthcare Providers and Systems (CAHPS) Health Plan survey, Adult Version	90 days	Calendar year	Annually	Required (AD_38A or AD_38B. States do not have to report both.)	N								
AD_38B	Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention (rate 1) [PCPI Foundation; NQF #0028]	This metric consists of the following components: 1. Percentage of beneficiaries aged 18 years and older who were screened for tobacco use one or more times within 24 months 2. Percentage of beneficiaries aged 18 years and older who were screened for tobacco use and identified as a tobacco user who received tobacco cessation intervention 3. Percentage of beneficiaries aged 18 years and older who were screened for tobacco use one or more times within 24 months AND who received cessation intervention if identified as a tobacco user	1.1.8 Quality of care and health outcomes	Claims and encounters	90 days	Calendar year	Annually	Required (AD_38A or AD_38B. States do not have to report both.)	Y	01/01/2020 -12/31/2021	Increase	Increase	Y		N	NA	
AD_39-1	Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA-AD) [NCQA; NQF # 3488; Medicaid adult Core Set; Adjusted HEDIS measure]	Percentage of ED visits for beneficiaries age 18 and older with a principal diagnosis of alcohol or other drug (AOD) abuse or dependence who had a follow-up visit for AOD abuse or dependence. Two rates are reported: 1. Percentage of ED visits for which the beneficiary received follow-up within 30 days of the ED visit (31 total days) 2. Percentage of ED visits for which the beneficiary received follow-up within 7 days of the ED visit (8 total days)	1.1.8 Quality of care and health outcomes	Claims and encounters	90 days	Calendar year	Annually	Required	Y	01/01/2020-12/31/2020	Increase	Increase	Y		N	NA	
AD_39-2	Follow-Up After Emergency Department Visit for Mental Illness (FUM-AD) [NCQA; NQF # 3489; Medicaid adult Core Set; Adjusted HEDIS measure]	Percentage of ED visits for beneficiaries age 18 and older with a principal diagnosis of mental illness or intentional self-harm, and who had a follow-up visit for mental illness. Two rates are reported: 1. Percentage of ED visits for mental illness for which the beneficiary received follow-up within 30 days of the ED visit (31 total days). 2. Percentage of ED visits for mental illness for which the beneficiary received follow-up within 7 days of the ED visit (8 total days).	1.1.8 Quality of care and health outcomes	Claims and encounters	90 days	Calendar year	Annually	Required	Y	01/01/2020-12/31/2020	Increase	Increase	Y				
AD_40	Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET-AD) [NCQA; NQF #0004; Medicaid Adult Core Set; Adjusted HEDIS measure]	Percentage of beneficiaries age 18 and older with a new episode of AOD abuse or dependence who received the following: 1. Initiation of AOD Treatment. Percentage of beneficiaries who initiate treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization, telehealth, or medication assisted treatment (MAT) within 14 days of the diagnosis 2. Engagement of AOD Treatment. Percentage of beneficiaries who initiate treatment and who were engaged in ongoing AOD treatment within 34 days of the initiation visit The following diagnosis cohorts are reported for each rate: (1) Alcohol abuse or dependence, (2) Opioid abuse or dependence, (3) Other drug abuse or dependence, and (4) Total AOD abuse or dependence. A total of 8 separate rates are reported for this measure.	1.1.8 Quality of care and health outcomes	Claims and encounters or EHR	90 days	Calendar year	Annually	Required	Y	01/01/2020-12/31/2020	Increase	Increase	N	The chemical dependency benefit requirement will be excluded from the continuous enrollment criteria. Multiple engagement visits on the same day will not be allowed. Only paid claims are utilized. The process defines the intake period as beginning of the measurement year through 47 days prior to the end of the measurement year. HEDIS states to use the new General Guideline 44 to determine if the ED visit or Observation visit results in an admission. Due to technical constraint and lack of admission details we cannot determine the exact discharge date of the admission. Our logic identifies if the ED Visit or Observation visit is one day prior to the date of the admission to determine if the visit resulted in an inpatient stay. When the initiation event started as an inpatient admission, the engagement events starts the day after discharge. We don't have the full admission event which prevents us identifying the date of discharge; logic will use the last date of service on the claim for the inpatient stay instead of discharge date.	N	NA	
AD_41	PQI 01: Diabetes Short-Term Complications Admission Rate (PQI01-AD) [AHRQ; NQF #0272; Medicaid Adult Core Set]	Number of inpatient hospital admissions for diabetes short-term complications (ketoacidosis, hyperosmolarity, or coma) per 100,000 beneficiary months for beneficiaries age 18 and older.	1.1.8 Quality of care and health outcomes	Claims and encounters	90 days	Calendar year	Annually	Required	Y	01/01/2020-12/31/2020	Decrease	Decrease	N	For Obstetric admissions exclusions, will not use MDC Code Admit = 14, and instead use the following Value Sets: Pregnancy. For transfer exclusions, will not use SID A Source = 2,3, will instead add E&F to Point of Origin codes.	N	NA	
AD_42	PQI 05: Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults Admission Rate (PQI05-AD) [AHRQ; NQF #0275; Medicaid Adult Core Set]	Number of inpatient hospital admissions for chronic obstructive pulmonary disease (COPD) or asthma per 100,000 beneficiary months for beneficiaries age 40 and older.	1.1.8 Quality of care and health outcomes	Claims and encounters	90 days	Calendar year	Annually	Required	Y	01/01/2020-12/31/2020	Decrease	Decrease	N	For Obstetric admissions exclusions, will not use MDC Code Admit = 14, and instead use the following Value Sets: Pregnancy. For transfer exclusions, will not use SID A Source = 2,3, will instead add E&F to Point of Origin codes.	N	NA	
AD_43	PQI 08: Heart Failure Admission Rate (PQI08-AD) [AHRQ; NQF #0277; Medicaid Adult Core Set]	Number of inpatient hospital admissions for heart failure per 100,000 beneficiary months for beneficiaries age 18 and older.	1.1.8 Quality of care and health outcomes	Claims and encounters	90 days	Calendar year	Annually	Required	Y	01/01/2020-12/31/2020	Decrease	Decrease	N	For Obstetric admissions exclusions, will not use MDC Code Admit = 14, and instead use the following Value Sets: Pregnancy. For transfer exclusions, will not use SID A Source = 2,3, will instead add E&F to Point of Origin codes.	N	NA	
AD_44	PQI 15: Asthma in Younger Adults Admission Rate (PQI15-AD) [AHRQ; NQF #0283; Medicaid Adult Core Set]	Number of inpatient hospital admissions for asthma per 100,000 beneficiary months for beneficiaries aged 18 to 39.	1.1.8 Quality of care and health outcomes	Claims and encounters	90 days	Calendar year	Annually	Required	Y	01/01/2020-12/31/2020	Decrease	Decrease	N	For Obstetric admissions exclusions, will not use MDC Code Admit = 14, and instead use the following Value Sets: Pregnancy. For transfer exclusions, will not use SID A Source = 2,3, will instead add E&F to Point of Origin codes.	N	NA	
AD_45	Administrative cost of demonstration operation	Cost of contracts or contract amendments and staff time equivalents required to administer demonstration policies, including premium collection, healthy behavior incentives, premium assistance, and/or retroactive eligibility waivers.	1.1.9 Administrative cost	Administrative records	None	Demonstration year	Annually	Recommended	N								

Medicaid Section 1115 Eligibility and Coverage Demonstrations Monitoring Protocol (Part A) - Planned metrics (PR) (Version 3.0)

State: Iowa
Demonstration Name: Iowa Wellness Plan

Table: Eligibility and Coverage Demonstration Planned Metrics - Premiums and Account Payments (PR)

Standard information on CMS-provided metrics										Baseline, annual goals, and demonstration target			Alignment with CMS-provided technical specifications manual		Phased-in metrics reporting		
#	Metric name	Metric description	Reporting topic[a]	Data source	Calculation lag	Measurement period	Reporting frequency	Reporting priority	State will report (Y/N/n.a.)	Baseline reporting period (MM/DD/YYYY - MM/DD/YYYY)	Annual goal	Overall demonstration target	Attest that planned reporting matches the CMS-provided technical specifications manual (Y/N)	Explanation of any deviations from the CMS-provided technical specifications manual (different data sources or state-specific definitions, policies, codes, target populations, etc.), or other considerations[b][c]	State plans to phase in reporting (Y/N)	EandC monitoring report in which metric will be phased in (Format DY1Q#; e.g., DY1Q3)	Explanation of any plans to phase in reporting over time
EXAMPLE: PR_21 ***(Do not delete or edit this row)***	*EXAMPLE: Third-party premium payment*	*EXAMPLE: Number of beneficiaries enrolled in the demonstration who had any portion of their premium or other monthly payments paid by a third party.*	*EXAMPLE: PR.Mod_1: Eligibility and payment amounts*	*EXAMPLE: Administrative records*	*EXAMPLE: 30 days*	*EXAMPLE: Month*	*EXAMPLE: Quarterly*	*EXAMPLE: Required*	*EXAMPLE: Y*	*EXAMPLE: 01/01/2020 - 01/31/2020*	*EXAMPLE: Consistent*	*EXAMPLE: Consistent*	*EXAMPLE: Y*	*EXAMPLE:*	*EXAMPLE: N*	*EXAMPLE:*	*EXAMPLE:*
PR_1	Beneficiaries subject to premium policy (or account contribution) during the month, not exempt	The number of beneficiaries enrolled in the demonstration whose income and eligibility group were subject to the premium policy (or account contribution policy), regardless of whether they paid or did not pay during the measurement period.	PR.Mod_1: Eligibility and payment amounts	Administrative records	30 days	Month	Quarterly	Required	Y	01/01/2020-12/31/2020	Consistent	Consistent	Y		N	NA	
PR_2	Beneficiaries who were exempt from premiums for that month	Among beneficiaries enrolled in the demonstration who were subject to the premium (or account contribution) policy on the basis of income or eligibility group, the count of those exempt from owing premiums or other monthly payments, and therefore not required to make payments. For example, demonstration policies may exempt beneficiaries who would otherwise be subject to premiums as incentives for healthy behaviors or other activities.	PR.Mod_1: Eligibility and payment amounts	Administrative records	30 days	Month	Quarterly	Required	Y	01/01/2020-12/31/2020	Consistent	Consistent	Y		N	NA	
PR_3	Beneficiaries who paid a premium during the month	Among beneficiaries enrolled in the demonstration whose income and eligibility group were subject to the premium (or account contribution) policy, number of beneficiaries who paid this month.	PR.Mod_1: Eligibility and payment amounts	Administrative records	30 days	Month	Quarterly	Required	Y	01/01/2020-12/31/2020	Increase	Increase	Y		N	NA	
PR_4	Beneficiaries who were subject to premium policy but declare hardship for that month	Among beneficiaries enrolled in the demonstration whose income and eligibility group were subject to the premium (or account contribution) policy, number of beneficiaries who were able to claim temporary hardship and were therefore not required to make a payment in the measurement period.	PR.Mod_1: Eligibility and payment amounts	Administrative records	30 days	Month	Quarterly	Required if the state allows beneficiaries to avoid paying premiums or other monthly payments by claiming temporary hardship	Y	01/01/2020-12/31/2020	Consistent	Consistent	Y		N	NA	
PR_5	Beneficiaries in short-term arrears (grace period)	Among beneficiaries enrolled in the demonstration whose income and eligibility group were subject to the premium (or account contribution) policy, the number of those who did not pay in the measurement period, but had not yet exceeded their grace period (i.e., allowable period of noncompliance).	PR.Mod_5: Operationalize strategies for noncompliance	Administrative records	30 days	Month	Quarterly	Required if the state has a grace period	Y	01/01/2020-12/31/2020	Decrease	Decrease	Y		N	NA	
PR_6	Beneficiaries in long-term arrears	Among beneficiaries enrolled in the demonstration whose income and eligibility group were subject to the premium (or account contribution) policy, number of beneficiaries who did not pay this month, and who remain enrolled even though they had exceeded the grace period, i.e., allowable period of noncompliance.	PR.Mod_5: Operationalize strategies for noncompliance	Administrative records	30 days	Month	Quarterly	Required if the state has a grace period and allows continued enrollment for any income and eligibility groups otherwise subject to premiums once the grace period has been exceeded	N								
PR_7	Beneficiaries with collectible debt	Among beneficiaries enrolled in the demonstration whose income and eligibility group were subject to the premium policy (or account contribution policy), number of beneficiaries who had collectible debt.	PR.Mod_5: Operationalize strategies for noncompliance	Administrative records	30 days	Month	Quarterly	Required	Y	01/01/2020-12/31/2020	Decrease	Decrease	N	Iowa will collect this information at the time of application. However, the metric counts cannot be captured after initial enrollment because when the case numbers/ledger keys are in Subject to Recovery status, then there is no way to determine if they had paid the debt or still owe it. They might have paid it in collections or it could have been cancelled after being set to subject to recovery.			
PR_8	Beneficiaries in enrollment duration tier 1	Number of beneficiaries enrolled in the demonstration and subject to premium policies whose cumulative length of enrollment fell in tier 1 – the shortest enrollment duration, during which beneficiaries are subject to the first set of program rules and requirements. Tiers are defined in terms of enrollment periods that are distinguished by different premium or copayment liabilities.	PR.Mod_1: Eligibility and payment amounts	Administrative records	30 days	Month	Quarterly	Recommended if the state has time-variant premium policies	N								
PR_9	Beneficiaries in enrollment duration tier 2	Number of beneficiaries enrolled in the demonstration and subject to premium policies whose cumulative length of enrollment fell in tier 2 – the enrollment duration that follows tier 1, during which beneficiaries are subject to the set of program rules and requirements in effect after exceeding the enrollment duration for tier 1. Tiers are defined in terms of enrollment periods that are distinguished by different premium or copayment liabilities.	PR.Mod_1: Eligibility and payment amounts	Administrative records	30 days	Month	Quarterly	Recommended if the state has time-variant premium policies	N								
PR_10	Beneficiaries in enrollment duration tiers 3+	Number of beneficiaries enrolled in the demonstration and subject to premium policies whose cumulative length of enrollment fell in tier 3 – the enrollment duration that follows tier 2, during which beneficiaries are subject to the set of program rules and requirements in effect after exceeding the enrollment duration for tier 2. Tiers are defined in terms of enrollment periods that are distinguished by different premium or copayment liabilities. A state with more than three tiers of program rules should calculate additional metrics to report enrollment counts for current enrollees within each additional tier.	PR.Mod_1: Eligibility and payment amounts	Administrative records	30 days	Month	Quarterly	Recommended if the state has time-variant premium policies	N								
PR_11	Beneficiaries for whom the state processed a mid-year change in circumstance in household or income information and who remained enrolled in the demonstration	Among beneficiaries enrolled in the demonstration who were not in their renewal month, number of beneficiaries for whom the state processed a change in household size or income during the measurement period and who remained enrolled in the demonstration.	PR.Mod_1: Eligibility and payment amounts	Administrative records	30 days	Month	Quarterly	Recommended	N								
PR_12	No premium change following mid-year processing of a change in household or income information	Among beneficiaries enrolled in the demonstration who experienced a change in household size or income during the month (not their renewal month) and remained enrolled in the demonstration as of the last day of the measurement period, the number whose premium obligations or other monthly payments did not change.	PR.Mod_1: Eligibility and payment amounts	Administrative records	30 days	Month	Quarterly	Recommended	N								
PR_13	Premium increase following mid-year processing of change in household or income information	Among beneficiaries enrolled in the demonstration who experienced a change in household size or income during the month (not their renewal month) and remained enrolled in the demonstration as of the last day of the measurement period, the number whose premium obligations or other monthly payments increased.	PR.Mod_1: Eligibility and payment amounts	Administrative records	30 days	Month	Quarterly	Recommended	N								
PR_14	Premium decrease following mid-year processing of change in household or income information	Among beneficiaries enrolled in the demonstration who experienced a change in household size or income during the month (not their renewal month) and remained enrolled in the demonstration as of the last day of the measurement period, the number whose premium obligations or other monthly payments decreased.	PR.Mod_1: Eligibility and payment amounts	Administrative records	30 days	Month	Quarterly	Recommended	N								
PR_15	Beneficiaries disenrolled from the demonstration for failure to pay and therefore disenrolled from Medicaid	Number of demonstration beneficiaries disenrolled from Medicaid as of the last day of the measurement period for failure to pay premiums.	PR.Mod_5: Operationalize strategies for noncompliance	Administrative records	30 days	Month	Quarterly	Required if the state has premiums or monthly payment with a policy of termination for failure to pay	Y	01/01/2020- 12/31/2020	Increase	Increase	Y		N	NA	
PR_16	Beneficiaries in a non-eligibility period who were disenrolled for failure to pay and are prevented from re-enrolling for a defined period of time	The number of prior demonstration beneficiaries who were disenrolled from Medicaid for failure to pay premiums and are in a non-eligibility period, meaning they are prevented from re-enrolling for some defined period of time, including those prevented from re-enrolling until their redetermination date.	PR.Mod_5: Operationalize strategies for noncompliance	Administrative records	30 days	Month	Quarterly	Required if the state has a non-eligibility period policy	N								
PR_17	Beneficiaries whose benefits are suspended for failure to pay	Number of demonstration beneficiaries whose benefits were suspended during the measurement period for failure to pay premiums.	PR.Mod_5: Operationalize strategies for noncompliance	Administrative records	30 days	Month	Quarterly	Required if the state has premiums or monthly payment with a policy of suspending benefits (without disenrollment) for failure to pay	N								
PR_18	No premium change	Number of beneficiaries enrolled in the demonstration due for renewal during the measurement period who are redetermined as eligible for the demonstration and remain in income and eligibility groups subject to premiums, with no change in premiums or other monthly payments.	PR.Mod_1: Eligibility and payment amounts	Administrative records	30 days	Month	Quarterly	Recommended	N								
PR_19	Premium increase	Number of beneficiaries enrolled in the demonstration due for renewal during the measurement period who were redetermined as eligible for the demonstration and remain in income and eligibility groups subject to premiums, with an increase in required premiums or other monthly payments.	PR.Mod_1: Eligibility and payment amounts	Administrative records	30 days	Month	Quarterly	Recommended	N								
PR_20	Premium decrease	Number of beneficiaries enrolled in the demonstration due for renewal during the measurement period who were redetermined as eligible for the demonstration and remained in income and eligibility groups subject to the demonstration, with a decrease in required premiums or other monthly payments.	PR.Mod_1: Eligibility and payment amounts	Administrative records	30 days	Month	Quarterly	Recommended	N								
PR_21	Third-party premium payment	Number of beneficiaries enrolled in the demonstration who had any portion of their premium or other monthly payments paid by a third party.	PR.Mod_1: Eligibility and payment amounts	Administrative records	30 days	Month	Quarterly	Required	N								
State-specific metrics																	
PR_S1_IA	Beneficiaries who transitioned to basic dental benefits for failure to pay dental premiums	The number of beneficiaries subject to Dental Wellness Plan premiums who transitioned from the full to basic dental benefit package during the measurement period for failure to pay dental premiums.	PR.Mod_5: Operationalize strategies for noncompliance	Administrative records	30 days	Month	Quarterly	Reqquired	Y	01/01/2020 - 12/31/2020	Decrease	Decrease	Y		N	NA	

[a] The reporting topics correspond to the premiums or account payments (PR) reporting topics in Section 3 of the monitoring report template.

[b] If the state is not reporting a required metric (i.e., column J = "N"), enter explanation in corresponding row in column O.

[c] The state should use column O to outline calculation methods for specific metrics as explained in Version 3.0 of the Medicaid Section 1115 Eligibility and Coverage Demonstrations Monitoring Protocol Instructions.

Medicaid Section 1115 Eligibility and Coverage Demonstrations Monitoring Protocol (Part A) - Planned metrics (HB) (Version 3.0)

State: Iowa
Demonstration Name: Iowa Wellness Plan

Table: Eligibility and Coverage Demonstration Planned Metrics - Healthy Behavior Incentives (HB)

Standard information on CMS-provided metrics										Baseline, annual goals, and demonstration target			Alignment with CMS-provided technical specifications manual		Phased-in metrics reporting		
#	Metric name	Metric description	Reporting topic[a]	Data source	Calculation lag	Measurement period	Reporting frequency	Reporting priority	State will report (Y/N/n.a.)	Baseline reporting period (MM/DD/YYYY - MM/DD/YYYY)	Annual goal	Overall demonstration target	Attest that planned reporting matches the CMS-provided technical specifications manual (Y/N)	Explanation of any deviations from the CMS-provided technical specifications manual or other considerations (different data sources or state-specific definitions, policies, codes, target populations, etc.)[b,c]	State plans to phase in reporting (Y/N)	EandC monitoring report in which metric will be phased in (Format DYQQ; e.g., DY1Q3)	Explanation of any plans to phase in reporting over time
EXAMPLE: HB_7 ***(Do not delete or edit this row)***	*EXAMPLE: Beneficiaries granted a reward in the form of additional covered benefits for completion of incentivized healthy behaviors*	*EXAMPLE: Number of beneficiaries enrolled in the demonstration who were flagged for or granted a reward that takes the form of an additional covered benefit or service, by benefit or service type, during the measurement period.*	*EXAMPLE: HB.Mod_1: Healthy behavior incentives*	*EXAMPLE: Administrative records*	*EXAMPLE: 90 days*	*EXAMPLE: Quarter*	*EXAMPLE: Quarterly*	*EXAMPLE: Required*	*EXAMPLE: Y*	*EXAMPLE: 10/01/2019 - 01/01/2020*	*EXAMPLE: Increase*	*EXAMPLE: Increase*	*EXAMPLE: Y*	*EXAMPLE:*	*EXAMPLE: N*	*EXAMPLE:*	*EXAMPLE:*
HB_1	Total enrollment among beneficiaries subject to Healthy behavior incentives	Number of beneficiaries subject to healthy behavior incentive policies who were enrolled in the demonstration at any time during the measurement period.	HB.Mod_1: Healthy behavior incentives	Administrative records	90 days	Quarter	Quarterly	Required	Y	01/01/2020 - 12/31/2020	Increase	Increase	Y		N	NA	
HB_2	Beneficiaries using incentivized services that can be documented through claims, by service	Total number of beneficiaries enrolled in the demonstration at any point during the measurement period who utilized financially incentivized services that can be documented through claims since the beginning of their enrollment spell.	HB.Mod_1: Healthy behavior incentives	Administrative records, claims and encounters	90 days	Quarter	Quarterly	Required	Y	01/01/2020 - 12/31/2020	Increase	Increase	Y		Y	Unknown at this time due to the Public Health Emergency	We are working with CMS to determine implementation after the Public Health Emergency for all Medicaid and IWP members.
HB_3	Completion of incentivized healthy behavior(s) not documented through claims analysis (i.e. health risk assessments), by healthy behavior	Number of beneficiaries enrolled in the demonstration at any point during the measurement period who have completed each incentivized healthy behavior not documented through claims analysis (i.e. health risk assessments) since the beginning of their enrollment spell.	HB.Mod_1: Healthy behavior incentives	Administrative records	90 days	Quarter	Quarterly	Required	Y	01/01/2020-12/21/2020	Increase	Increase	Y		N	NA	
HB_4	Completion of all incentivized healthy behaviors (both claims-based and other), if there are multiple	Number of beneficiaries enrolled in the demonstration at any point during the measurement period who have completed all incentivized healthy behaviors (including incentivized services documented through claims and other healthy behaviors not documented through claims) since the beginning of their enrollment spell.	HB.Mod_1: Healthy behavior incentives	Administrative records, claims and encounters	90 days	Quarter	Quarterly	Required	Y	01/01/2020 - 12/31/2020	Increase	Increase	Y		N	NA	
HB_5	Beneficiaries granted a premium reduction for completion of incentivized healthy behaviors	Number of beneficiaries enrolled in the demonstration who were flagged for or granted a reward related to premium obligations during the measurement period, regardless of whether the premium reduction occurs during the measurement period or in the future.	HB.Mod_1: Healthy behavior incentives	Administrative records	90 days	Quarter	Quarterly	Required if the state provides rewards for health incentives in the form of premium reductions	N								
HB_6	Beneficiaries granted a financial reward other than a premium reduction for completion of incentivized healthy behaviors	Number of beneficiaries enrolled in the demonstration who were flagged for or granted a reward other than a premium reduction during the measurement period, regardless of when the reward is realized.	HB.Mod_1: Healthy behavior incentives	Administrative records	90 days	Quarter	Quarterly	Required if the state provides financial rewards for health incentives other than in the form of premium reductions	N								
HB_7	Beneficiaries granted a reward in the form of additional covered benefits for completion of incentivized healthy behaviors	Number of beneficiaries enrolled in the demonstration who were flagged for or granted a reward that takes the form of an additional covered benefit or service, by benefit or service type, during the measurement period.	HB.Mod_1: Healthy behavior incentives	Administrative records	90 days	Quarter	Quarterly	Required if the state provides rewards for health incentives in the form of additional covered benefits or services	N								
State-specific metrics																	
[Insert row(s) for any additional state-specific metrics by right-clicking on row 18 and selecting "Insert"]																	

[a] The reporting topic corresponds to the healthy behavior incentives (HB) reporting topic in Section 3 of the monitoring report template.

[b] If the state is not reporting a required metric (i.e., column J = "N"), enter explanation in corresponding row in column O.

[c] The state should use column O to outline calculation methods for specific metrics as explained in Version 3.0 of the Medicaid Section 1115 Eligibility and Coverage Demonstrations Monitoring Protocol Instructions.

Medicaid Section 1115 Eligibility and Coverage Demonstrations Monitoring Protocol (Part A) - Planned metrics (RW) (Version 3.0)

State: Iowa
Demonstration Name: Iowa Wellness Plan

Table: Eligibility and Coverage Demonstration Planned Metrics - Retroactive Eligibility Waiver (RW)

Standard information on CMS-provided metrics										Baseline, annual goals, and demonstration target			Alignment with CMS-provided technical specifications manual		Phased-in metrics reporting		
#	Metric name	Metric description	Reporting topic[a]	Data source	Calculation lag	Measurement period	Reporting frequency	Reporting priority	State will report (Y/N/n.a.)	Baseline reporting period (MM/DD/YYYY - MM/DD/YYYY)	Annual goal	Overall demonstration target	Attest that planned reporting matches the CMS-provided technical specifications manual (Y/N)	Explanation of any deviations from the CMS-provided technical specifications manual (different data sources or state-specific definitions, policies, codes, target populations, etc.), or other considerations[b][c]	State plans to phase in reporting (Y/N)	EandC monitoring report in which metric will be phased in (Format DY1Q#; e.g., DY1Q3)	Explanation of any plans to phase in reporting over time
EXAMPLE: RW_1 ***(Do not delete or edit this row)***	*EXAMPLE: Beneficiaries who indicated that they had unpaid medical bills at the time of application*	*EXAMPLE: The number of demonstration beneficiaries in income and eligibility groups that were subject to the waiver of retroactive eligibility policy, who began a new enrollment period in the reporting month, and who indicated at the time of application for Medicaid that they had unpaid medical bills from the past three months or other time period specified in the state's Medicaid application question.*	*EXAMPLE: RW.Mod_1: Retroactive eligibility and demonstration requirements*	*EXAMPLE: Administrative records*	*EXAMPLE: 30 days*	*EXAMPLE: Month*	*EXAMPLE: Quarterly*	*EXAMPLE: Required*	*EXAMPLE: Y*	*EXAMPLE: 01/01/2020 - 01/31/2020*	*EXAMPLE: Consistent*	*EXAMPLE: Consistent*	*EXAMPLE: Y*	*EXAMPLE:*	*EXAMPLE: N*	*EXAMPLE:*	*EXAMPLE:*
RW_1	Beneficiaries who indicated that they had unpaid medical bills at the time of application	The number of demonstration beneficiaries in income and eligibility groups that were subject to the waiver of retroactive eligibility policy, who began a new enrollment period in the reporting month, and who indicated at the time of application for Medicaid that they had unpaid medical bills from the past three months or other time period specified in the state's Medicaid application question.	RW.Mod_1: Retroactive eligibility and demonstration requirements	Administrative records	30 days	Month	Quarterly	Required	Y	01/01/2020-12/31/2020	Consistent	Consistent	Y		N	NA	
RW_2	Beneficiaries who had a coverage gap at renewal	The number of demonstration beneficiaries in income and eligibility groups that were subject to the waiver of retroactive eligibility policy who re-enrolled in the demonstration within 90 days after a previous enrollment spell in the demonstration ended because the beneficiary did not comply with renewal processes on time.	RW.Mod_1: Retroactive eligibility and demonstration requirements	Administrative records	90 days	Quarter	Quarterly	Required	N								
RW_3	Beneficiaries who had a coverage gap at renewal and had claims denied	The number of demonstration beneficiaries in income and eligibility groups that were subject to the waiver of retroactive eligibility policy who re-enrolled in the demonstration within 90 days after a previous enrollment spell in the demonstration ended, and for whom claims were submitted for services rendered during the period of disenrollment that were denied by the state.	RW.Mod_1: Retroactive eligibility and demonstration requirements	Administrative records	90 days	Quarter	Quarterly	Required	N								
State-specific metrics																	
[Insert row(s) for any additional state-specific metrics by right-clicking on row 14 and selecting "Insert"]																	

[a] The reporting topic corresponds to the retroactive eligibility waiver (RW) reporting topic in Section 3 of the monitoring report template.

[b] If the state is not reporting a required metric (i.e., column J = "N"), enter explanation in corresponding row in column O.

[c] The state should use column O to outline calculation methods for specific metrics as explained in Version 3.0 of the Medicaid Section 1115 Eligibility and Coverage Demonstrations Monitoring Protocol Instructions.

Medicaid Section 1115 Eligibility and Coverage Demonstration Monitoring Protocol - Planned metrics (DWP) (Version 3.0)
State Iowa
Demonstration Name Iowa Wellness Plan

Table: Eligibility and Coverage Demonstration Planned Metrics - Dental Wellness Plan (DWP)

Standard information on CMS-provided metrics										Baseline, annual goals, and demonstration target			Alignment with CMS-provided technical specifications manual		Phased-in metrics reporting		
#	Metric name	Metric description	Reporting topic[a]	Data source	Calculation lag	Measurement period	Reporting frequency	Reporting priority	State will report (Y/N/n.a.)	Baseline reporting period (MM/DD/YYYY - MM/DD/YYYY)	Annual goal	Overall demonstration target	Attest that planned reporting matches the CMS-provided technical specifications manual (Y/N)	Explanation of any deviations from the CMS-provided technical specifications manual (different data sources or state-specific definitions, policies, codes, target populations, etc.)	State plans to phase in reporting (Y/N)	Report in which metric will be phased in (EandC DY and Q; Format: DY1Q3)	Explanation of any plans to phase in reporting over time
EXAMPLE: AD_33 ***(Do not delete or edit this row)***	*EXAMPLE: Preventive care and office visit utilization*	*EXAMPLE: Total utilization of preventive care and office visits per 1,000 demonstration beneficiary months during the measurement period*	*EXAMPLE: 1.1.7 Access to care*	*EXAMPLE: Claims and encounters and other administrative records*	*EXAMPLE: 90 days*	*EXAMPLE: Quarter*	*EXAMPLE: Quarterly*	*EXAMPLE: Recommended*	*EXAMPLE: Y*	*EXAMPLE: 10/01/2019 - 01/01/2020*	*EXAMPLE: Increase*	*EXAMPLE: Increase*	*EXAMPLE: Y*	*EXAMPLE:*	*EXAMPLE: N*	*EXAMPLE: DY1Q4*	*EXAMPLE:*
State-specific DWP metrics[b]																	
IA_DWP_1	EDV-CH-A: Ambulatory Care Sensitive Emergency Department Visits for Dental Caries in Children	Number of emergency department visits for caries-related reasons per 100,000 member months for children	1.1.8 Quality of care and health outcomes	Administrative records; claims and encounters	90 days	Calendar year	Annually	Required	Y								
IA_DWP_2	IDQA: NQF #2689] EDF-CH-A: Follow-Up after Emergency Department Visits for Dental Caries in Children	The percentage of caries-related emergency department visits among children 0 through 20 years in the reporting period for which the member visited a dentist within (a) 7 days and (b) 30 days of the ED visit	1.1.8 Quality of care and health outcomes	Administrative records; claims and encounters	90 days	Calendar year	Annually	Recommended	N								
IA_DWP_3	IDQA: NQF #2695] OEV-CH-A: Oral Evaluation, Dental Services	Percentage of enrolled children under age 21 who received a comprehensive or periodic oral evaluation within the reporting year	1.1.8 Quality of care and health outcomes	Administrative records; claims and encounters	90 days	Calendar year	Annually	Required	Y								
IA_DWP_4	IDQA: NQF #2517] TFL-CH-A: Prevention: Topical Fluoride for Children at Elevated Caries Risk, Dental Services	Percentage of children aged 1–21 years who are at "elevated" risk (i.e. "moderate" or "high") who received at least 2 topical fluoride applications within the reporting year	1.1.8 Quality of care and health outcomes	Administrative records; claims and encounters	90 days	Calendar year	Annually	Required	Y								
IA_DWP_5	IDQA: NQF #2528] SFM-A-A: Prevention: Sealant Receipt on Permanent 1st Molars	Percentage of enrolled children, who have ever received sealants on permanent first molar teeth: (1) at least one sealant and (2) all four molars sealed by the 10th birthdate	1.1.8 Quality of care and health outcomes	Administrative records; claims and encounters	90 days	Calendar year	Annually	Required	Y								
IA_DWP_6	Appeals, denial of benefits	Number of appeals filed by beneficiaries enrolled in the demonstration during the measurement period regarding denial of benefits	1.1.6 Appeals and grievances	Administrative records	None	Quarter	Quarterly	Required	Y				N	This metric is an adaptation of AD_25. It should include DWP related appeals.			
IA_DWP_7	Grievances, care quality	Number of grievances filed by beneficiaries enrolled in the demonstration during the measurement period regarding the quality of care or services provided	1.1.6 Appeals and grievances	Administrative records	None	Quarter	Quarterly	Required	Y				N	This metric is an adaptation of AD_26. It should include DWP related grievances.			
IA_DWP_8	Grievances, provider or managed care entities	Number of grievances filed by beneficiaries enrolled in the demonstration during the measurement period regarding a provider or managed care entity. Managed care entities include Managed Care Organizations (MCO), Prepaid Inpatient Health Plans (PIHP), and Prepaid Ambulatory Health Plans (PAHP).	1.1.6 Appeals and grievances	Administrative records	None	Quarter	Quarterly	Required	Y				N	This metric is an adaptation of AD_27. It should include DWP related grievances.			
IA_DWP_9	Primary care provider availability	Number of primary care providers enrolled to deliver Medicaid services to members <age 21 at the end of the measurement period	1.1.7 Access to care	Provider enrollment databases	90 days	Quarter	Quarterly	Required	Y				N	This metric is an adaptation of AD_29. It should include the number of general dentists and pediatric dentists.			
IA_DWP_10	Primary care provider active participation	Number of primary care providers enrolled to deliver Medicaid services with service to members <age 21 claims for 3 or more demonstration beneficiaries during the measurement period	1.1.7 Access to care	Provider enrollment databases and claims and encounters	90 days	Quarter	Quarterly	Required	Y				N	This metric is an adaptation of AD_30. It should include the number of general dentists and pediatric dentists.			
IA_DWP_11	Specialist provider availability	Number of specialists enrolled to deliver Medicaid services to members <age 21 at the end of the measurement period	1.1.7 Access to care	Provider enrollment databases	90 days	Quarter	Quarterly	Required	Y				N	This metric is an adaptation of AD_31. It should include orthodontists and oral/maxillofacial surgeons providing services to DWP children.			
IA_DWP_12	Specialist provider active participation	Number of specialists enrolled to deliver Medicaid services to members <age 21 with service claims for 3 or more demonstration beneficiaries during the measurement period	1.1.7 Access to care	Provider enrollment databases and claims and encounters	90 days	Quarter	Quarterly	Required	Y				N	This metric is an adaptation of AD_32. It should include orthodontists and oral/maxillofacial surgeons providing services to DWP children.			

[a] The reporting topics correspond to the prompts for the any demonstration (AD) reporting topic in Section 4 of the monitoring report template.
[b] These metrics are not in the technical specifications manual, instead they are special metrics for which details have been agreed upon by CMS. Please follow general instructions for protocol completion.
End of workbook

Medicaid Section 1115 Eligibility and Coverage Demonstrations Monitoring Protocol (Part A) - Planned subpopulations (AD) (Version 3.0)

State Iowa

Demonstration Name Iowa Wellness Plan

Table: Eligibility and Coverage Demonstration Planned Subpopulations - Any Demonstration (AD)

Planned subpopulation reporting						Alignment with CMS-provided technical specifications manual			
						Subpopulations		Relevant metrics	
Subpopulation category[a]	Subpopulations	Reporting priority	Relevant metrics	Subpopulation type	State will report (Y/N)	Attest that planned subpopulation reporting within each category matches the description in the CMS-provided technical specifications manual (Y/N)	For state-specific subpopulation categories, or if the planned reporting of subpopulations does not match (i.e., column G = "N"), list the subpopulations state plans to report (Format comma separated)[b,c]	Attest that metrics reporting for subpopulation category matches CMS-provided technical specifications manual (Y/N)	If the planned reporting of relevant metrics does not match (i.e., column I = "N"), list the metrics for which state plans to report for each subpopulation category (Format metric number, comma separated)
EXAMPLE: *Income groups* ***(Do not delete or edit this row)***	*EXAMPLE:* *Less than 50% of the federal poverty level (FPL), 50-100% FPL, and greater than 100% FPL*	*EXAMPLE:* *Recommended*	*EXAMPLE:* *AD_1 - AD_23, AD_33 - AD_44*	*EXAMPLE:* *CMS-provided*	*EXAMPLE:* *Y*	*EXAMPLE:* *Y*	*EXAMPLE:*	*EXAMPLE:* *Y*	*EXAMPLE:*
Income groups	Less than 50% of the federal poverty level (FPL), 50-100% FPL, and greater than 100% FPL	Recommended	AD_1 - AD_23, AD_33 - AD_44	CMS-provided	Y	N	At or below 50% of the federal poverty level (FPL), 51-100% FPL, 101-133% FPL, and greater than 133% FPL	Y	
Specific demographic groups	Age (less than 19, 19-26, 27-35, 36-45, 46-55, or 56-64), sex (male or female), race (White, Black or African American, Asian, American Indian or Alaskan Native, other, or unknown), and ethnicity (Hispanic, non-Hispanic, or unknown)	Recommended	AD_1 - AD_11, AD_15 - AD_23, AD_33 - AD_37	CMS-provided	Y	Y		Y	
Exempt groups	Eligibility and income groups that are enrolled in the demonstration but are not required to participate in elements of the demonstration (such as paying premiums) for reasons other than income *EXAMPLE:* *Geographic exemptions, employer sponsored insurance exemptions, exemptions due to medical frailty*	Recommended	AD_1 - AD_11, AD_15 - AD_23, AD_33 - AD_37	State-specific	N				
Specific eligibility groups	Medicaid eligibility groups included in the state's demonstration based on the STCs authorizing the demonstration *EXAMPLE:* *Section 1931 parents, the new adult group, transitional medical assistance beneficiaries*	Required	AD_1 - AD_11, AD_15 - AD_23, AD_33 - AD_44	State-specific	Y		FPL 51 to 100%, FPL 101-133% for IWP, MAGI adult and Non-MAGI adult for Dental Wellness Plan	N	Specific elgibility groups include MAGI and Non-MAGI populations. MAGI populations are new adult group, parents and other caretaker relatives, Tansitional Medical Assistance, Pregnant women, former fost care children up to age 26, breast and cervical cancer treatment program. Non-Magi groups are: Mandatory aged, blind & disabled individuals, optional eligiblity who meet income & resource of case assistance programs, optional eligibility for individuals who would be eligible for cas assistance if they were not in Medical instituions, institutionalized individuals, Medicaid for Employed people, 1915(c) HCBS, physical disability, Health and Disability waiver, elderly waiver, intellectual disability waiver, ADIS waiver, brain injury waiver

[a] For definitions of subpopulations, see CMS-provided technical specifications on subpopulation categories.

[b] If the state is not reporting a required subpopulation category (i.e., column F = "N"), enter explanation in corresponding row in column H.

[c] If the state is planning to phase in the reporting of any of the subpopulation categories, the state should provide an explanation and the report (DY and Q) in which it will begin reporting the subpopulation category in column H.

Medicaid Section 1115 Eligibility and Coverage Demonstrations Monitoring Protocol (Part A) - Planned subpopulations (PR) (Version 3.0)

State Iowa
Demonstration Name Iowa Wellness Plan

Table: Eligibility and Coverage Demonstration Planned Subpopulations - Premiums and Account Payments (PR)

Planned subpopulation reporting						Alignment with CMS-provided technical specifications manual			
						Subpopulations		Relevant metrics	
Subpopulation category[a]	Subpopulations	Reporting priority	Relevant metrics	Subpopulation type	State will report (Y/N)	Attest that planned subpopulation reporting within each category matches the description in the CMS-provided technical specifications manual (Y/N)	For state-specific subpopulation categories, or if the planned reporting of subpopulations does not match (i.e., column G = "N"), list the subpopulations state plans to report (Format comma separated)[b,c]	Attest that metrics reporting for subpopulation category matches CMS-provided technical specifications manual (Y/N)	If the planned reporting of relevant metrics does not match (i.e., column I = "N"), list the metrics for which state plans to report for each subpopulation category (Format metric number, comma separated)
EXAMPLE: *Income groups* ***(Do not delete or edit this row)***	*EXAMPLE:* *Less than 50% of the federal poverty level (FPL), 50-100% FPL, and greater than 100% FPL*	*EXAMPLE:* *Recommended*	*EXAMPLE:* *PR_1 - PR_21*	*EXAMPLE:* *CMS-provided*	*EXAMPLE:* *Y*	*EXAMPLE:* *Y*	*EXAMPLE:*	*EXAMPLE:* *Y*	*EXAMPLE:*
Income groups	Less than 50% of the federal poverty level (FPL), 50-100% FPL, and greater than 100% FPL	Recommended	PR_1 - PR_21	CMS-provided	Y	Y		Y	
Specific demographic groups	Age (less than 19, 19-26, 27-35, 36-45, 46-55, or 56-64), sex (male or female), race (White, Black or African American, Asian, American Indian or Alaskan Native, other, or unknown), and ethnicity (Hispanic, non-Hispanic, or unknown)	Recommended	PR_15 - PR_17	CMS-provided	Y	Y		Y	
Specific eligibility groups	Medicaid eligibility groups included in the state's demonstration based on the STCs authorizing the demonstration *EXAMPLE:* *Section 1931 parents, the new adult group, transitional medical assistance beneficiaries*	Required	PR_1 - PR_21	State-specific	Y		FPL 51 to 100%, FPL 101-133% for IWP, MAGI adult and Non-MAGI adult for Dental Wellness Plan	N	for the Dental Wellness Plan, the MAGI adult and Non-MAGI adult groups. MAGI groups include populations are new adult group, parents and other caretaker relatives, Tansitional Medical Assistance, Pregnant women, former fost care children up to age 26, breast and cervical cancer treatment program. Non-Magi groups are: Mandatory aged, blind & disabled individuals, optional eligiblity who meet income & resource of case assistance programs, optional elgibility for individuals who would be eligible for cas assistance if they were not in Medical instituions, institutionalized individuals, Medicaid for Employed people, 1915(c) HCBS, physcal disability, Health and Dsability waiver, elderly waiver, intellectual disability waiver, ADIS waiver, brain injury waiver

[a] For definitions of subpopulations, see CMS-provided technical specifications on subpopulation categories.

[b] If the state is not reporting a required subpopulation category (i.e., column F = "N"), enter explanation in corresponding row in column H.

[c] If the state is planning to phase in the reporting of any of the subpopulation categories, the state should provide an explanation and the report (DY and Q) in which it will begin reporting the subpopulation category in column H.

Medicaid Section 1115 Eligibility and Coverage Demonstrations Monitoring Protocol (Part A) - Planned subpopulations (HB) (Version 3.0)

State Iowa
Demonstration Name Iowa Wellness Plan

Table: Eligibility and Coverage Demonstration Planned Subpopulations - Healthy Behavior Incentives (HB)

Planned subpopulation reporting						Alignment with CMS-provided technical specifications manual			
						Subpopulations		Relevant metrics	
Subpopulation category[a]	Subpopulations	Reporting priority	Relevant metrics	Subpopulation type	State will report (Y/N)	Attest that planned subpopulation reporting within each category matches the description in the CMS-provided technical specifications manual (Y/N)	For state-specific subpopulation categories, or if the planned reporting of subpopulations does not match (i.e., column G = "N"), list the subpopulations state plans to report (Format comma separated)[b,c]	Attest that metrics reporting for subpopulation category matches CMS-provided technical specifications manual (Y/N)	If the planned reporting of relevant metrics does not match (i.e., column I = "N"), list the metrics for which state plans to report for each subpopulation category (Format metric number, comma separated)
EXAMPLE: *Income groups* ***(Do not delete or edit this row)***	*EXAMPLE:* *Less than 50% of the federal poverty level (FPL), 50-100% FPL, and greater than 100% FPL*	*EXAMPLE:* *Recommended*	*EXAMPLE:* *HB_1 - HB_7*	*EXAMPLE:* *CMS-provided*	*EXAMPLE:* *Y*	*EXAMPLE:* *Y*	*EXAMPLE:*	*EXAMPLE:* *Y*	*EXAMPLE:*
Income groups	Less than 50% of the federal poverty level (FPL), 50-100% FPL, and greater than 100% FPL	Recommended	HB_1 - HB_7	CMS-provided	Y	Y		Y	
Specific demographic groups	Age (less than 19, 19-26, 27-35, 36-45, 46-55, or 56-64), sex (male or female), race (White, Black or African American, Asian, American Indian or Alaskan Native, other, or unknown), and ethnicity (Hispanic, non-Hispanic, or unknown)	Recommended	HB_1 - HB_7	CMS-provided	Y	Y		Y	
Specific eligibility groups	Medicaid eligibility groups included in the state's demonstration based on the STCs authorizing the demonstration *EXAMPLE:* *Section 1931 parents, the new adult group, transitional medical assistance beneficiaries*	Required	HB_1 - HB_7	State-specific	Y		FPL 51 to 100%, FPL 101-133% for IWP, MAGI adult and Non-MAGI adult for Dental Wellness Plan	N	Specific elgibility groups include MAGI and Non-MAGI populations. MAGI populations are new adult group, parents and other caretaker relatives, Tansitional Medical Assistance, Pregnant women, former fost care children up to age 26, breast and cervical cancer treatment program. Non-Magi groups are: Mandatory aged, blind & disabled individuals, optional eligiblity who meet income & resource of case assistance programs, optional elgibility for individuals who would be eligible for cas assistance if they were not in Medical institutions, institutionalized individuals, Medicaid for Employed people, 1915(c) HCBS, physical disability, Health and Disability waiver, elderly waiver, intellectual disability waiver, ADIS waiver, brain injury waiver

[a] For definitions of subpopulations, see CMS-provided technical specifications on subpopulation categories.

[b] If the state is not reporting a required subpopulation category (i.e., column F = "N"), enter explanation in corresponding row in column H.

[c] If the state is planning to phase in the reporting of any of the subpopulation categories, the state should provide an explanation and the report (DY and Q) in which it will begin reporting the subpopulation category in column H.

Medicaid Section 1115 Eligibility and Coverage Demonstration Monitoring Protocol - Planned subpopulations (DWP) (Version 3.0)

State: Iowa
Demonstration Name: Iowa Wellness Plan

Table: Eligibility and Coverage Demonstration Planned Subpopulations - Dental Wellness Plan (DWP)

Planned subpopulation reporting						Alignment with CMS-provided technical specifications manual			
						Subpopulations		Relevant metrics	
Subpopulation category[a]	Subpopulations	Reporting priority	Relevant metrics	Subpopulation type	State will report (Y/N)	Attest that planned subpopulation reporting within each category matches the description in the CMS-provided technical specifications manual (Y/N)	For state-specific subpopulation categories, or if the planned reporting of subpopulations does not match (i.e., column G = "N" or grey), list the subpopulations state plans to report (Format comma separated)	Attest that metrics reporting for subpopulation category matches CMS-provided technical specifications manual (Y/N)	If the planned reporting of relevant metrics does not match (i.e., column I = "N"), list the metrics for which state plans to report for each subpopulation category (Format: metric number, comma separated)
EXAMPLE: *Income groups* ***(Do not delete or edit this row)***	*EXAMPLE:* *Less than 50% of the federal poverty level (FPL), 50-100% FPL, and greater than 100% FPL*	*EXAMPLE:* *Recommended*	*EXAMPLE:* *AD_1 - AD_23, AD_33 - AD_44*	*EXAMPLE:* *CMS-provided*	*EXAMPLE:* *Y*	*EXAMPLE:* *Y*	*EXAMPLE:*	*EXAMPLE:* *Y*	*EXAMPLE:*
Specific demographic groups	Age (<1, 1-2, 3-5, 6-9, 10-14, 15-18, 19-20)	Required	IA_DWP_1-IA_DWP_4	State-specific	Y		The state should report all DWP planned metrics (IA_DWP_1-IA_DWP_4) for DWP children by age (<1, 1-2, 3-5, 6-9, 10-14, 15-18, 19-20)		
Specific demographic groups	Geographic region	Recommended	IA_DWP_1-IA_DWP_14	State-specific	Y		The state should report all DWP planned metrics (IA_DWP_1-IA_DWP_5) and DWP adaptations of AD metrics (IA_DWP_6-IA_DWP_14) by geographic region.		

[a] For definitions of subpopulations, see CMS-provided technical specifications on subpopulation categories.

[b] If applicable. See CMS-provided technical specifications on subpopulation categories.

Medicaid Section 1115 Eligibility and Coverage Demonstrations Monitoring Protocol (Part A) - Reporting Schedule (Version 3.0)

State: Iowa
Demonstration Name: Iowa Wellness Plan

Instructions:

(1) In the reporting periods input table (Table 1), use the prompt in column A to enter the requested information in the corresponding row of column B. All monitoring report names and reporting periods should use the format DY#Q# or CY# and all dates should use the format MM/DD/YYYY with no spaces in the cell. The information entered in these cells will auto-populate the eligibility and coverage demonstration reporting schedule in Table 2. All cells in the input table must be completed in entirety and in the correct format for the standard reporting schedule to be accurately auto-populated.

(2) Review the state's reporting schedule in the eligibility and coverage demonstration reporting schedule table (Table 2). For each of the reporting categories listed in columns E and F, select Y or N in the "Deviation from standard reporting schedule (Y/N)" column to indicate whether the state plans to report according to the standard reporting schedule. If a state's planned reporting does not match the standard reporting schedule for any quarter and/or reporting category, the state should describe these deviations in the "Explanation for deviations" column and use the "Proposed deviations from standard reporting schedule" column to indicate the measurement periods with which it wishes to overwrite the standard schedule. All other columns are locked for editing and should not be altered by the state.

Table 1. Eligibility and Coverage Demonstration Reporting Periods Input Table

	Demonstration reporting periods/dates			
	AD	PR	HB	RW
Dates of first demonstration year				
Start date (MM/DD/YYYY)	01/01/2020	01/01/2020	01/01/2020	01/01/2020
End date (MM/DD/YYYY)	12/31/2020	12/31/2020	12/31/2020	12/31/2020
Dates of first quarter of the baseline reporting period for CMS-constructed metrics				
Reporting period (EandC DY and Q) (Format DY#Q#; e.g. DY1Q1)	DY1Q1	DY1Q1	DY1Q1	DY1Q1
Start date (MM/DD/YYYY)[a]	01/01/2020	01/01/2020	01/01/2020	01/01/2020
End date (MM/DD/YYYY)	03/31/2020	03/31/2020	03/31/2020	03/31/2020
Broader section 1115 demonstration reporting period corresponding with the first EandC reporting quarter, if applicable. If there is no broader demonstration, fill in the first eligibility and coverage policy reporting period. (Format DY#Q#; e.g. DY1Q3)	DY1Q1	DY1Q1	DY1Q1	DY1Q1
First monitoring report due date (per STCs) (MM/DD/YYYY)	05/31/2020	05/31/2020	05/31/2020	05/31/2020
First monitoring report in which the state plans to report calendar year (CY) metrics with a 90 day lag				
Reporting period (Format CY#; e.g. CY2019)	CY2020			
DY and Q associated with monitoring report (Format DY#Q#; e.g. DY1Q1)	DY2Q3			
DY and Q start date (MM/DD/YYYY)	07/01/2021			
DY and Q end date (MM/DD/YYYY)	09/30/2021			
Dates of last reporting quarter:				
Start date (MM/DD/YYYY)	10/01/2024	10/01/2024	10/01/2024	10/01/2024
End date (MM/DD/YYYY)	12/31/2024	12/31/2024	12/31/2024	12/31/2024

Table 2. Eligibility and Coverage Demonstration Reporting Schedule

Reporting quarter start date (MM/DD/YYYY)	Reporting quarter end date (MM/DD/YYYY)	Monitoring report due (per STCs) (MM/DD/YYYY)	Broader section 1115 DY (if applicable, otherwise the first eligibility and coverage policy reporting period) (Format DY#Q#; e.g. DY1Q3)	Reporting category: Calculation lag	Reporting category: Measurement period	For each reporting category, measurement period for which information is captured in monitoring report per standard reporting schedule (Format DY#Q#; e.g., DY1Q3)[b]				Deviation from standard reporting schedule (Y/N/n.a.)	Explanation for deviations	Proposed deviation in measurement period from standard reporting schedule (Format DY#Q#; e.g., DY1Q3)			
						AD	PR	HB	RW			AD	PR	HB	RW
01/01/2020	03/31/2020	05/31/2020	DY1Q1	None	Narrative information	DY1Q1	DY1Q1	DY1Q1	DY1Q1						
				30 days	Month	DY1Q1	DY1Q1		DY1Q1						
				None	Quarter	DY1Q1				Y	The state should additionally report IA_DWP_6 - IA_DWP_10 in DY1Q1.				
				90 days	Quarter										
				90 days	Calendar year										
				None	Demonstration year										
04/01/2020	06/30/2020	08/29/2020	DY1Q2	None	Narrative information	DY1Q2	DY1Q2	DY1Q2	DY1Q2						
				30 days	Month	DY1Q2	DY1Q2		DY1Q2						
				None	Quarter	DY1Q2				Y	The state should additionally report IA_DWP_6 - IA_DWP_10 in DY1Q2.				
				90 days	Quarter	DY1Q1		DY1Q1	DY1Q1	Y	The state should additionally report IA_DWP_11 - IA_DWP_14 in DY1Q1.				
				90 days	Calendar year										
				None	Demonstration year										
07/01/2020	09/30/2020	11/29/2020	DY1Q3	None	Narrative information	DY1Q3	DY1Q3	DY1Q3	DY1Q3						
				30 days	Month	DY1Q3	DY1Q3		DY1Q3						
				None	Quarter	DY1Q3				Y	The state should additionally report IA_DWP_6 - IA_DWP_10 in DY1Q3.				
				90 days	Quarter	DY1Q2		DY1Q2	DY1Q2	Y	The state should additionally report IA_DWP_11 - IA_DWP_14 DY1Q2.				
				90 days	Calendar year										
				None	Demonstration year										
10/01/2020	12/31/2020	03/31/2021	DY1Q4	None	Narrative information	DY1Q4	DY1Q4	DY1Q4	DY1Q4						
				30 days	Month	DY1Q4	DY1Q4		DY1Q4						
				None	Quarter	DY1Q4				Y	The state should additionally report IA_DWP_6 - IA_DWP_10 in DY1Q4.				
				90 days	Quarter	DY1Q3		DY1Q3	DY1Q3	Y	The state should additionally report IA_DWP_11 - IA_DWP_14 in DY1Q3.				
				90 days	Calendar year										
				None	Demonstration year	DY1									
01/01/2021	03/31/2021	05/30/2021	DY2Q1	None	Narrative information	DY2Q1	DY2Q1	DY2Q1	DY2Q1						
				30 days	Month	DY2Q1	DY2Q1		DY2Q1						
				None	Quarter	DY2Q1				Y	The state should additionally report IA_DWP_6 - IA_DWP_10 in DY2Q1.				
				90 days	Quarter	DY1Q4		DY1Q4	DY1Q4	Y	The state should additionally report IA_DWP_11 - IA_DWP_14 in DY1Q4.				
				90 days	Calendar year										
				None	Demonstration year										
04/01/2021	06/30/2021	08/29/2021	DY2Q2	None	Narrative information	DY2Q2	DY2Q2	DY2Q2	DY2Q2						
				30 days	Month	DY2Q2	DY2Q2		DY2Q2						
				None	Quarter	DY2Q2				Y	The state should additionally report IA_DWP_6 - IA_DWP_10 in DY2Q2.				
				90 days	Quarter	DY2Q1		DY2Q1	DY2Q1	Y	The state should additionally report IA_DWP_11 - IA_DWP_14 in DY2Q1.				
				90 days	Calendar year										
				None	Demonstration year										
07/01/2021	09/30/2021	11/29/2021	DY2Q3	None	Narrative information	DY2Q3	DY2Q3	DY2Q3	DY2Q3						
				30 days	Month	DY2Q3	DY2Q3		DY2Q3						
				None	Quarter	DY2Q3				Y	The state should additionally report IA_DWP_6 - IA_DWP_10 in DY2Q3.				
				90 days	Quarter	DY2Q2		DY2Q2	DY2Q2	Y	The state should additionally report IA_DWP_11 - IA_DWP_14 in DY2Q2.				
				90 days	Calendar year	CY2020				Y	The state should additionally report IA_DWP_1 - IA_DWP_5 in CY2020.				
				None	Demonstration year										
10/01/2021	12/31/2021	03/31/2022	DY2Q4	None	Narrative information	DY2Q4	DY2Q4	DY2Q4	DY2Q4						
				30 days	Month	DY2Q4	DY2Q4		DY2Q4						
				None	Quarter	DY2Q4				Y	The state should additionally report IA_DWP_6 - IA_DWP_10 in DY2Q4.				
				90 days	Quarter	DY2Q3		DY2Q3	DY2Q3	Y	The state should additionally report IA_DWP_11 - IA_DWP_14 in DY2Q3.				
				90 days	Calendar year										
				None	Demonstration year	DY2									
01/01/2022	03/31/2022	05/30/2022	DY3Q1	None	Narrative information	DY3Q1	DY3Q1	DY3Q1	DY3Q1						
				30 days	Month	DY3Q1	DY3Q1		DY3Q1						
				None	Quarter	DY3Q1				Y	The state should additionally report IA_DWP_6 - IA_DWP_10 in DY3Q1.				
				90 days	Quarter	DY2Q4		DY2Q4	DY2Q4	Y	The state should additionally report IA_DWP_11 - IA_DWP_14 in DY2Q4.				
				90 days	Calendar year										
				None	Demonstration year										
04/01/2022	06/30/2022	08/29/2022	DY3Q2	None	Narrative information	DY3Q2	DY3Q2	DY3Q2	DY3Q2						
				30 days	Month	DY3Q2	DY3Q2		DY3Q2						
				None	Quarter	DY3Q2				Y	The state should additionally report IA_DWP_6 - IA_DWP_10 in DY3Q2.				
				90 days	Quarter	DY3Q1		DY3Q1	DY3Q1	Y	The state should additionally report IA_DWP_11 - IA_DWP_14 in DY3Q1.				
				90 days	Calendar year										
				None	Demonstration year										
07/01/2022	09/30/2022	11/29/2022	DY3Q3	None	Narrative information	DY3Q3	DY3Q3	DY3Q3	DY3Q3						
				30 days	Month	DY3Q3	DY3Q3		DY3Q3						
				None	Quarter	DY3Q3				Y	The state should additionally report IA_DWP_6 - IA_DWP_10 in DY3Q3.				
				90 days	Quarter	DY3Q2		DY3Q2	DY3Q2	Y	The state should additionally report IA_DWP_11 - IA_DWP_14 in DY3Q2.				
				90 days	Calendar year	CY2021				Y	The state should additionally report IA_DWP_1 - IA_DWP_5 in CY2021.				
				None	Demonstration year										
10/01/2022	12/31/2022	03/31/2023	DY3Q4	None	Narrative information	DY3Q4	DY3Q4	DY3Q4	DY3Q4						
				30 days	Month	DY3Q4	DY3Q4		DY3Q4						
				None	Quarter	DY3Q4				Y	The state should additionally report IA_DWP_6 - IA_DWP_10 in DY3Q4.				
				90 days	Quarter	DY3Q3		DY3Q3	DY3Q3	Y	The state should additionally report IA_DWP_11 - IA_DWP_14 in DY3Q3.				
				90 days	Calendar year										
				None	Demonstration year	DY3									
01/01/2023	03/31/2023	05/30/2023	DY4Q1	None	Narrative information	DY4Q1	DY4Q1	DY4Q1	DY4Q1						
				30 days	Month	DY4Q1	DY4Q1		DY4Q1						

Reporting quarter start date (MM/DD/YYYY)	Reporting quarter end date (MM/DD/YYYY)	Monitoring report due (per STCs) (MM/DD/YYYY)	Broader section 1115 DY (if applicable, otherwise the first eligibility and coverage policy reporting period) (Format DY#Q#; e.g., DY1Q3)	Reporting category: Calculation lag	Reporting category: Measurement period	For each reporting category, measurement period for which information is captured in monitoring report per standard reporting schedule (Format DY#Q#; e.g., DY1Q3)[b] AD	PR	HB	RW	Deviation from standard reporting schedule (Y/N/n.a.)	Explanation for deviations	Proposed deviation in measurement period from standard reporting schedule (Format DY#Q#; e.g., DY1Q3) AD	PR	HB	RW
				None	Quarter	DY4Q1				Y	The state should additionally report IA_DWP_6 - IA_DWP_10 in DY4Q1.				
				90 days	Quarter	DY3Q4		DY3Q4	DY3Q4	Y	The state should additionally report IA_DWP_11 - IA_DWP_14 in DY3Q4.				
				90 days	Calendar year										
				None	Demonstration year										
04/01/2023	06/30/2023	08/29/2023	DY4Q2	None	Narrative information	DY4Q2	DY4Q2	DY4Q2	DY4Q2						
				30 days	Month	DY4Q2	DY4Q2		DY4Q2						
				None	Quarter	DY4Q2				Y	The state should additionally report IA_DWP_6 - IA_DWP_10 in DY4Q2.				
				90 days	Quarter	DY4Q1		DY4Q1	DY4Q1	Y	The state should additionally report IA_DWP_11 - IA_DWP_14 in DY4Q1.				
				90 days	Calendar year										
				None	Demonstration year										
07/01/2023	09/30/2023	11/29/2023	DY4Q3	None	Narrative information	DY4Q3	DY4Q3	DY4Q3	DY4Q3						
				30 days	Month	DY4Q3	DY4Q3		DY4Q3						
				None	Quarter	DY4Q3				Y	The state should additionally report IA_DWP_6 - IA_DWP_10 in DY4Q3.				
				90 days	Quarter	DY4Q2		DY4Q2	DY4Q2	Y	The state should additionally report IA_DWP_11 - IA_DWP_14 in DY4Q2.				
				90 days	Calendar year	CY2022				Y	The state should additionally report IA_DWP_1 - IA_DWP_5 in CY2022.				
				None	Demonstration year										
10/01/2023	12/31/2023	03/30/2024	DY4Q4	None	Narrative information	DY4Q4	DY4Q4	DY4Q4	DY4Q4						
				30 days	Month	DY4Q4	DY4Q4		DY4Q4						
				None	Quarter	DY4Q4				Y	The state should additionally report IA_DWP_6 - IA_DWP_10 in DY4Q4.				
				90 days	Quarter	DY4Q3		DY4Q3	DY4Q3	Y	The state should additionally report IA_DWP_11 - IA_DWP_14 in DY4Q3.				
				90 days	Calendar year										
				None	Demonstration year	DY4									
01/01/2024	03/31/2024	05/30/2024	DY5Q1	None	Narrative information	DY5Q1	DY5Q1	DY5Q1	DY5Q1						
				30 days	Month	DY5Q1	DY5Q1		DY5Q1						
				None	Quarter	DY5Q1				Y	The state should additionally report IA_DWP_6 - IA_DWP_10 in DY5Q1.				
				90 days	Quarter	DY4Q4		DY4Q4	DY4Q4	Y	The state should additionally report IA_DWP_11 - IA_DWP_14 in DY4Q4.				
				90 days	Calendar year										
				None	Demonstration year										
04/01/2024	06/30/2024	08/29/2024	DY5Q2	None	Narrative information	DY5Q2	DY5Q2	DY5Q2	DY5Q2						
				30 days	Month	DY5Q2	DY5Q2		DY5Q2						
				None	Quarter	DY5Q2				Y	The state should additionally report IA_DWP_6 - IA_DWP_10 in DY5Q2.				
				90 days	Quarter	DY5Q1		DY5Q1	DY5Q1	Y	The state should additionally report IA_DWP_11 - IA_DWP_14 in DY5Q1.				
				90 days	Calendar year										
				None	Demonstration year										
07/01/2024	09/30/2024	11/29/2024	DY5Q3	None	Narrative information	DY5Q3	DY5Q3	DY5Q3	DY5Q3						
				30 days	Month	DY5Q3	DY5Q3		DY5Q3						
				None	Quarter	DY5Q3				Y	The state should additionally report IA_DWP_6 - IA_DWP_10 in DY5Q3.				
				90 days	Quarter	DY5Q2		DY5Q2	DY5Q2	Y	The state should additionally report IA_DWP_11 - IA_DWP_14 in DY5Q2.				
				90 days	Calendar year	CY2023				Y	The state should additionally report IA_DWP_1 - IA_DWP_5 in CY2023.				
				None	Demonstration year										
10/01/2024	12/31/2024	03/31/2025	DY5Q4	None	Narrative information	DY5Q4	DY5Q4	DY5Q4	DY5Q4						
				30 days	Month	DY5Q4	DY5Q4		DY5Q4						
				None	Quarter	DY5Q4				Y	The state should additionally report IA_DWP_6 - IA_DWP_10 in DY5Q4.				
				90 days	Quarter	DY5Q3		DY5Q3	DY5Q3	Y	The state should additionally report IA_DWP_11 - IA_DWP_14 in DY5Q3.				
				90 days	Calendar year										
				None	Demonstration year	DY5									
[Add rows for all additional demonstration reporting quarters]															

[a] **Eligibility and coverage demonstration start date:** For monitoring purposes, CMS defines the start date of the demonstration as the *effective date* listed in the state's STCs at the time of eligibility and coverage demonstration approval. For example, if the state's STCs at the time of eligibility and coverage demonstration approval note that the demonstration is effective January 1, 2020 – December 31, 2025, the state should consider January 1, 2020 to be the start date of the demonstration. Note that that the effective date is considered to be the first day the state may begin its eligibility and coverage demonstration. In many cases, the effective date is distinct from the approval date of a demonstration; that is, in certain cases, CMS may approve a section 1115 demonstration with an effective date that is in the future. For example, CMS may approve an extension request on December 15, 2020, with an effective date of January 1, 2021 for the new demonstration period. In many cases, the effective date also differs from the date a state begins implementing its demonstration. To generate an accurate reporting schedule, the start date as listed in Table 1 of the "EandC reporting schedule tab" should align with the first day of a month. If a state's eligibility and coverage demonstration begins on any day other than the first day of the month, the state should list its start date as the first day of the month in which the effective date occurs. For example, if a state's effective date is listed as January 15, 2020, the state should indicate "01/01/2020" as the start date in Table 1 of the "EandC reporting schedule" tab. Please see Appendix A of the Monitoring Protocol Instructions for more information on determining demonstration quarter timing.

[b] The auto-populated reporting schedule in Table 2 outlines the data the state is expected to report for each demonstration year and quarter. However, states are not expected to begin reporting any metrics data until after protocol approval. The state should see Section B of the Monitoring Report Instructions for more information on retrospective reporting of data following protocol approval.

Attachment D
Developing the Evaluation Design

Introduction

Both state and federal governments need rigorous quantitative and qualitative evidence to inform policy decisions. To that end, for states that are testing new approaches and flexibilities in their Medicaid programs through section 1115 demonstrations, evaluations are crucial to understand and disseminate what is or is not working and why. The evaluations of new initiatives seek to produce new knowledge and direction for programs and inform Medicaid policy for the future. While a narrative about what happened during a demonstration provides important information, the principal focus of the evaluation of a section 1115 demonstration should be obtaining and analyzing data on the process (e.g., whether the demonstration is being implemented as intended), outcomes (e.g., whether the demonstration is having the intended effects on the target population), and impacts of the demonstration (e.g., whether the outcomes observed in the targeted population differ from outcomes in similar populations not affected by the demonstration).

Expectations for Evaluation Designs

CMS expects Evaluation Designs to be rigorous, incorporate baseline and comparison group assessments, as well as statistical significance testing. Technical assistance resources for constructing comparison groups and identifying causal inferences are available on Medicaid.gov: https://www.medicaid.gov/medicaid/section-1115-demonstrations/1115-demonstration-monitoring-evaluation/1115-demonstration-state-monitoring-evaluation-resources/index.html. If the state needs technical assistance using this outline or developing the Evaluation Design, the state should contact its demonstration team.

All states with Medicaid section 1115 demonstrations are required to conduct an evaluation, and the Evaluation Design is the roadmap for conducting the evaluation. The roadmap begins with the stated goals for the demonstration followed by the measurable evaluation questions and quantifiable hypotheses, all to support a determination of the extent to which the demonstration has achieved its goals. When conducting analyses and developing the evaluation reports, every effort should be made to follow the approved methodology. However, the state may request, and CMS may agree to, changes in the methodology in appropriate circumstances.

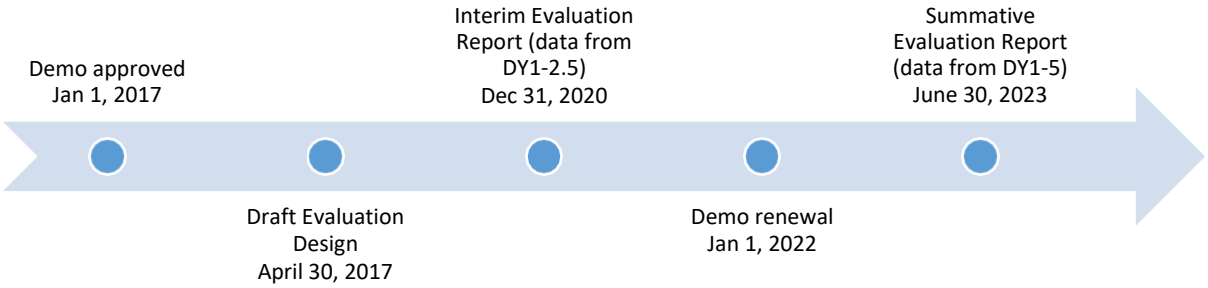
The format for the Evaluation Design is as follows:

A. General Background Information;
B. Evaluation Questions and Hypotheses;
C. Methodology;
D. Methodological Limitations; and
E. Attachments.

Submission Timelines

There is a specified timeline for the state's submission of Evaluation Design and Reports. (The graphic below depicts an example of this timeline for a 5-year demonstration period). In addition, the state should be aware that section 1115 evaluation documents are public

records. The state is required to publish the Evaluation Design to the state's website within thirty (30) days of CMS approval, as per 42 CFR 431.424(e). CMS will also publish a copy to the Medicaid.gov website.



Required Core Components of All Evaluation Designs
The Evaluation Design sets the stage for the Interim and Summative Evaluation Reports. It is important that the Evaluation Design explain the goals and objectives of the demonstration, the hypotheses related to the demonstration, and the methodology (and limitations) for the evaluation. A copy of the state's Driver Diagram (described in more detail in paragraph B2 below) should be included with an explanation of the depicted information.

A. General Background Information – In this section, the state should include basic information about the demonstration, such as:

1) The issue/s that the state is trying to address with its section 1115 demonstration and/or expenditure authorities, the potential magnitude of the issue/s, and why the state selected this course of action to address the issue/s (e.g., a narrative on why the state submitted an 1115 demonstration proposal).

2) The name of the demonstration, approval date of the demonstration, and period of time covered by the evaluation;

3) A brief description of the demonstration and history of the implementation, and whether the draft Evaluation Design applies to an amendment, extension, renewal, or expansion of, the demonstration;

4) For renewals, amendments, and major operational changes: A description of any changes to the demonstration during the approval period; the primary reason or reasons for the change; and how the Evaluation Design was altered or augmented to address these changes.

5) A description of the population groups impacted by the demonstration.

B. Evaluation Questions and Hypotheses – In this section, the state should:

1) Describe how the state's demonstration goals are translated into quantifiable targets for improvement, so that the performance of the demonstration in achieving these targets could be measured.

2) Include a Driver Diagram to visually aid readers in understanding the rationale behind the cause and effect of the variants behind the demonstration features and intended outcomes. A driver diagram is a particularly effective modeling tool when working to improve health and health care through specific interventions. The diagram includes information about the goal of the demonstration, and the features of the demonstration. A driver diagram depicts the relationship between the aim, the primary drivers that contribute directly to achieving the aim, and the secondary drivers that are necessary to achieve the primary drivers for the demonstration. For an example and more information on driver diagrams: https://innovation.cms.gov/files/x/hciatwoaimsdrvrs.pdf

3) Identify the state's hypotheses about the outcomes of the demonstration:
   a. Discuss how the evaluation questions align with the hypotheses and the goals of the demonstration;
   b. Address how the research questions / hypotheses of this demonstration promote the objectives of Titles XIX and/or XXI.

C. Methodology – In this section, the state is to describe in detail the proposed research methodology. The focus is on showing that the evaluation meets the prevailing standards of scientific and academic rigor, and the results are statistically valid and reliable, and that where appropriate it builds upon other published research (use references).

This section provides the evidence that the demonstration evaluation will use the best available data; reports on, controls for, and makes appropriate adjustments for the limitations of the data and their effects on results; and discusses the generalizability of results. This section should provide enough transparency to explain what will be measured and how. Specifically, this section establishes:

1) *Evaluation Design* – Provide information on how the evaluation will be designed. For example, will the evaluation utilize a pre/post comparison? A post-only assessment? Will a comparison group be included?

2) *Target and Comparison Populations* – Describe the characteristics of the target and comparison populations, to include the inclusion and exclusion criteria. Include information about the level of analysis (beneficiary, provider, or program level), and if populations will be stratified into subgroups. Additionally discuss the sampling methodology for the populations, as well as support that a statistically reliable sample size is available.

3) *Evaluation Period* – Describe the time periods for which data will be included.

4) *Evaluation Measures* – List all measures that will be calculated to evaluate the demonstration. Include the measure stewards (i.e., the organization(s) responsible for the evaluation data elements/sets by "owning", defining, validating; securing; and submitting for endorsement, etc.) Include numerator and denominator information. Additional items to ensure:

a. The measures contain assessments of both process and outcomes to evaluate the effects of the demonstration during the period of approval.
b. Qualitative analysis methods may be used, and must be described in detail.
c. Benchmarking and comparisons to national and state standards, should be used, where appropriate.
d. Proposed health measures could include CMS's Core Set of Health Care Quality Measures for Children in Medicaid and CHIP, Consumer Assessment of Health Care Providers and Systems (CAHPS), the Initial Core Set of Health Care Quality Measures for Medicaid-Eligible Adults and/or measures endorsed by National Quality Forum (NQF).
e. Proposed performance metrics can be selected from nationally recognized metrics, for example from sets developed by the Center for Medicare and Medicaid Innovation or for meaningful use under Health Information Technology (HIT).
f. Among considerations in selecting the metrics shall be opportunities identified by the state for improving quality of care and health outcomes, and controlling cost of care.

5) *Data Sources* – Explain where the data will be obtained, and efforts to validate and clean the data. Discuss the quality and limitations of the data sources.

If primary data (data collected specifically for the evaluation) – The methods by which the data will be collected, the source of the proposed question/responses, the frequency and timing of data collection, and the method of data collection. (Copies of any proposed surveys must be reviewed with CMS for approval before implementation).

6) *Analytic Methods* – This section includes the details of the selected quantitative and/or qualitative measures to adequately assess the effectiveness of the demonstration. This section should:

a. Identify the specific statistical testing which will be undertaken for each measure (e.g., t-tests, chi-square, odds ratio, ANOVA, regression). Table A is an example of how the state might want to articulate the analytic methods for each research question and measure.
b. Explain how the state will isolate the effects of the demonstration (from other initiatives occurring in the state at the same time) through the use of comparison groups.
c. A discussion of how propensity score matching and difference in differences design may be used to adjust for differences in comparison populations over time (if applicable).
d. The application of sensitivity analyses, as appropriate, should be considered.

7) *Other Additions* – The state may provide any other information pertinent to the Evaluation Design of the demonstration.

Table A. Example Design Table for the Evaluation of the Demonstration

Research Question	Outcome measures used to address the research question	Sample or population subgroups to be compared	Data Sources	Analytic Methods
Hypothesis 1				
Research question 1a	-Measure 1 -Measure 2 -Measure 3	-Sample e.g. All attributed Medicaid beneficiaries -Beneficiaries with diabetes diagnosis	-Medicaid fee-for-service and encounter claims records	-Interrupted time series
Research question 1b	-Measure 1 -Measure 2 -Measure 3 -Measure 4	-sample, e.g., PPS patients who meet survey selection requirements (used services within the last 6 months)	-Patient survey	Descriptive statistics
Hypothesis 2				
Research question 2a	-Measure 1 -Measure 2	-Sample, e.g., PPS administrators	-Key informants	Qualitative analysis of interview material

D. Methodological Limitations – This section provides detailed information on the limitations of the evaluation. This could include the design, the data sources or collection process, or analytic methods. The state should also identify any efforts to minimize the limitations. Additionally, this section should include any information about features of the demonstration that effectively present methodological constraints that the state would like CMS to take into consideration in its review.

CMS recognizes that there may be certain instances where a state cannot meet the rigor of an evaluation as expected by CMS. In these instances, the state should document for CMS why it is not able to incorporate key components of a rigorous evaluation, including comparison groups and baseline data analyses. Examples of considerations include when the demonstration is considered successful without issues or concerns that would require more regular reporting, such as:

a. The demonstration is operating smoothly without administrative changes; and
b. There are no or minimal appeals and grievances; and

c. There are no state issues with CMS 64 reporting or budget neutrality; and
d. There are no Corrective Action Plans (CAP) for the demonstration.

E. Attachments

1) **Independent Evaluator.** This includes a discussion of the state's process for obtaining an independent entity to conduct the evaluation, including a description of the qualifications that the selected entity must possess, and how the state will assure no conflict of interest. Explain how the state will assure that the Independent Evaluator will conduct a fair and impartial evaluation, prepare an objective Evaluation Report, and that there would be no conflict of interest. The evaluation design should include a "No Conflict of Interest" statement signed by the independent evaluator.

2) **Evaluation Budget.** A budget for implementing the evaluation shall be provided with the draft Evaluation Design. It will include the total estimated cost, as well as a breakdown of estimated staff, administrative, and other costs for all aspects of the evaluation. Examples include, but are not limited to: the development of all survey and measurement instruments; quantitative and qualitative data collection; data cleaning and analyses; and reports generation. A justification of the costs may be required by CMS if the estimates provided do not appear to sufficiently cover the costs of the draft Evaluation Design or if CMS finds that the draft Evaluation Design is not sufficiently developed.

3) **Timeline and Major Milestones.** Describe the timeline for conducting the various evaluation activities, including dates for evaluation-related milestones, including those related to procurement of an outside contractor, if applicable, and deliverables. The Final Evaluation Design shall incorporate an Interim and Summative Evaluation. Pursuant to 42 CFR 431.424(c)(v), this timeline should also include the date by which the Final Summative Evaluation report is due.

Attachment E
Preparing the Evaluation Report

Introduction
Both state and federal governments need improved quantitative and qualitative evidence to inform policy decisions. To that end, for states that are testing new approaches and flexibilities in their Medicaid programs through section 1115 demonstrations, evaluations are crucial to understand and disseminate what is or is not working and why. The evaluations of new initiatives seek to produce new knowledge and direction for programs and inform Medicaid policy for the future. While a narrative about what happened during a demonstration provide important information, the principal focus of the evaluation of a section 1115 demonstration should be obtaining and analyzing data on the process (e.g., whether the demonstration is being implemented as intended), outcomes (e.g., whether the demonstration is having the intended effects on the target population), and impacts of the demonstration (e.g., whether the outcomes observed in the targeted population differ from outcomes in similar populations not affected by the demonstration).

Expectations for Evaluation Reports
All states with Medicaid section 1115 demonstrations are required to conduct evaluations that are valid (the extent to which the evaluation measures what it is intended to measure), and reliable (the extent to which the evaluation could produce the same results when used repeatedly). To this end, the already approved Evaluation Design is a map that begins with the demonstration goals, then transitions to the evaluation questions, and to the specific hypotheses, which will be used to investigate whether the demonstration has achieved its goals. States should have a well-structured analysis plan for their evaluation. With the following kind of information, states and CMS are best poised to inform and shape Medicaid policy in order to improve the health and welfare of Medicaid beneficiaries for decades to come. When conducting analyses and developing the evaluation reports, every effort should be made to follow the approved methodology. However, the state may request, and CMS may agree to, changes in the methodology in appropriate circumstances.

When submitting an application for renewal, the Interim Evaluation Report should be posted on the state's website with the application for public comment. Additionally, the interim evaluation report must be included in its entirety with the application submitted to CMS.

Intent of this Attachment
Title XIX of the Social Security Act (the Act) requires an evaluation of every section 1115 demonstration. In order to fulfill this requirement, the state's submission must provide a comprehensive written presentation of all key components of the demonstration, and include all required elements specified in the approved Evaluation Design. This Attachment is intended to assist states with organizing the required information in a standardized format and understanding the criteria that CMS will use in reviewing the submitted Interim and Summative Evaluation Reports.

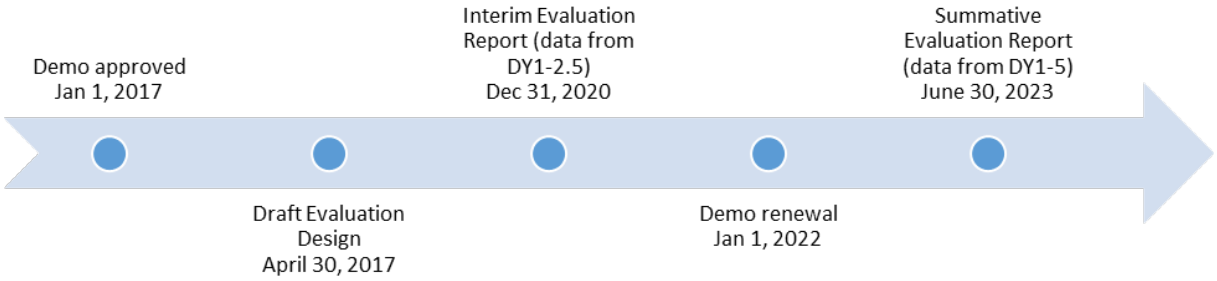
The format for the Interim and Summative Evaluation reports is as follows:

A. Executive Summary;
B. General Background Information;

C. Evaluation Questions and Hypotheses;
D. Methodology;
E. Methodological Limitations;
F. Results;
G. Conclusions;
H. Interpretations, and Policy Implications and Interactions with Other State Initiatives;
I. Lessons Learned and Recommendations; and
J. Attachment(s).

Submission Timelines

There is a specified timeline for the state's submission of Evaluation Designs and Evaluation Reports. These dates are specified in the demonstration Special Terms and Conditions (STCs). (The graphic below depicts an example of this timeline for a 5-year demonstration). In addition, the state should be aware that section 1115 evaluation documents are public records. In order to assure the dissemination of the evaluation findings, lessons learned, and recommendations, the state is required to publish the evaluation design and reports to the state's website within thirty (30) days of CMS approval, as per 42 CFR 431.424(d). CMS will also publish a copy to the Medicaid.gov website.



Required Core Components of Interim and Summative Evaluation Reports

The section 1115 Evaluation Report presents the research about the section 1115 Demonstration. It is important that the report incorporate a discussion about the structure of the Evaluation Design to explain the goals and objectives of the demonstration, the hypotheses related to the demonstration, and the methodology for the evaluation. A copy of the state's Driver Diagram (described in the Evaluation Design Attachment) must be included with an explanation of the depicted information. The Evaluation Report should present the relevant data and an interpretation of the findings; assess the outcomes (what worked and what did not work); explain the limitations of the design, data, and analyses; offer recommendations regarding what (in hindsight) the state would further advance, or do differently, and why; and discuss the implications on future Medicaid policy. Therefore, the state's submission must include:

A. Executive Summary – A summary of the demonstration, the principal results, interpretations, and recommendations of the evaluation.

B. General Background Information about the Demonstration – In this section, the state should include basic information about the demonstration, such as:

1) The issues that the state is trying to address with its section 1115 demonstration and/or expenditure authorities, how the state became aware of the issue, the potential magnitude of the issue, and why the state selected this course of action to address the issues.
2) The name of the demonstration, approval date of the demonstration, and period of time covered by the evaluation;
3) A brief description of the demonstration and history of the implementation, and if the evaluation is for an amendment, extension, renewal, or expansion of, the demonstration;
4) For renewals, amendments, and major operational changes: A description of any changes to the demonstration during the approval period; whether the motivation for change was due to political, economic, and fiscal factors at the state and/or federal level; whether the programmatic changes were implemented to improve beneficiary health, provider/health plan performance, or administrative efficiency; and how the Evaluation Design was altered or augmented to address these changes.
5) A description of the population groups impacted by the demonstration.

C. Evaluation Questions and Hypotheses – In this section, the state should:

1) Describe how the state's demonstration goals were translated into quantifiable targets for improvement, so that the performance of the demonstration in achieving these targets could be measured. The inclusion of a Driver Diagram in the Evaluation Report is highly encouraged, as the visual can aid readers in understanding the rationale behind the demonstration features and intended outcomes.
2) Identify the state's hypotheses about the outcomes of the demonstration;
    a. Discuss how the goals of the demonstration align with the evaluation questions and hypotheses;
    b. Explain how this Evaluation Report builds upon and expands earlier demonstration evaluation findings (if applicable); and
    c. Address how the research questions / hypotheses of this demonstration promote the objectives of Titles XIX and XXI.

D. Methodology – In this section, the state is to provide an overview of the research that was conducted to evaluate the section 1115 demonstration consistent with the approved Evaluation Design. The evaluation Design should also be included as an attachment to the report. The focus is on showing that the evaluation builds upon other published research (use references), and meets the prevailing standards of scientific and academic rigor, and the results are statistically valid and reliable.

An interim report should provide any available data to date, including both quantitative and qualitative assessments. The Evaluation Design should assure there is appropriate data development and collection in a timely manner to support developing an interim evaluation.

This section provides the evidence that the demonstration evaluation used the best available data and describes why potential alternative data sources were not used; reported on, controlled for, and made appropriate adjustments for the limitations of the data and their effects on results; and discusses the generalizability of results. This section should provide enough transparency to explain what was measured and how. Specifically, this section establishes that the approved Evaluation Design was followed by describing:

1) *Evaluation Design*—Will the evaluation be an assessment of: pre/post, post-only, with or without comparison groups, etc.?

2) *Target and Comparison Populations*—Describe the target and comparison populations; include inclusion and exclusion criteria.

3) *Evaluation Period*—Describe the time periods for which data will be collected.

4) *Evaluation Measures*—What measures are used to evaluate the demonstration, and who are the measure stewards?

5) *Data Sources*—Explain where the data will be obtained, and efforts to validate and clean the data.

6) *Analytic methods*—Identify specific statistical testing which will be undertaken for each measure (t-tests, chi-square, odds ratio, ANOVA, regression, etc.).

7) *Other Additions* – The state may provide any other information pertinent to the evaluation of the demonstration.

E. Methodological Limitations
This section provides sufficient information for discerning the strengths and weaknesses of the study design, data sources/collection, and analyses.

F. Results – In this section, the state presents and uses the quantitative and qualitative data to show to whether and to what degree the evaluation questions and hypotheses of the demonstration were achieved. The findings should visually depict the demonstration results (tables, charts, graphs). This section should include information on the statistical tests conducted.

G. Conclusions – In this section, the state will present the conclusions about the evaluation results.

1) In general, did the results show that the demonstration was/was not effective in achieving the goals and objectives established at the beginning of the demonstration?

2) Based on the findings, discuss the outcomes and impacts of the demonstration and identify the opportunities for improvements. Specifically:
    a. If the state did not fully achieve its intended goals, why not? What could be done in the future that would better enable such an effort to more fully achieve those purposes, aims, objectives, and goals?

H. Interpretations, Policy Implications and Interactions with Other State Initiatives – In this section, the state will discuss the section 1115 demonstration within an overall Medicaid context and long range planning. This should include interrelations of the demonstration with other aspects of the state's Medicaid program, interactions with other Medicaid demonstrations, and other federal awards affecting service delivery, health outcomes and the cost of care under Medicaid. This section provides the state with an opportunity to provide interpretation of the data using evaluative reasoning to make judgments about the demonstration. This section should also include a discussion of the implications of the findings at both the state and national levels.

I. Lessons Learned and Recommendations – This section of the Evaluation Report involves the transfer of knowledge. Specifically, the "opportunities" for future or revised demonstrations to inform Medicaid policymakers, advocates, and stakeholders is just as significant as identifying current successful strategies. Based on the evaluation results:

1) What lessons were learned as a result of the demonstration?

2) What would you recommend to other states which may be interested in implementing a similar approach?

J. Attachment

1) Evaluation Design: Provide the CMS-approved Evaluation Design

Iowa Wellness Plan Evaluation Design

The University of Iowa
Public Policy Center

April 28, 2021

I. Contents

II. Tables

III. Figures

Iowa Wellness Plan Evaluation Design

Introduction

This Iowa Wellness Plan Evaluation design provides detailed information for the period July 1, 2020 through December 31, 2024.

The following sections are included in this proposal.

General Background Information about the evaluation

General Data Sources, Analyses Methods, and Measures

Potential impacts of the COVID-19 pandemic

Evaluation time periods

Identifiable limitations with the proposed data and analyses.

Policy Components of the evaluation, as requested by CMS including the goals, hypotheses and research questions, component area methodology as well as the tables listing the outcome measures and analytic approaches and the approaches taken to evaluate them.

1) Healthy Behavior Incentives (HBI)
2) Dental Wellness Plan (DWP)
3) Retroactive Eligibility
4) Cost Sharing
5) Cost Outcomes and Sustainability
6) Waiver of Non-Emergency Medical Transportation (NEMT)
7) Iowa Wellness Plan Member Experiences from Increased Healthcare Coverage

Assurance of independent evaluator

Budget

Evaluation timeline and major milestones

General Background Information

Iowa Wellness Plan

Originally two demonstrations were approved on December 10, 2013, both to start on January 1, 2014: Iowa Wellness Plan (Project Number 11-W-00289/5) and Iowa Marketplace Choice (Project Number l 1-W-00288/5). Wellness Plan (WP) was a program operated by the Iowa Department of Human Services providing health coverage for uninsured Iowans from 0-100% of the Federal Poverty Level (FPL) and Marketplace Choice (MPC) was a premium support program for Iowans from 101-133% FPL. These two demonstrations encompassed a bipartisan solution to health care coverage for low-income adults not otherwise eligible for public supports and were put under the common name of Iowa Health and Wellness Plan (IHAWP). More information regarding the formulation and implementation of these two demonstrations can be found online at http://dhs.iowa.gov/ime/about/initiatives/iowa-health-and-wellness-plan.

IHAWP changes

IHAWP was modified in significant ways in the first two years (Table 1). The first major change occurred when CoOportunity Health withdrew as a Qualified Health Plan (QHP) for MPC members at the end of November 2014.[1] Approximately 9,700 CoOportunity Health members were automatically transitioned to Medicaid providers on December 1, 2014 through MediPASS (primary care case management program), Meridian (HMO), or traditional Medicaid (fee-for-service payment mechanism); however, they retained their designation as MPC members. IHAWP members who were not in CoOportunity Health remained in Coventry, the other QHP.

During calendar year 2015, it was mandated that all Medicaid members, including all IHAWP members, were to be placed into one of three managed care organizations (MCOs) beginning January 1, 2016. Due to a three-month implementation delay, IHAWP members previously enrolled with Coventry were placed in the traditional Medicaid FFS program effective December 31, 2015, until the Medicaid Managed Care Organizations (MCOs) began accepting members on April 1, 2016.

Effective January 1, 2016, the MPC program was not renewed. All MPC members were rolled into WP. The Iowa Health and Wellness Plan (IHAWP) became the Iowa Wellness Plan (IWP) covering Iowans not categorically eligible for Medicaid with incomes from 0-133% FPL. During CY 2016 members were enrolled with one of three MCOs: Amerigroup Iowa, Inc; AmeriHealth Caritas, Inc.; or UnitedHealthcare Plan of the River Valley, Inc.

Effective November 30, 2017 AmeriHealth stopped serving as an MCO for Iowa Medicaid. Amerigroup was not prepared to accept the AmeriHealth members, so UnitedHealthcare accepted the transfer of the bulk of AmeriHealth members. Effective June 30, 2019, UnitedHealthcare also exited the Iowa Medicaid program and Iowa Total Care was added.

Waiver of Retroactive Eligibility

An amendment to the IWP demonstration was submitted on August 10, 2017 requesting a waiver of retroactive eligibility for all but pregnant women and children under 1. The waiver was granted on October 27, 2017 with members enrolling on or after November 1, 2017 subject to the waiver. New

[1] Iowa Marketplace Choice Plan Changes. Iowa Department of Human Services. November 2014. Available at: https://dhs.iowa.gov/sites/default/files/CoOpTransition_FAQ_11052014.pdf. Accessed July 2, 2015.

members were no longer granted 90 days of retrospective enrollment, instead they were guaranteed enrollment from the first day of the month in which they applied. On July 1, 2019 nursing home residents were no longer subject to the waiver. One January 1, 2020 the waiver was renewed for another 5 years and children 1-19 years of age were no longer subject to the waiver.

Table 1. Timeline for Iowa Wellness Plan Development

Date	Change
January 2014	First IHAWP members enrolled
May 2014	MPC members enrolled in Dental Wellness Plan with Delta Dental of Iowa, a three-tiered benefit plan
July 2014	MPC members enrolled in the Healthy Behaviors Incentive Program
November 2014	MPC members in CoOportunity were moved to MediPASS (PCCM program), Meridian (HMO), or Coventry (QHP)
November 2015	MPC members in Coventry were moved to MediPASS or Fee-for-service (MPC component dormant)
December 2015	MPC demonstration ended, WP extended to members 100-133% FPL and renamed Iowa Wellness Plan
April 2016	IWP members moved to one of three MCOs - AmeriGroup Iowa, AmeriHealth Caritas, or UnitedHealthcare Plan of the River Valley
August 2017	All Medicaid adults enrolled in Dental Wellness Plan 2.0 with Delta Dental or MCNA a two-tiered benefit plan
August 2017	Iowa files an amendment to the IWP requesting a waiver of retroactive eligibility for all Medicaid programs
November 2017	AmeriHealth Caritas exits Medicaid program
October 2017	CMS officially approves IWP amendment for waiver of retroactive eligibility
November 2017	Waiver of retroactive eligibility begins, including all but pregnant women and children under 1
July 2018	Waiver of retroactive eligibility is amended to remove nursing home residents
July 2019	UnitedHealthcare exits Medicaid program as an MCO Iowa Total Care enters Medicaid program as an MCO
January 2020	Waiver is renewed for 5 years; children 1-19 years of age are removed from the retroactive eligibility waiver

Dental Wellness Plan

DWP 1.0: May 2014 – June 2017

On May 1, 2014, the Iowa began offering dental benefits to Iowa Health and Wellness Plan (IHAWP) members through the CMS-approved Dental Wellness Plan (DWP). Originally, DWP offered tiered dental benefits to the state's Medicaid expansion population (ages 19 to 64) with members earning enhanced benefits by returning for regular periodic recall exams every 6-12 months (DWP 1.0).

Three years later, on May 1, 2017, the State of Iowa proposed a waiver amendment to be effective July 1, 2017 that redesigned DWP as an integrated dental program for all Medicaid enrollees aged 19 and over.

DWP 2.0: July 2017 – June 2024

Benefit Design

Along with merging dental benefits into a single program, the 1115 waiver amendment also modified the DWP benefit structure. Originally, the DWP incorporated an earned benefits model. Medicaid enrollees were eligible for the same set of benefits; however, they did not have the same requirements for recall exams. The DWP 2.0 structure eliminates the tiered benefits in response to concerns that too few members had become eligible for Tiers 2 and 3. Comprehensive dental benefits are available to members in the DWP 2.0 during their first year of enrollment.

The modified earned benefit structure in DWP 2.0 requires members to complete State designated "healthy dental behaviors" annually in order to maintain comprehensive dental benefits after the first year of enrollment. Healthy dental behaviors include completion of an oral health self-assessment and a preventive dental visit.

Cost Sharing

Previously, adult Medicaid enrollees 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. However, members with incomes over 50% of the Federal Poverty Level (FPL) who do not complete the required healthy dental behaviors during their first year of enrollment will have a premium obligation beginning in year two. If members fail to make monthly $3 premium payments, benefits will be reduced to basic coverage benefits only. Certain DWP members (e.g., pregnant women) are exempted from the premium obligations and reduced benefits for failure to complete the healthy dental behaviors.

Consistent with the previous Medicaid 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 maximum was implemented for the DWP program.

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 PAHPs to deliver DWP benefits: Delta Dental of Iowa and MCNA Dental. Beginning July 1, 2017, all adult Medicaid enrollees were transitioned from the fee-for-service delivery system to one of these two PAHPs; existing Medicaid enrollees were assigned evenly between the two plans. Going forward, newly eligible individuals are also assigned evenly between the two plans. Members have the option to change PAHPs within the first 90 days of enrollment without cause.

Healthy Behaviors Incentives

One unique feature of the IWP is the Healthy Behaviors Incentive Program (HBI). Starting in 2015, IWP members who are above 50% of the Federal Poverty Level (FPL) could avoid paying a monthly premium for their insurance after their first year of coverage by participating in the HBI. Individuals who are at 0-50% of the FPL are not required to pay monthly premiums. The HBI 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 in 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). The member must then pay the monthly premium or claim financial hardship. Members who are above 100% FPL can be disenrolled for failure to pay their premium.

Previous findings

This IWP waiver evaluation design builds upon the findings of the first demonstration result by providing ongoing evaluation of key experiences and outcomes for the expansion population, improving the evaluation design to capture additional information for ongoing policies and undertaking an investigation of new policies that were enacted after the first waiver approval. Reports encompassing the first waiver evaluation can be found at https://ppc.uiowa.edu/health/study/evaluation-iowas-medicaid-expansion-iowa-health-and-wellness-plan.

Related Publications

- Evaluation of the Iowa Wellness Plan (IWP): Member Experiences in 2016
- Evaluation of Provider Adequacy in the Iowa Health and Wellness Plan During the Second Year
- Healthy Behaviors Dis-enrollment Interviews Report: In-depth interviews with Iowa Health and Wellness Plan members who were recently disenrolled due to failure to pay required premiums
- Iowa Health and Wellness Plan Evaluation Interim Report
- Evaluation of Provider Adequacy in the Iowa Health and Wellness Plan during the second year
- Healthy Behaviors Incentive Program Evaluation
- Non-Emergency Medical Transportation Policy Brief
- Non-Emergency Medical Transportation and the Iowa Health and Wellness Plan
- Evaluation of the Dental Wellness Plan: Member Experiences in the First Year
- Evaluation of Provider Adequacy in the Iowa Health and Wellness Plan During the First Year
- Iowa Dental Wellness Plan: Evaluation of Baseline Provider Network
- Evaluation of the Iowa Health and Wellness Plan: Member Experiences in the First Year
- First Look at Iowa's Medicaid Expansion: How Well Did Members Transition to the Iowa Health & Wellness Plan from IowaCare

Additional reports are posted on the Iowa Medicaid Enterprise and University of Iowa Public Policy Center websites as they are approved by CMS and the Iowa Department of Human Services (IDHS).

General Data Sources, Analysis Methods, and Measures

This section outlines the general methodologic approaches taken throughout the seven policy components (Healthy Behavior Incentives; Dental Wellness Plan; Retroactive Eligibility; Cost Sharing; Cost and Sustainability; Waiver of Non-Emergency Medical Transportation; and IWP Member Experiences). The methods specific to policy questions are included with each component. Each section describing the evaluation of the policy component will provide detailed descriptions of the related hypotheses, questions, populations/samples, and methods.

Evaluation Design

This evaluation design is complex and rigorous, encompassing up to 11 years of administrative and survey data. For many hypotheses we will be able to take advantage of pre- and post-implementation data at both the state and national level. We have also 1) built in more comparisons to other states, 2) increased our collection and utilization of Social Determinants of Health (SDOH) data, 3) added process measure collection and analysis, and 4) improved processing, maintenance, and use of the Medicaid data lake. Additionally, with the COVID-19 pandemic occurring during the first year of the renewal period, there are multiple adaptations we are considering for analytical strategies to reflect related changes in Medicaid policies, the health care system and population norms around health services need and utilization.

The State will work within policies and procedures established under the Iowa Code to contract with an independent entity to complete the evaluation activities. In the past, The University of Iowa Public Policy Center (UI PPC) has conducted many independent evaluations of Medicaid changes (please see: http://ppc.uiowa.edu/health). We fully anticipate that the PPC will meet the requirements of an independent entity under these policies and procedures. In addition, the University of Iowa brings the ability to meet the prevailing standards of scientific and academic rigor as appropriate and feasible for each aspect of the evaluation, including standards for the evaluation design, conduct, and interpretation and the reporting of findings. The PPC has in the past, and will continue to 1) use the best available data; 2) use controls and adjustments for limitations of the data, 3) report the effects of limitations on results; and 4) discuss the generalizability of results.

Target and Comparison populations

The current Iowa Wellness Plan program evolved into one demonstration from two separate but linked demonstrations on January 1, 2016 as outlined in Table 1. This change provides multiple possibilities for comparison groups over the life of the demonstration (January 1, 2014 through December 31, 2024). The groups described below may be utilized as target or comparison groups to test the hypotheses within the various components of the evaluation. The descriptions and information provided below are designed to provide a general understanding of the IWP population and population groups that may be used for comparison. All estimates are based on the most recent month for which data exists or CY 2019. Specific comparisons are included in the sections detailing the methods for the evaluation of the policy components.

Target population: Iowa Wellness Plan Members

Iowa Wellness Plan (IWP) members are the primary target population for this evaluation (except for Retroactive Eligibility). IWP members are between 19 and 64 years of age, are not categorically

eligible for any other Medicaid program, and have incomes between 0-133% of the Federal Poverty Level (FPL). Due to the evaluation's complexity, there are number of subsets to this target population described within the policy component sections.

January 2014-December 2015 (Original Iowa Health and Wellness Plan)

Iowa Wellness Plan originally included members enrolled in either Wellness Plan or Marketplace Choice. These plans included the following enrollment pathways and had the plan options listed below.

Wellness Plan enrollment pathways

1. People previously enrolled in a limited benefit plan (IowaCare) who had incomes from 0 to 100% FPL.
2. People who were not enrolled in a public insurance program but met the income eligibility criterion (0-100% FPL) could actively enroll.

Wellness Plan options

HMO: Until December 31, 2015, Meridian Health Plan was the only Medicaid HMO option in the state, operating in 29 counties in Iowa. It was available to Wellness Plan members in these 29 counties, where approximately half of the members were initially assigned to the HMO (e.g., the PCP option mentioned below). Members had the option to change from the HMO to other options available in their county. Though Meridian began operating in Iowa in March 2012, the plan was not awarded a contract under the IA Health Link managed care program.

Wellness Plan PCP: Operated through the Iowa Medicaid Enterprise, the PCP option was available in 88 counties statewide. Members were assigned a primary care provider (PCP) who was reimbursed $8 per member per month to manage specialty and emergency care for these patients. PCP assignment within the HMO or PCP was based on history of enrollment with a provider, provider closest to home, and appropriate provider specialty. Members had the option to change the assigned provider.

Fee-for service: Members in the 11 counties with no managed care option (HMO or PCP) were part of a fee-for-service program, not actively managed by the state or another entity.

Marketplace Choice enrollment pathways

1) People previously enrolled in a limited benefit plan (IowaCare) who had incomes from 101 to 133% FPL
2) People who were not enrolled in a public insurance program but met the income eligibility criterion (101-138% FPL) could actively enroll through the Marketplace.

Marketplace Choice options

People enrolled in Marketplace Choice were given a choice of two Qualified Health plans that both operated in all 99 Iowa counties.

CoOportunity Health was a non-profit co-operative health plan offered on the Health Insurance Marketplace through the federal government portal. It was established with start-up funds provided through the ACA, and operates statewide in Iowa and Nebraska, in alliance with HealthPartners of Minnesota and Midlands Choice provider network.

Coventry Health Care was a "diversified national managed care company based in Bethesda, MD". They were also operating statewide and available on the Health Insurance Marketplace through the federal portal.

Medically Frail IWP members

Wellness Plan options were available for Marketplace Choice members who were deemed 'Medically Frail'. The broader range of options provided more access to behavioral health services and eliminated copay and premiums. Members deemed 'Medically Frail' are removed from the study population for most analyses and will either be considered a comparison population or additional target population, depending on the analytical strategy selected in each topic area.

January-March 2016

Enrollment continued for Wellness Plan and Marketplace Choice during January-March 2016. However, all Medicaid members were placed into fee-for-service as the IA Health Link managed care program was implemented.

April 2016-present

On January 2016 Wellness Plan and Marketplace Choice merged to create Iowa Wellness Plan (IWP). Adult Iowans with 0-133% FPL who were not categorically eligible for Medicaid were eligible for IWP. Beginning April 1, 2016 all Medicaid members (with few exceptions such as PACE), were enrolled with one of three Medicaid Managed Care Organizations operating throughout Iowa: AmeriGroup Iowa, AmeriHealth Caritas, or UnitedHealthcare Plan of the River Valley. There have been changes to the MCOs over time with AmeriHealth Caritas ending their contract in November 2017, UnitedHealthcare Plan of the River Valley choosing not to renew their contract in July 2019 and Iowa Total Care executing a contract in July 2019. These changes make it important to control for which MCO a member is enrolled with as we look at outcomes that may be affected by MCO policies, quality assurance activities, and reimbursement strategies.

Comparison population: IowaCare

IowaCare was a limited provider/limited benefit program operating from 2005-2013.

Pre-IWP implementation: CY 2011-2013

The provider network included 1) a public hospital in Des Moines, 2) the largest teaching hospital in the state and 3) 6 federally qualified health centers. IowaCare enrolled adults, not categorically eligible for Medicaid, with incomes up to 200% FPL.

IowaCare was replaced by the Wellness Plan (WP) and Marketplace Choice (MPC) options. Table 2 details WP and MPC members by demographic characteristics and whether they were auto enrolled from IowaCare. Columns 1 and 2 provide the number of WP and MPC members who have pre-IWP experience through IowaCare (41,088 and 8,188, respectively). Columns 3 and 4 provide the number of WP and MPC members who were first enrolled through IWP and had no experience in Medicaid or IowaCare at the start of IWP (77,446 and 26,780, respectively). By the close of CY 2014 there were over 35,000 Marketplace Choice members and nearly 120,000 Wellness Plan members.

Table 2. Wellness Plan and Marketplace Choice members by IowaCare auto-enrollment (CY 2014)

	Auto enrolled from IowaCare		Not auto enrolled from IowaCare	
	Enrolled in Wellness Plan N (%)	Enrolled in Marketplace Choice N (%)	Enrolled in Wellness Plan N (%)	Enrolled in Marketplace Choice N (%)
Gender				
Female	20,673 (49%)	5,290 (60%)	39,860 (52%)	16,539 (62%)
Male	21,211 (51%)	3,528 (40%)	37,586 (48%)	10,241 (38%)
Race				
White	21,866 (52%)	4,587 (52%)	52,386 (68%)	18,399 (69%)
Black	3,183 (8%)	465 (5%)	6,310 (8%)	1,529 (6%)
American Indian	329 (1%)	52 (1%)	1,130 (2%)	272 (1%)
Asian	553 (1%)	138 (2%)	1,567 (2%)	683 (3%)
Hispanic	788 (2%)	224 (3%)	2,950 (4%)	1,350 (5%)
Pacific Islander	35 (<1%)	12 (<1%)	396 (1%)	293 (1%)
Multiple-Hispanic	270 (1%)	60 (1%)	739 (1%)	264 (1%)
Multiple-Other	116 (<1%)	27 (<1%)	622 (1%)	220 (1%)
Undeclared	14,744 (35%)	3,253 (37%)	11,346 (15%)	3,770 (14%)
Age				
18-21 years	1,355 (3%)	272 (3%)	7,314 (9%)	1,781 (7%)
22-30 years	9,699 (23%)	1,732 (20%)	22,228 (29%)	8,305 (31%)
31-40 years	8,627 (21%)	1,773 (20%)	17,624 (23%)	7,310 (27%)
41-50 years	10,378 (25%)	1,976 (22%)	14,018 (18%)	4,592 (17%)
51 and over	11,825 (28%)	3,065 (35%)	16,262 (21%)	4,792 (18%)
County rural/urban status				
Metropolitan	26,530 (63%)	5,451 (62%)	46,293 (60%)	15,466 (58%)
Non-metropolitan, urban	1,667 (4%)	420 (5%)	3,448 (5%)	1,408 (5%)
Non-metropolitan, rural	13,687 (33%)	2,947 (33%)	27,705 (36%)	9,906 (37%)
Total members	**41,884**	**8,818**	**77,446**	**26,780**

Comparison population: Family Medical Assistance Plan (FMAP) Members

The FMAP group is composed of adult parents/guardians of children in Medicaid in families with incomes less than 50% FPL.

Pre- and post-IWP implementation: CY 2011-2015

HMO: Meridian Health Plan is an HMO option for State Plan enrollees eligible because of low income in 29 counties. Members have the option to change their assigned provider.

MediPASS PCCM: Iowa Medicaid State Plan has had a Primary Care Case Management (PCCM) program called MediPASS-(Medicaid Patient Access to Services System) since 1990. This program was available in 93 counties and had approximately 200,000 members. In counties where managed care was available, new enrollees were randomly assigned to a primary care provider (PCP) within either the PCCM (or the HMO if available in the county). Only members enrolled in Medicaid due to low income enroll in MediPASS.

Fee-for service: Members in the 15 counties with no managed care option are part of a traditional fee-for-service payment structure.

Post-IWP implementation: CY 2016-2024

Enrolled in MCO option April 1, 2016. See discussion under IWP population.

Comparison population: Supplemental Security Income (SSI)

The SSI group is composed of Medicaid State Plan members enrolled due to a disability determination. The FPL for these members may range from 0 to 200%. We utilize this comparison group with caution as Medicaid members enrolled through disability determination may have different trends in cost and utilization than those Medicaid members who enroll due to income eligibility. We expect that their pre-program trends may be steeper. We will test the appropriateness of this comparison group empirically prior to their inclusion in analyses.

Pre- and post-IWP demonstration: CY 2011-2015

The only payment structure for these members was fee-for-service. Enrollees who were enrolled in Medicare are removed from evaluation analyses.

Post-IWP implementation: CY 2016-2024

Enrolled in MCO option April 1, 2016. See discussion under IWP population.

Table 3 below provides the demographics for members enrolled through IWP (not Medically Frail), FMAP, SSI and IWP (Medically Frail) for CY 2019.

Table 3. Comparison of Target population with three Medicaid comparison groups

	IWP not Medically Frail N (%)	FMAP N (%)	SSI N (%)	IWP Medically Frail N (%)
Gender				
Female	95,960 (52%)	43,555 (77%)	17,905 (51%)	14,769 (51%)
Male	88,398 (48%)	12,822 (23%)	16,647 (48%)	13,924 (49%)
Race				
White	109,628 (60%)	34,002 (60%)	22,694 (66%)	20,892 (73%)
Black	16,707 (9%)	7,013 (12%)	4,063 (12%)	1,932 (7%)
American Indian	2,804 (1%)	1,168 (2%)	436 (1%)	628 (2%)
Asian	4,884 (3%)	958 (2%)	257 (1%)	175 (1%)
Hispanic	9,635 (5%)	3,205 (6%)	552 (2%)	714 (2%)
Pacific Islander	977 (<1%)	354 (1%)	53 (<1%)	81 (<1%)
Multiple-Hispanic	2,774 (1%)	1,062 (2%)	312 (1%)	337 (1%)
Multiple-Other	2,125 (1%)	782 (1%)	162 (<1%)	265 (1%)
Undeclared	34,824 (19%)	7,833 (14%)	6,020 (17%)	3,669 (13%)
Age				
19-21 years	22,808 (12%)	2,695 (5%)	1,519 (4%)	744 (3%)
22-30 years	51,106 (28%)	19,442 (35%)	5,496 (16%)	5,938 (21%)
31-40 years	42,471 (23%)	21,717 (39%)	6,066 (18%)	7,570 (26%)
41-50 years	30,260 (16%)	9,914 (18%)	6,368 (18%)	6,648 (23%)
51-64 years	37,713 (21%)	2,609 (5%)	15,103 (44%)	7,793 (27%)
County rural/urban status				
Metropolitan	108,464 (59%)	31,765 (56%)	19,576 (57%)	17,248 (60%)
Non-metropolitan, urban	8,748 (5%)	2,725 (5%)	1,529 (4%)	1,208 (4%)
Non-metropolitan, rural	62,734 (34%)	19,847 (35%)	12,139 (35%)	9,876 (34%)
Months eligibility				
1-6 months	38,598 (21%)	8,505 (15%)	2,528 (7%)	2,981 (10%)
7-10 months	27,600 (15%)	6,572 (12%)	2,502 (7%)	2,997 (10%)
11-12 months	1118,160 (64%)	41,300 (73%)	29,522 (85%)	22,715 (79%)
Total	184,358	56,377	34,552	28,693

Target population: State of Iowa

For a variety of measures data for the entire state will be utilized especially with regard to sustainability, outcomes driven by access to care such as ED use, and long-term effects of utilization changes driven through a focus on primary/preventive care such as avoidable hospitalizations.

As a state, Iowa is considered rural with just over 3 million residents. Of these 60% are between the ages of 19 and 64, 50% are female and 91% are white. The largest minority group in Iowa is Hispanic or Latino with 6%. The Black or African American population represents 4% of Iowans. The median income for Iowans is $58,000 with 11% of Iowans living in poverty. Over 85% report having a computer with nearly 80% reporting an internet subscription. Out of the 99 counties comprising Iowa, 20 are considered rural with no metropolitan area, and 58 are considered rural with metropolitan area. 21 are considered urban metropolitan.

Comparison population: Other states

The process for identifying comparison states, both that have and have not expanded their Medicaid programs is ongoing. There are many data sources including TMSS, American Community Survey, BRFSS, that can provide data for Iowa and comparison states over time. However, extensive assessment is required during the first year of the evaluation to determine which of these data sources can provide the data needed for each hypothesis and for those datasets, which states are most comparable. As a small state, Iowa may not have enough representation in a dataset to allow analytical comparisons, the MEPS is one such data source that does not include enough Iowans to allow for state level comparisons.

Target population: Provider entities

Throughout the demonstration many policies and reimbursement/utilization strategies have operated through provider entities. For example, the $8 copayment for non-emergent ED use had to be charged by the ED. Additionally, many provider entities can choose what covered groups they would like to serve. Not all dentists or physicians are willing to see Medicaid members due to restrictive policies or poor reimbursements. Provider entities are an important target population to understand both the process and outcomes of demonstration activities.

Provider entities may include medical offices, dental offices, hospitals, long-term care facilities, and pharmacies.

Comparison population: Provider entities

There are two comparison populations: provider entities prior to the demonstration (CY 2011-2013) and provider entities not engaged in the demonstration. A data lake of Medicaid provider surveys dating back to before the demonstration will provide needed comparison data, however, there may be few provider entities that are not engaged in the demonstration.

Data Availability and Primary Collection

Data Access

The PPC has a data sharing Memorandum of Understanding (MOU) with the State of Iowa to utilize Medicaid claims, enrollment, encounter and provider data for evaluation purposes.

Administrative data

The PPC houses a Medicaid Data Repository encompassing over 300 million claims, encounter and eligibility records for all Iowa Medicaid enrollees for the period January 2000 through the present. Data are assimilated into the repository monthly. 95% of medical and pharmaceutical claims are completely adjudicated within 3 months of the first date of service, while average adjudication for institutional claims is 6 months. The PPC staff also has extensive experience with these files as well as over 20 years of experience with HEDIS measures. The PPC is a member of the National Quality Forum and the Academy Health State-University Partnership Learning Network.

The Medicaid database allows members to be followed for long periods of time over both consecutive enrollment months and periods before and after gaps in coverage due to a unique member number that is retained for at least 3 years after the last enrollment and is never reused.

This allows long-term linkage of member information including enrollment, cost and utilization even if they switch between Medicaid coverage options.

The evaluation strategy outlined here is designed to maximize the use of outcome measures derived through administrative data manipulation using nationally recognized protocols from the National Quality Forum (NQF) and National Committee on Quality Assurance (NCQA) HEDIS.

A synopsis of administrative data types and sources that will be used in this evaluation are provided below.

1. Medicaid encounter and claims data
   Contains all claim and encounter data for Medicaid members during the evaluation period. The data is housed within the PPC Medicaid data repository and is updated monthly
2. Medicaid enrollment data
   Contains data regarding enrollment and eligibility maintenance such as MCO enrollment, presence of an exemption from any demonstration activities, and Housed within the PPC Medicaid data repository with monthly updates
3. Medicaid provider certification data
   Housed within the PPC Medicaid data repository with monthly updates

Surveys

Surveys with IWP members and providers will be conducted to provide a consumer perspective and provider perspective about the program. The University of Iowa Public Policy Center (PPC) has extensive experience conducting consumer surveys with Medicaid members, having conducted member surveys for almost thirty years and publishing numerous articles on methods to increase response rates with Medicaid populations. In addition, the PPC participated on the development team for the original CAHPS survey and has been modifying the survey instrument to fit the needs for evaluating Iowa Medicaid waivers for the past 23 years. This experience also provides the evaluation team with access to CAHPS enrollee survey results for comparison purposes where appropriate.

Table 4 shows the different types of surveys that we are proposing for the IWP evaluation. This includes surveys of both members and providers as appropriate to evaluate the impact of the different policy components.

The sample sizes for these surveys, rather than being based on specific power calculations, are based on a combination of the power calculations that were conducted for the national CAHPS surveys (on which we were partners in the development), and our long historical foundation of previous surveys with Iowa Medicaid enrollees so we can predict the respondent numbers we need for sub-group analyses for items that are known. We do not believe it is appropriate to use power calculations for items for which we do not know the prevalence in the population since this is what the power calculations would be based on. We routinely increase our sample size where there is this level of uncertainty.

Table 4. IWP Survey Projects – CY 2021-2024

Survey	Policy Component	Sample Size	Expected Completes	Field Periods*	Incentives
Disenrollment	HBI	TBD	TBD	Rolling monthly thru waiver period	$2 pre; 20 GC post
HBI Phone	HBI	6000	1800	Yearly, beginning in Q1/Q2	$2 pre; $10 GC post
HBI Panel	HBI	TBD	TBD	Fall 2021, Fall 2022	$2 pre; $10 GC post
DWP Member	DWP	12,000	2400	Every 18 months	$2 pre; GC lottery
DWP Provider	DWP	1300	585	Every 18 months	$2 pre
Enrollment Phone	Retroactive Eligibility	5600	1680	Spring 2021-Spring 2022	None
IWP Member	Member experiences; NEMT	4500	900	Every 18 months	$2 pre; GC lottery
ED Experience	Cost sharing	600	300	CY 2022	None

*The schedule for the conduct of these surveys may be modified as appropriate based on changes in policies for the IWP; both for policies changed to respond to the COVID pandemic and for routine policy changes implemented by the Iowa Medicaid Enterprise.

Interviews

Several types of interviews/focus groups will be used as part of the process evaluation of the IWP. These include:

1. Medicaid member interviews
   Data and results from previous structured telephone interviews with subsets of Medicaid members are house at the PPC. Telephone interviews will be designed and fielded as needed for the policy components.
2. Medicaid program staff and contractors
   Medicaid program staff and contractors will be engaged to provide a more complete examination of demonstration implementation and ongoing activities and adjustments. Staff and contractors may participate in varying data collection strategies including in-person interviews, focus groups and surveys. This process evaluation approach was most recently utilized in the PPC evaluation of the State Innovation Model (SIM).

Additional secondary data sources

The additional sources of local and national secondary data listed below will be used to improve the evaluation of IWP providing a broader perspective on certain aspects of the program.

1. State and local secondary sources such as letters to providers, webpages, newsletters, and notices to members have been collected and stored. These will continue to be collected to provide context to the evaluation.
2. Iowa inpatient and outpatient hospital claims data
   The Iowa Hospital Association houses all hospital claims (inpatient and outpatient) for the state of Iowa. These data are available for the period 2013-present. Currently PPC houses the data for 2013-2017.
3. Possible national-level data sources
   - Healthcare Cost and Utilization Project (HCUP)
     https://www.hcup-us.ahrq.gov/HCUP_Overview/HCUP_Overview/index.html
     Annual claims for 37 states from 2006-2017 lacking location information. Can buy state specific database with zipcode location for ~$800 per state per year.
   - Transformed Medicaid Statistical Information System (T-MSIS)
     https://www.medicaid.gov/medicaid/data-and-systems/macbis/tmsis/index.html
     Claims from all state Medicaid programs, 2013-2016 with location information. However, due to changes in 2015-2018 there are only a handful of states that match Iowa's cutover date from TMAX to TMSIS.
     Data is obtained through ResDAQ. PPC has obtained Medicare data from ResDAQ in the past and maintains a secured server for these data.
   - Behavioral Risk Factor Surveillance System (BRFSS)
     https://www.cdc.gov/brfss
     Annual national survey from 1995-2018. Oversampling in Iowa provides an opportunity to compare to other states either through aggregate statistics easily obtainable on the web or through securing the more detailed, state-level datasets.
   - County Health Rankings and Roadmaps (CHRR)
     https://www.countyhealthrankings.org
     These annual (2011-2019) data ranking for each county in the US are compiled from other data sources and may provide needed county-level SDOH.
   - American Community Survey (ACS)
     https://www.census.gov/programs-surveys/acs
     An ongoing survey providing information about the economy, healthcare, housing and other topics designed to help public health officials and planners.
   - NCQA Quality Compass
     The PPC has purchased the NCQA Quality Compass data for commercial and Medicaid providers in the past. We will also investigate the advantage of utilizing CAHPS through AHRQ.
   - Iowa Medicaid Social Determinants of Health Data
     The Iowa Medicaid Enterprise is beginning to collect SDOH data on enrollees. The data is still in the testing phase, but we will request access if the data becomes available during the evaluation period.

Data analyses

The four major analytical strategies used in this evaluation are listed below. Each will be described in more detail within the specific policy component evaluation section.

1) Process measures
    a) Content analyses
    b) Document analyses
2) Bivariate analyses
    a) Parametric methods, e.g., paired and two-sample t-tests (or means tests)
    b) Non-parametric methods, e.g., Wilcoxon signed-rank tests, chi-square test of independence
3) Multivariate modelling
    a) Comparative Interrupted Time Series (CITS including Difference-in-Difference (DID))
        i) OLS for continuous dependent variables
        ii) Maximum likelihood estimators (logit or probit) for binary dependent variables
        iii) Special regressor method for binary dependent variables with endogenous regressors
    b) Zero-inflated (modified) Poisson Regression for count dependent variables
    c) Survival analyses
    d) Other supplementary techniques
        i) Matching methods (propensity scores, coarsened exact matching)
        ii) Inverse probability of treatment weights
4) Qualitative analyses

Data Limitations and Considerations

There are five primary sets of limitations within this evaluation: 1) those related to primary data, 2) limitations of secondary data, 3) program selection bias, 4) study populations, and 5) COVID-19 considerations.

Primary Data

Primary data collection is based on self-reported information and the recall of the member. This can result in recall bias. Whenever possible, we utilize multiple methods to address hypotheses. Coupling primary data collection with secondary data collection and qualitative data provides an opportunity to describe and analyze hypotheses more fully.

Past surveys and interviews with Medicaid members in Iowa, and across the nation, have low response rates, ranging from 20-40%. Non-response bias tests will be conducted to determine if the characteristics of respondents differ significantly from non-respondents on measured qualities. COVID-19 poses a unique set of limitations that are discussed below.

Secondary Data

Administrative data are collected for billing and tracking purposes and may not always reflect the service provided accurately. Payers focus on specific areas that may result in sudden changes in primary diagnoses or care patterns. For example, when diabetes became a key quality focus for payers, the use of diabetes as a primary diagnosis and the rates of HbA1c increased. Though this system change is positive, it is not a result of the IWP. We will attempt to keep informed of all changes in Medicaid and MCO coding and quality focus.

Program Selection Bias

There may be a propensity for enrollees who have the most to gain from insurance coverage to have accessed services earlier than those with less to gain. This has the potential to bias all the estimates of program effects on quality measures and costs for the period prior to Iowa Wellness Plan. Essentially, those who are sicker may use services earlier and the reduction in costs accounted for these enrollees by the Wellness Plan may be greater than for later enrollees. Risk adjustments will used where appropriate to attempt to correct for this potential bias. Some methods may result in estimates that are more valid but only pertain to a segment of the population.

Study populations

Iowa Wellness Plan has undergone many changes during the first demonstration period. In particular, certain aspects of IWP have been extended to the general Medicaid population, e.g. PHAP dental coverage, enrollment in MCOs. These changes make it more difficult to identify appropriate comparison populations. Additionally, in other studies we have found it difficult to identify states that are comparable to Iowa for state-level comparisons. We will continue to identify comparison groups at all levels, while attempting to adjust for differences that would affect our results.

COVID-19 Considerations

The COVID-19 pandemic has disrupted established systems of care throughout our nation. Changes such as the increased use of telehealth, increased use of acute care related to COVID-19 concerns, and the avoidance of routine/chronic care make it necessary to adapt methods and analytics to adjust for these changes. At the individual level we are conceptualizing a person-month unit of analyses that can utilize dichotomous variables to identify key trigger points. Additionally, we are working to identify methods of accounting for the level of COVID-19 penetration in an area as a covariate to generally adjust for these effects. We will continue to communicate with other evaluators nationally to determine what best practices are being developed around complex analytics and COVID-19. This could negatively impact the ability to identify comparison states as we now add COVID-19 exposure and Medicaid program policy changes, to the list of characteristics that may need to be matched or accounted for, at least for certain time periods.

We anticipate at this point in COVID-19 pandemic, three impacts of COVID-19 on the evaluation plan, including methods, analytic considerations, and interpretation of findings.

Methods

At the individual level we are conceptualizing a person-month unit of analyses that can utilize dichotomous variables to identify key trigger points. COVID-19 may have implications for the comparison groups we use in our analyses. For example, in policy component 7, we rely on a national comparison group of CAHPS survey respondents. Our teams will need to assess the appropriateness of this group given the different ways states have implemented policy changes related to COVID-19. There are questions about comparability between states. Similarly, at the state-level it becomes more and more difficult to identify comparison states as we now add COVID-19 exposure and responses to the list of characteristics that may need to be matched or accounted for.

Early reports indicate that survey response rates are improved during, and perhaps following, the COVID-19 pandemic. As individuals shelter in place, they are more likely to take the time to be interviewed or complete a survey. The salience of the pandemic and its relationship to health care utilization, may increase the willingness of certain respondents to complete surveys and questionnaires. Though this may improve response rates, we do not know whether the sample of respondents completing surveys during the pandemic share the same underlying characteristics as past respondents. Given this consideration, our team of researchers will compare respondents based on their underlying characteristics to determine whether further analytic adjustments are required.

Analytic Considerations

Though we propose specific analytical tools within this evaluation and even go so far as to link analytical strategies to hypotheses, we may find that additional analytical strategies will have to be employed. For example, we are considering how to account for the level of COVID-19 penetration in a geographical area as a covariate to generally adjust for these effects. Propensity scoring, instrumental variables and survival analyses are all techniques that we will retain in our list of possible techniques. As we become more familiar with the distribution of the outcomes and the data we will be using, we need to be comfortable modelling and testing each outcome with the strategy that will provide us with the most accurate and useful results. We will continue to communicate with other evaluators to determine what best practices are being developed around complex analytics and COVID-19.

Table 5 lists possible ways that the COVID-19 pandemic, and associated policy changes could have an impact on the data, analyses and results of the IWP evaluation. We are expanding the scope of our process evaluation to include state policy changes related to COVID-19. A summary of the changes to date are found in Table 6.

Table 5. Anticipated Impact of COVID-19 on IWP Evaluation Plan

Topic Area	Examples of Potential Impact	Rationale
Insurance Coverage Gaps and Churning	1. Monitor changes to churning due to people changing health insurance plans and losing eligibility 2. Increased gaps in insurance coverage 3. Decreased consecutive coverage	CDC projects multiple waves of COVID-19-related unemployment, potentially leading to variations in Medicaid and IWP coverage. As Iowans gain and lose employer-based health insurance, Iowans' reliance on Medicaid and IWP will fluctuate.
Dental Wellness Plan	1. Decreased access to dental care 2. Provider willingness to accept new DWP members	Dental providers are vulnerable to COVID-19 exposure and face strict requirements for reopening (e.g., enough PPE stock), limiting the number of dental providers available to new and existing patients.
Telehealth (*new topic*)	1. Decreased face-to-face primary care, dental, mental health, and preventive care visits.	Healthcare providers have transitioned to virtual appointments. Our current evaluation plan does not measure telehealth services. The shift from in-person to virtual healthcare visits may impact hypotheses across our evaluation plan. We may add telehealth questions where applicable.

Table 6. Iowa Wellness Plan: COVID-19 State Changes Timeline, 2020

Date CY 2020	Summary
January 1	Reinstatement of retroactive coverage for children and pregnant women. Guidelines found here.
February 20	CDC issues coding guidelines for novel Coronavirus for health care encounters and deaths related to COVID-19. Guidelines found here.
March 1	Updates to billing procedure for telehealth services establishing "originating" and "Distant" site changes. Guidelines found here.
March 6	New coding for virtual care services, telehealth related services, and Coronavirus lab tests established in light of COVID-19 pandemic. Guidelines found here.

Date CY 2020	Summary
March 13	DHS waives all Medicaid co-pays, premiums and contributions, Prescription refill guideline changes, Telehealth streamlining of appropriate service changes including modifier 95 designation and POS codes for telehealth billing. Guidelines found here. Complete Summary list of submitted federal waivers found here. Changes and eligibility criteria for Home delivered meals, Homemaker services and companion services with changes in billing and coding. Includes information for finding service providers and information for case managers. Guidelines found here.
March 18	All pharmacy PA's extended through June 30th. Prescription member copayments suspended including potential for refunds. Pharmacy benefit manager (PBM) audits suspended with changed guidelines. Patient signatures for medication receipt waived. Due date of Cost of Dispensing (COD) survey extended to April 30th Guidelines found here.
April 1	Changing waiving criteria for Prior Authorizations (PAs) for Medicaid members, and also changes to extensions for MCO approved PAs. Changes to claims filing for medical claims including a 90 day extension to first time medical claims and encounters for MC claims. Guidelines found here.
April 2	Expansion of list of telehealth services with billing and coding changes. Expansion of provider types included in telehealth services where appropriate. Guidelines and frequently asked questions found here.
April	Unemployment and stimulus benefit considerations for Medicaid recipients FAQs found here.
May 6	CMS guidance for nursing homes to procure communicative technology for residents and restrictions implemented to prevent visitation. Guidelines on use and sharing of communicative devices. Grant funding requirements for nursing homes' procurement of communicative devices for residents. Guidelines found here.
May 15	Guidance for retainer payments during the month of April 2020 with a list of allowable services with appropriate codes to use for seeking retainer payments Guidelines found here.

Date CY 2020	Summary
May 19	New guidance on additional codes pertaining to COVID-19 including new diagnostic coding, laboratory tests and specimen collection. Guidelines found here.
June 1	The Families First Coronavirus Response Act (FFCRA) establishes a new Medicaid eligibility group for uninsured individuals for the purposes of COVID-19 testing. All details and guidance for the new beneficiary group found here.
June 19	Updated Medicaid provider toolkit found here.

Table 7 refers to COVID-related policies that affected members of the Dental Wellness Plan:

Table 7.Iowa Dental Wellness Plan: COVID-19 State Changes Timeline

Date CY 2020	Summary
March 13	Coding and billing for teledentistry services including legal parameters and details of requirements for teledentistry encounters established. Guidelines found here.
March 16	UI College of Dentistry ceases elective patient care ADA recommends dentists "focus only on urgent and emergency procedures"
March 17	IDA and IDB recommend that dentists cease elective care for 3 weeks
March 22	Iowa Governor issues Proclamation of Emergency Disaster
March 27	Iowa Governor mandates cessation of non-emergency dental care, effective through April 16
April 2	Iowa Governor extends proclamation, which includes ban on non-emergency dental care, to expire on May 1
April 16	Federal government shares guidelines for re-opening
April 27	Iowa Governor extends prohibition of nonessential dental services through May 15
May 3	CDC recommends postponing elective dental care "during this period of the pandemic (no end date provided)
May 6	Iowa Governor issues proclamation that any dental care resume with adherence to safety guidelines, effective May 8. State of public health disaster emergency currently set to expire on May 27th.
May 8	Dentists in Iowa may begin providing routine dental care
May 26	Iowa Governor issues extension of previous proclamation and extends the window until June 25th.
July 1	IME issued IL 2148-FFS-D-CVD announcing an enhanced dental payment to address facility and safety upgrades.

Evaluation Period

Evaluation Timeframes:
Start and End Dates of the Iowa Wellness Plan Demonstration.

- Total demonstration time period January 1, 2014 – December 31, 2024

Start and End Dates of the Dental Wellness Plan Demonstration.

- Total demonstration time period May 1, 2014 – December 31, 2024

Start and End Dates of Retroactive Eligibility Demonstration.

- Total demonstration time period November 1, 2017 – December 31, 2024

Policy Components

This section provides more detail about the approach and rigor being proposed to evaluate the key policy components that CMS has indicated were of particular interest.

1) Healthy Behaviors Incentive Program (HBI)
2) Dental Wellness Plan (DWP)
3) Waiver of Retroactive Eligibility
4) Cost Sharing
5) Cost and Sustainability
6) Waiver of Non-Emergency Medical Transportation (NEMT)
7) Iowa Wellness Plan Member Experiences from Increased Healthcare Coverage

1) Healthy Behaviors Incentive Program (HBI)

HBI Background

One unique feature of the IWP is the Healthy Behaviors Incentive Program (HBI). IWP members who are above 50% of the Federal Poverty Level (FPL) can avoid paying a monthly premium for their insurance after their first year of coverage by participating in the HBI. Individuals who are at 0-50% of the FPL are not required to pay monthly premiums. The HBI 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 in 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). The member must then pay the monthly premium or claim financial hardship. Members who are above 100% FPL can be disenrolled for failure to pay their premium.

As a part of the IWP, enrollees are encouraged to participate in the HBI involving two components: 1) a wellness exam and 2) a health risk assessment (HRA).

Starting in 2015, a small monthly contribution by the member was required depending on family income. Members with incomes above 50% FPL and up to 100% FPL contributed $5 per month, while members with incomes above 100% FPL contributed $10 per month. Members with individual earnings 50% or less of the FPL did not have monthly contributions. IWP members who completed the wellness exam and the HRA were not be responsible for a monthly contribution.

Members earning over 50% of the FPL were given a 30-day grace period after the enrollment year to complete the healthy behaviors to have the contribution waived. If members did not complete the behaviors after the grace period ended, members received a billing statement and a request for a hardship exemption form. For members with incomes above 50% FPL and up to 100% FPL, all unpaid contributions were considered a debt owed to the State of Iowa but would not, however, result in termination from the IWP. If, at the time of reenrollment, the member did not reapply for or was no longer eligible for Medicaid coverage and had no claims for services after the last premium payment, the member's debt would be forgiven. For members with incomes above 100% FPL, unpaid contributions after 90 days resulted in the termination of the member's enrollment status. The member's outstanding contributions were considered a collectable debt and subject to recovery. A member whose IWP benefits were terminated for nonpayment of monthly contributions needed to reapply for Medicaid coverage. The IME would permit the member to reapply at any time; however, the member's outstanding contribution payments would remain subject to recovery.

Wellness Exam and Health Risk Assessment

The wellness exam is an annual preventive wellness 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 are part of the preventive services covered by the plans and therefore do not cost the member anything out-of-pocket. A 'sick visit' can count towards the requirement of the preventive exam, if wellness visit components are included and the modifier 25 is used. The wellness exam definition was expanded in 2016 to include a dental exam (D0120, D0140, D0150, D0180). A health risk assessment (HRA) is a survey tool that can be used to evaluate a member's health. The MCOs are currently encouraging members to complete an HRA. The format of the HRA differs by MCO.

Implementation of the HBI 2020

There were several changes between the planned and actual implementation of the HBI in the original waiver period. Table 8 describes changes to the HBI overall while Table 9 describes changes in the HBI related to the transition of the IWP to managed care. The HBI was reapproved as part of the extension of the IWP effective January 1, 2020. Table 8 and Table 9 also show the planned implementation for the HBI as described in the extension where applicable.

Table 8. Changes to the Healthy Behaviors Incentive Program (does not include changes related to COVID-19)

Original Planned implementation	Actual implementation	Planned implementation for 2020-2025
Wellness exam was defined as CPT codes 99385, 99386, 99395, and 99396 or a "sick visit" with a modifier code of 25.	Additionally, members could report having a wellness exam without documentation. In year 2 a preventive dental exam also fulfilled the requirement.	No change.
Members needed to complete the Assess My Health HRA tool. The data would be available to IME, providers, and members.	This information is not shared with the providers or the members.	The MCOs are responsible for members completing the HRA.
A communication campaign would ensure members, providers, and clinic staff awareness and knowledge of the program.	There were limited communication efforts.	Unknown.
The Marketplace Choice would provide members with insurers to select from.	The MPC members were converted to the Wellness Plan when both QHPs were no longer participating in the IHAWP	No change.
Members were to be disenrolled for non-payment of contribution and not completing the HRA and wellness exam.	Systems were not in place to make disenrollment possible until the 4th quarter of the 2nd year.	Members are disenrolled for non-payment or not completing the HBI.
Members could complete HRA online with/out provider.	Members could report having completed a HRA without documentation. Some health systems helped members complete the HRA over the telephone.	The mode of completion differs by MCO.
Co-pay of $8 for emergency department visit.	The copayment for non-emergency use of the emergency department was implemented on December 1, 2016.	No change.

Table 9. Managed care related changes to the Healthy Behaviors Incentive Program

Original Planned implementation	Actual implementation	Planned implementation for 2020-2025
Members needed to complete the Assess My Health HRA tool. The data would be available to IME, providers, and members.	Each MCO has a different screening or risk assessment tool.	No change.
An outside vendor was supposed to implement a program to incentivize members to complete other behaviors.	Following the transition to statewide managed care, the MCOs offered "value added benefits," such as rewards programs that served the purpose of incentivizing members to complete behaviors.	Not part of the implementation.
Members were supposed to complete the wellness exam and the HRA to be eligible for the additional incentivized behaviors.	Any MCO member can participate in the MCO's rewards program.	Not part of the implementation.
Providers were to receive incentives to encourage patients to complete HBI.	MCOs were given flexibility to implement provider incentive programs to be reviewed and approved by IME.	Not part of the implementation.
Data from the HRA was to be used to make programmatic decisions.	The data from HRA cannot be used because the data is housed by the MCOs.	Not part of the implementation.
Three MCOs were available for IWP members to select from.	Two MCOs exited the state while one MCO entered,	There currently two MCOs (Amerigroup and Iowa Total Care)

Previous evaluation findings

IWP member experiences during the first year of the IWP program have been reported previously and can be found online at http://ppc.uiowa.edu/health/study/evaluation-iowas-medicaid-expansion-iowa-health-and-wellness-plan.

We used claims data to conduct rigorous secondary analyses including descriptive analyses of trends in completion rates stratified by income level, multivariable regression analyses to model the likelihood of completing required activities, and quasi-experimental approaches to model health care utilization and spending as a function of completing both required activities. Over the first 5 years of the HBI program, the proportion of members completing both required activities—the wellness exam and HRA—averaged 11% for lower-income members and 18% for higher-income members. In any given year, the rate of completing both required activities never exceeded 32%. Over time, the completion rates dropped among the lower-income members shielded from disenrollment (and in some cases, premiums), while increasing among the higher-income members, suggesting that members are responsive to the disincentives being placed on them. Still, completion rates were generally below 25% even among the more compliant higher-income group. We have consistently found that the program may unintentionally exacerbate disparities in health insurance coverage, as members who are younger, male, non-white, and/or live in a rural area are less likely to complete both healthy behaviors and therefore more likely to owe a monthly premium or face disenrollment (Wright, et al., 2018; Askelson, et al., 2017). Finally, using difference-in-differences modeling we found that those who completed both required HBI activities had fewer ED visits and

hospitalizations, but spent more in health care costs, even after controlling for the effects of Medicaid expansion (Wright, et al., 2020).

To more fully explore the experiences of IWP members with regards to the HBI, we conducted qualitative interviews in 2015 with members who had been enrolled in the program at least 6 months. These results can be found at http://ppc.uiowa.edu/health/study/healthy-behaviors-incentive-program. We analyzed 146 in-depth interviews. We found that member awareness of the program requirements was low, and many respondents did not recall receiving information about the program. Of those who participated in the interviews, the majority had not received an invoice for premiums. Most of those who did receive an invoice did not have difficulties paying their premiums. Interviewees identified encouraging the use of preventive care, promoting health, and lowering health care costs as reasons for them to participate in the HBI. Members also said that a benefit of participating would be thinking more about their own health and lifestyle choices. Overall, interview participants stated that health insurance coverage was important for them because of current medical conditions and future unknown medical needs.

Based on the qualitative interviews with members, we developed a survey to assess member awareness of the HBI, knowledge of the program, perceptions of the program, and experiences with completing the behaviors and paying premiums. The first survey was fielded in 2017, we randomly sampled 6,000 members and had 1,375 respondents. We found that there was low awareness of the program and its requirements and that many members did not complete the program requirements. The vast majority of respondents stated they would rather complete the program requirements than pay $10 per month. In 2018, we followed up with members who completed the 2017 survey to reassess their awareness and completion of program requirements. We surveyed 1,102 members and had 641 respondents. A significant number of members remained unaware of the HBI despite being enrolled in the program for at least two years. In 2019, we repeated the sampling and recruitment methods from 2017. From a random sample of 6,000 members who had not previously participated in other data collections for this evaluation, we had 1,353 respondents. We found that awareness of the program was still low. The weighted percent of respondents who completed a wellness exam (WE) was about 45%, the completion of the HRA was only approximately 15%. Under half of the members recalled being told to complete a medical WE (43.7%), dental WE (41.1%), or HRA (31.0%). Despite this, the respondents once again overwhelmingly stated they would rather complete the program requirements than pay $10 per month.

We also conducted qualitative interviews and surveys with disenrolled members. We conducted two rounds of interviews, with 37 interviews in 2016 and 35 interviews in 2017. The overall themes did not differ between years. An overarching theme was that many interviewees were not aware of the HBI. While for some disenrollment was a minor inconvenience, other interviewees experienced financial hardship because of their disenrollment and engaged in behaviors that could be detrimental to their health (e.g., not refilling prescriptions or stretching medication and delaying or skipping previously scheduled health care appointments). Interviewees also noted confusion around the disenrollment and reenrollment processes. Many were not able to reenroll either in the IWP or another insurance program. In 2017 (n = 237) and 2019 (n= 109), we surveyed disenrolled members about their experiences. Similar to our qualitative interviews, many of the disenrolled members we surveyed were not aware of the HBI (27% in 2017 and 39% in 2019). Very few (under 30% in both years) members were able to reenroll in the IWP at the time of the survey. Respondents delayed filling prescriptions, stretched medication, and delayed or did not seeking care. They also reported paying more for health care, dental care, or prescriptions due to their disenrollment. Over half of respondents were concerned about their debt being sent to collections.

Findings from other state's healthy behavior programs evaluations

Other states have implemented healthy behavior programs that are similar in design to Iowa's program (particularly Michigan and Indiana) and the results are comparable to those seen in our evaluation. The evaluation of the Heathy Michigan Plan showed over 80% received at least one preventive care service in the first two years of its implementation, but only about 25% of participants completed an HRA (Clark, Cohn, & Ayanian, 2018). A survey with primary care providers in Michigan in 2015 also showed low awareness of financial incentives associated with HRAs but indicated that providers found the HRA useful for discussing health behaviors with their patients (Zhang et al, 2020). In 2018, enrollee surveys showed lingering low awareness of the HRA while claims data showed about 75% of enrollees having at least one preventive care visit in the previous two years and almost half of enrollees completing the HRA (Goold et al, 2020). Limited program awareness and low completion rates of program requirements were also seen in components of the Healthy Indiana Plan (Lewin Group, 2019). Over half of enrollees who were eligible for a premium under the Healthy Indiana Plan were moved to a limited benefits package or lost coverage due to failure to pay premiums (Rudowitz, Musumeci, Hinton, 2018). This was often due to an inability to pay or confusion about the program requirements (Rudowitz, Musumeci, Hinton, 2018).

References

Askelson, N.M., Wright, B., Bentler, S., Momany, E.T., & Damiano, P. (2017).Iowa's Medicaid expansion promoted healthy behaviors but was challenging to implement and attracted few participants. *Health Affairs.* 36(5):799-807.

Clark, S., Cohn, L., & Ayanian, J. (2018). Healthy Michigan Plan Evaluation: Report on Health Behaviors, Utilization, and Health Outcomes in the Healthy Michigan Plan. Retrieved from https://www.michigan.gov/mdhhs/0,5885,7-339-71547_2943_66797-490239--,00.html

Goold, S., Clark, S., Kullgren, J., Beathard, E., Kirch, M., Bryant, C., ... & Ayanian, J. (2020). Healthy Michigan Plan Evaluation: 2018 Healthy Michigan Voices Cohort II Survey Report.

Lewin Group. (2019). Indiana Healthy Indiana Plan Interim Evaluation Report. Retrieved from https://www.in.gov/fssa/hip/files/IN_HIP_Interim_Evaluation_Report_Final.pdf

Rudowitz, R., Musumeci, M., Hinton, E. (2018). Digging Into the Data: What Can We Learn from the State Evaluation of Healthy Indiana (HIP 2.0) Premiums. The Henry J. Kaiser Family Foundation. Retrieved from https://www.kff.org/medicaid/

Wright, B., Askelson, N.M., Ahrens, M., Momany, E., Bentler, S., & Damiano, P. (2018). Completion of requirements in Iowa's Medicaid expansion premium disincentive program, 2014–2015. *American Journal of Public Health.* 108(2):219-223.

Wright, B., Jung, Y.S., Askelson, N.M., Momany, E.T., & Damiano, P. (2020). Iowa's Medicaid Healthy Behaviors Program associated with reduced hospital-based care but higher spending, 2012–17: An examination of whether Iowa's Health Behaviors Medicaid program reduces hospital-based care and lowers health care costs. *Health Affairs.* 2020;39(5):876-883.

Zhang, E., Tipirneni, R., Beathard, E. R., Lee, S., Kirch, M. A., Salman, C., ... & Ayanian, J. Z. (2020). Health Risk Assessments in Michigan's Medicaid Expansion: Early Experiences in Primary Care. *American Journal of Preventive Medicine*.

HBI Goals

The goals of the Healthy Behavior Incentives that are included as part of the Iowa Wellness program are designed to:

- Empower members to make healthy behavior changes.
- 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.

HBI Hypotheses and Research Questions

Hypothesis 1: The proportion of members who complete a wellness exam, health risk assessment, or both will vary.

Research Question 1.1: What proportion of members complete a wellness exam in a given year?

Research Question 1.2: What proportion of members complete an HRA in a given year?

Research Question 1.3: What proportion of members complete both required activities in a given year?

Hypothesis 2: The proportion of members completing a wellness exam, health risk assessment, or both will change over time and by income level.

Research Question 2.1: Has the proportion of members completing a wellness exam decreased among lower-income members and increased among higher-income members?

Research Question 2.2: Has the proportion of members completing an HRA decreased among lower-income members and increased among higher-income members?

Research Question 2.3: Has the proportion of members completing both required activities decreased among lower-income members and increased among higher-income members?

Hypothesis 3: Member characteristics are associated with the likelihood of completing both required HBI activities.

Research Question 3.1: Are older, non-Hispanic white females living in metropolitan counties more likely to complete both required activities?

Research Question 3.2: Are members assigned to some MCOs more likely than members assigned to other MCOs to complete both required activities?

Research Question 3.3: Is the length of time in the program positively associated with the likelihood of completing both required activities?

Research Question 3.4: Are members with more negative social determinants of health (SDoH) less likely to complete both required activities?

Research Question 3.5: Is the highest income group most likely to complete both required activities?

Hypothesis 4: Completing HBI requirements is associated with a member's use of the emergency department (ED).

Research Question 4.1: Are members who complete the HBI requirements equally likely to have an ED visit?

Research Question 4.2: Do members who complete the HBI requirements have fewer total ED visits annually?

Research Question 4.3: Are members who complete the HBI requirements less likely to have a non-emergent ED visit?

Research Question 4.4: Do members who complete the HBI requirements have fewer total non-emergent ED visits annually?

Research Question 4.5: Are members who complete the HBI requirements less likely to have a 3-day, 7-day, or 30-day return ED visit?

Research Question 4.6: Do members who complete the HBI requirements have fewer total 3-day, 7-day, or 30-day return ED visits annually?

Hypothesis 5: Completing HBI requirements is associated with a member's use of hospital observation stays.

Research Question 5.1: Are members who complete the HBI requirements equally likely to have a hospital observation stay?

Research Question 5.2: Do members who complete the HBI requirements have fewer total hospital observation stays annually?

Hypothesis 6: Completing HBI requirements is associated with a member's use of inpatient hospital care.

Research Question 6.1: Are members who complete the HBI requirements equally likely to be hospitalized?

Research Question 6.2: Do members who complete the HBI requirements have fewer total hospitalizations annually?

Research Question 6.3: Are members who complete the HBI requirements less likely to have a potentially preventable hospitalization?

Research Question 6.4: Do members who complete the HBI requirements have fewer total potentially preventable hospitalizations annually?

Research Question 6.5: Are members who complete the HBI requirements less likely to have a 30-day all-cause readmission?

Research Question 6.6: Do members who complete the HBI requirements have fewer total 30-day all-cause readmissions annually?

Hypothesis 7: Completing HBI requirements is associated with shifts in patterns of member's health care utilization.

Research Question 7.1: Do members who complete the HBI requirements have fewer potentially preventable hospitalizations as a proportion of total hospitalizations?

Research Question 7.2: Do members who complete the HBI requirements have fewer non-emergent ED visits as a proportion of total ED visits?

Research Question 7.3: Do members who complete the HBI requirements have more primary care visits as a proportion of total outpatient visits?

Hypothesis 8: Completing HBI requirements is associated with a member's health care expenditures.

Research Question 8.1: Do members who complete the HBI requirements have lower spending in all categories?

Hypothesis 9: Disparities exist in the relationships between HBI completion and outcomes.

Research Question 9.1: Do disparities exist in the following populations- high utilizers, individuals with multiple chronic conditions, individuals with OUD, individuals from racial and ethnic groups, rural individuals, and by sex?

Hypothesis 10: Members who have been enrolled longer are more aware of the HBI program than those who have been enrolled a shorter period of time.

Research Question 10.1: What is the level of awareness about the HBI program among members?

Research Question 10.2: How long are members enrolled in the program?

Research Question 10.3: Is there a relationship between length of enrollment and awareness of the HBI program?

Hypothesis 11: Members who have been enrolled longer have more knowledge about the HBI program than those who have been enrolled a shorter period of time

Research Question 11.1: What specific knowledge about the HBI program do members report?

Research Question 11.2: Do members understand incentive/disincentive part of the HBI program?

Research Question 11.3: Do members know they need to pay a premium monthly?

Research Question 11.4: Do members know about the hardship waiver?

Research Question 11.5: How long have members been enrolled?

Hypothesis 12: Those who are aware of the HBI program are more likely to complete the behaviors (HRA and well exam) compared to those who are not aware.

Research Question 12.1: What is the level of awareness of the HBI program?

Research Question 12.2: What is the level of completion of the HRA and well exam?

Hypothesis 13: Those who have more knowledge about the HBI program are more likely to complete the behaviors (HRA and well exam) than those with less knowledge.

Research Question 13.1: What is the level of knowledge about the HBI program?

Research Question 13.2: What is the level of completion of the HRA and well exam?

Hypothesis 14: Member socio-demographic characteristics and perceptions/attitudes are associated with awareness of the HBI program.

Research Question 14.1: What is the level awareness of the HBI program?

Research Question 14.2: What are the socio-demographic characteristics (age, gender, income, education, employment, race, and ethnicity) of members?

Research Question 14.3: What are the perceptions/attitudes (self-efficacy, response efficacy, perceived susceptibility, perceived severity, and perceived benefit) of members?

Hypothesis 15: Member socio-demographic characteristics and perceptions/attitudes are associated with knowledge of the HBI program.

Research Question 15.1: What is the level knowledge of the HBI program?

Research Question 15.2: What are the socio-demographic characteristics (age, gender, income, education, employment, race, and ethnicity) of members?

Research Question 15.3: What are the perceptions/attitudes (self-efficacy, response efficacy, perceived susceptibility, perceived severity, and perceived benefit) of members?

Hypothesis 16: Member socio-demographic characteristics and perceptions/attitudes are associated with completion of the HRA and well exam.

Research Question 16.1: What is the level of completion of the HRA and well exam?

Research Question 16.2: What are the socio-demographic characteristics (age, gender, income, education, employment, race, and ethnicity) of members?

Research Question 16.3: What are the perceptions/attitudes (self-efficacy, response efficacy, perceived susceptibility, perceived severity, and perceived benefit) of members?

Hypothesis 17: Members are most likely to hear about the HBI program from their MCO.

Research Question 17.1: Where are members learning about the HBI program and HBI program components?

Hypothesis 18: Members report challenges in using hardship waiver.

Research Question 18.1: What are the perceptions of the ease of use of the hardship waiver?

Research Question 18.2: What are the challenges members report in using the hardship waiver?

Hypothesis 19: Members who do not complete the HRA and wellness exam, report barriers to completing the behaviors.

Research Question 19.1: What are the barriers to completing the HRA and wellness exam as reported by the members?

Hypothesis 20: Disenrolled members report no knowledge of the HBI program.

Research Question 20.1: What is the level of HBI program knowledge among disenrolled members?

Hypothesis 21: Disenrolled members describe confusion around the disenrollment process.

Research Question 21.1: How do disenrolled members describe the process of learning about their disenrollment?

Hypothesis 22: Disenrolled members report consequences to their disenrollment.

Research Question 22.1: What happens after members are disenrolled for non-payment?

Research Question 22.2: Will disenrolled members be able to reenroll to health insurance coverage?

Research Question 22.3: Do the consequences change over time?

HBI Evaluation Periods

The claims-based evaluation of the HBI will span from January 2014 through December 2024, with analyses using data from 2014 through the most current year of Medicaid data available throughout the renewed 1115 waiver period (2020 – 2024). The survey data and interview data will be collected during the 2021-2024 time period.

HBI Data Sources, Analysis Methods, and Measures

This section describes our approach to testing hypotheses 1 – 9 by answering all research questions from 1.1 – 9.1. We provide an overview of the evaluation period, our data sources, a description of our sample, a discussion of our target and comparison groups, the definitions of our outcome measures (with numerators and denominators specified), the identification of healthy behaviors activities and model covariates, and a description of our analytic approach. For brevity and clarity, we present any of these items that apply across all hypotheses just once, while other items are presented in the context of the relevant hypotheses and research questions. We also describe limitations and alternative approaches to address them.

The objective of these analyses is to document rates of HBI participation, model HBI participation as a function of several member-level characteristics, assess changes in health care spending as a function of HBI participation, and model several measures of health care utilization as a function of HBI participation. Together, this will further our understanding of the extent to which members are engaging in the requirements outlined by the program, clarify which members are most and least likely to complete the activities required by the HBI program, and identify both the extent to which the HBI program is associated with increases or decreases in health care spending and the extent to which HBI participation can improve patient outcomes and reduce potentially avoidable care.

HBI Data Sources

We are proposing to use six data sources for the secondary analyses of Medicaid administrative claims data portion of the HBI evaluation. They include the following:

- Medicaid enrollment and claims data (January 2014 – December 2024)
- Iowa Medicaid Enterprise records on completion of wellness exams and health risk assessments (January 2014 – December 2024)

We will also adjust for other sociodemographic factors, social determinants of health, and available health care resources in members' local community using selected variables from:

- Area Deprivation Index
- U.S. Census Bureau's American Community Survey
- Health Resources and Services Administration's Area Health Resources File
- Social determinants of health data reported by managed care organizations to the Iowa Department of Human Services

HBI Sample

Our sample will consist of all members enrolled in IWP for a minimum of 12 consecutive months any time after January 1, 2014. We will assign members to one of three income groups: a **low-**

income group (≤50% FPL), a **medium-income group (51 – 100% FPL)**, and a **high-income group (101 – 138% FPL)** reflecting the categories of incentives that apply to members in these income ranges.

Using monthly data, we will create our sample using a rolling cohort method in which we identify the first 12 consecutive months in which a member was continuously and exclusively enrolled in IWP. 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 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 will not keep partial years of data. For example, if a member was enrolled for 18 months, we will keep only their initial 12 months, and drop the other 6.

After assigning members to cohorts, we will collapse the data to provide one observation per person per cohort. This method will ensure 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 for HBI participation, and corresponding to the period of time they have to complete activities before being charged a premium (excluding the additional 30-day grace period). In sensitivity analyses, we will extend our cohort definition to 13 months to capture this 1-month grace period after which premiums are enforced. For analyses examining year-over-year trends, we also limit our sample to members whose enrollment does not span calendar years.

HBI Target and Comparison Groups

For our analyses examining health care utilization and spending outcomes as a function of completing HBI requirements, we will use propensity score matching to generate a target and comparison group. The **target group** will be defined as members who completed both HBI requirements during the year and the **comparison group** will be defined as members who did not complete any HBI requirements during the year. Individuals who completed only one of the two required activities will be excluded. The propensity scores will be generated using the predicted likelihood of HBI participation. We will match members in our target and control groups based on their propensity scores using nearest neighbor matching and will visually inspect the covariates to confirm that our target and control groups are balanced with respect to observed covariates.

Identification of Healthy Behaviors and Covariates

At the core of the HBI program is the requirement for members to complete both a wellness exam and a health risk assessment (HRA) each year to avoid paying a monthly premium the following year. Completion of these activities can be identified in claims or reported by managed care organizations. In fact, members may also call the Iowa Medicaid Enterprise (IME) to report completion of the activities. Regardless of the mechanism by which the data are reported, IME data are used to make official determinations regarding premium waivers for members, and therefore they are the data that we have previously used (and propose to use) to identify receipt of a wellness exam and HRA completion.

HBI Covariates

Our multivariable models will include several additional covariates to adjust for factors plausibly associated with both the likelihood of completing the HBI requirements and our health care

utilization and spending outcomes. These will include demographic characteristics derived from the Medicaid data including age, gender, race/ethnicity, metropolitan area of residence (defined as metropolitan, micropolitan, small town, or rural, using rural-urban commuting areas), number of moves during the 12-month period (to account for lifestyle disruption), and income group. We will also use the Medicaid data to include a number of variables serving as proxies of health status including: an indicator for a mental health diagnosis, an indicator for a substance abuse diagnosis, the total annual number of outpatient visits, the annual number of prescriptions, and an indicator for the presence of each of 24 chronic conditions. We will also include an indicator for the managed care organization in which the member is enrolled and a running count of a member's total years of IWP enrollment as of the given year (to assess the extent to which members become more compliant the longer they are enrolled). We will also adjust for social determinants of health, community health care resources, and other contextual factors using variables of interest drawn from the Area Health Resources File, the Area Deprivation Index, the American Community Survey, and social determinants of health data collected by managed care organizations and reported to Iowa DHS. Cohort fixed effects will be captured using a binary variable to indicate the cohort to which a member was assigned. In sensitivity analyses, we will explore the use of fixed effects at the county level.

HBI Analytic Approach for Each Hypothesis and Research Question

We will employ a variety of quantitative analyses depending on the hypothesis and research question and the available data. Briefly, we will conduct univariate analyses to produce summary statistics (including time trends) on HBI participation and our outcomes of interest, bivariate analyses to assess the relationship between HBI participation and our outcomes of interest, and multivariate analyses to identify factors associated with the likelihood of HBI participation and assess the relationship between HBI participation and our outcomes of interest while adjusting for potential confounders and selection bias. All analyses will be stratified by—or otherwise account for—members' income group. Further details are provided in the following table organized by hypotheses and research questions.

Methods for HBI Policy Components

The above outlined research questions and hypotheses will be answered using a mixed-methods approach consisting of: 1) secondary analyses of Medicaid administrative claims data, 2) a member survey, 3) a disenrollment survey, and 4) interviews with disenrolled members. These qualitative and quantitative approaches allow for data and methods triangulation across both process and outcomes measures, which increases confidence in the validity of evaluation findings. Additional details are provided below for each approach.

HBI Member survey

We will be conducting a member telephone survey to specifically address evaluation questions related to awareness and knowledge of the HBI and participation and experience in the program. We have extensive experience surveying this population and have had success with the following design and procedures.

Study Design: We have both a panel and cross-sectional survey design to allow for us to examine trends over time in the same group of people who have continued exposure to the program and to provide a cross sectional look at the IWP population.

Panel Sample: In early 2021, we will draw a sample of IWP members who have been continuously enrolled for the previous 14 months. Individuals who have participated in previous evaluations and individuals without valid telephone numbers will be excluded from the sample. Only one person will be selected per household to reduce the relatedness of the responses and respondent burden.

The sample will be stratified by completion of activities (those who completed the HRA, those who completed the wellness exam, those who completed both the HRA and wellness exam, and those who completed neither). This stratification is vital because so few members have completed the activities. We will also stratify by income level (0-50%, 51-100%, and 101-133%) and MCO enrollment. We will draw a sample of 6,000 members. Based on our previous evaluations, we would plan on a 30% response rate. Based on previous surveys for this evaluation, this sample size and response rate will provide us with sufficient numbers to complete our proposed analyses (see past evaluation plans and published journal articles). A traditional sample size calculation is difficult as the variance of the variables of interest are not established. In the fall of 2021 and 2022, this same sample will be matched back to the Medicaid enrollment files. If the sample member from 2021 is still a Medicaid enrollee, the sample member will be included in the new survey. We will follow the same study procedures as outlined above. Based on our previous experience of re-surveying 2017 respondents in 2018, we would plan on a 60% response rate.

Cross-sectional survey: The survey data gathered in early 2021 will not only be the first time the panel is surveyed, but it will also serve as the first cross-sectional survey. In 2022 and 2023, we will redraw a sample from Medicaid members, using the same sampling method outlined above.

Survey protocol: Our survey protocol is informed by the latest research on survey design and our over 20 years of experience with this population. First, letters introducing the study will be mailed to potential respondents. The introductory letter will describe the evaluation, state why the respondent is being invited to participate, and ensure the participant of the anonymity of the responses. The letter will state that participation is completely voluntary, that refusal will not lead to any penalty or lost benefits, and provide a telephone number to ask questions, update contact information, or opt out of the study. In an effort to maximize response rates for the survey, both a premium and an incentive are used: each introductory letter includes a $2 bill, and respondents who complete the survey when contacted over the telephone will be sent a $10 gift card.

The telephone survey will be fielded by the Iowa Social Science Research Center at The University of Iowa. All survey staff are trained on the purpose of the evaluation, human subjects research protections, and the survey instrument. The research team provides specific HBI and Medicaid related information to the survey staff. Following the training, telephone calls are made to each sampled IWP member, the evaluation is introduced, the confidentiality of all responses and voluntary nature of participation is explained, informed consent is obtained, and either the interview will be conducted or an alternate time to complete the interview will be arranged. Approximately 8-10 attempts will be made to reach the potential respondents. The survey will consist of about 60 questions and will take approximately twenty minutes to complete.

Survey measures: The survey measures are informed by our previous qualitative and quantitative data collections, the existing literature, and reliable and validated measures, when available. Most of the survey measures derive from our previous surveys. These items capture self-report of awareness of the program, knowledge of specific program components, completion of the behaviors (HRA and wellness exam), facilitators and barriers to completion, perceptions of the program, self-efficacy, response efficacy, perceived susceptibility, perceived severity, and perceived on benefits. We will also explore how the members received information about the program. The surveys include CAHPS measures and supplemental items. The supplemental items address issues specific to the healthy behaviors. We include several demographic and self-reported health items to be used as adjustment variables in the analyses. See the Supplement to the Proposal for examples of past surveys. Table 10 provides a snapshot of the survey items we have used in the past.

Table 10. Survey Measures in 2019 Healthy Behaviors Incentive Program Evaluation Member Survey

Measure	Measure description	Sources	Previous use
Completion of healthy behavior	Whether a member completed a healthy behavior (medical wellness exam, dental wellness exam, medical health risk assessment, dental health risk assessment)	Original items, based on qualitative interviews	2017, 2018, and 2019
Members assessment of the cost, barriers, and benefits to program participation	Members indicate barriers	Original items, based on qualitative interviews	2017, 2018, and 2019
Members assessment of the cost, barriers, and benefits to program participation	Members indicate benefits	Original items, based on qualitative interviews	2017, 2018, and 2019
Members assessment of the value of the program to them	Members indicate importance	Original items, based on qualitative interviews	2017, 2018, and 2019
Member perception of ease of obtaining a yearly physical exam	Respondent report of how easy it is for them to obtain a yearly physical exam	Original items, based on qualitative interviews	2017, 2018, and 2019
Reported completion of healthy behavior by source of information	Told to complete healthy behavior and who told to complete healthy behavior	Original items, based on qualitative interviews	2017, 2018, and 2019
Self-rated health	How members rated their overall and oral health	Health and Performance Questionnaire	2017, 2018, and 2019
Knowledge of program requirements	Members knowledge of program requirements	Original items, based on qualitative interviews	2017, 2018, and 2019
Members understanding of insurance	Members understanding of insurance coverage and benefits, insurance plan's premiums, and what is needed to do to prevent being disenrolled form insurance coverage	Original items	2019
Members knowledge of payment process	Premium/Hardship waiver awareness	Original items, based on qualitative interviews	2017, 2018, and 2019
Members experience with premium payments	Online premium payment	Original items	2019

Measure	Measure description	Sources	Previous use
Members experience with premium payments	Barriers to premium payment	Original items, based on qualitative interviews	2017, 2018, and 2019
Value of incentive	Whether member would rather complete healthy behavior program requirements or pay premium	Original items, based on qualitative interviews	2017, 2018, and 2019
Regular source of care-personal doctor	Personal Doctor	CAHPS 5.0	2017, 2018, and 2019
Getting timely appointments, care, and information	Timely receipt of care	CAHPS 5.0	2017, 2018, and 2019
Members perceived locus of control	Locus of control	Validated measure	2017, 2018, and 2019
Members use of Federally Qualified Health Centers	Whether member received care from Federally Qualified Health clinics	Original items	2017, 2018, and 2019
MCO	Which Managed Care Organization member is enrolled in	Original item	2017, 2018, and 2019
Members use of government assistance programs	Whether member participated in government assistance programs	Original item	2017, 2018, and 2019
Food insecurity	Hunger Vital Signs	Hager, E. R., Quigg, A. M., Black, M. M., Coleman, S. M., Heeren, T., Rose-Jacobs, R., & Cutts, D. B. (2010). Development and validity of a 2-item screen to identify families at risk for food insecurity. *Pediatrics*, *126*(1), e26-e32.	2019
Health literacy	Single Item Literacy Screener	Morris, N. S., MacLean, C. D., Chew, L. D., & Littenberg, B. (2006). The Single Item Literacy Screener: evaluation of a brief instrument to identify limited reading ability. *BMC family practice*, *7*(1), 21.	2017, 2018, and 2019
Demographics	Age, gender, employment status, education, and race or ethnicity	Standard questions	2017, 2018, and 2019

Analysis: Survey data will be weighted as appropriate based on our stratified sampling. For the panel survey, we will be examining the survey results for trends over time, specifically looking to answer questions related to the length of exposure to the program and awareness, knowledge and completion. For some research questions and hypotheses, descriptive statistics will be sufficient. When we compare groups, we will use t-tests or chi-squared tests. Modified Poisson regression will be used for multivariate analyses. A modified Poisson regression will allow us to control for sociodemographic characteristics (race/ethnicity, age, gender, education, employment status), other characteristics and experience with programs , as well as other characteristics (health literacy, food insecurity status, participation in government assistant programs, and MCO enrollment), and perceptions/attitudes (perceived benefits, perceived severity, perceived susceptibility, self -efficacy, and response efficacy).

For the longitudinal analysis for the panel survey, we will be adjusting for the dependence from multiple observations from individuals. We have outlined the proposed analysis for each hypothesis in the table above (Table 10).

Limitations/Challenges: Our previous research indicates changes in program implementation can result in confusion among members. This confusion can impact survey responses. We have tested this survey and fielded it 3 times in the past evaluation cycle. We are confident that the survey questions have face validity and the lack of variation between survey years could be an indication of reliability. The COVID-19 pandemic may impact the ability to collect survey data. We are currently surveying Iowans using a variety of methods- online, telephone and mail back. Our experiences with these data collections over the next few months will inform any modifications we will need to make to this proposed data collection.

HBI Disenrollment Survey

To better understand the experiences of people who have been disenrolled due to failure to complete their healthy behavior activities and failure to pay their premiums, we will survey disenrolled members.

Study Design: We will be surveying all members who are have been disenrolled, starting in March 2021. We will continue surveying them at 6 and 12 months post disenrollment.

Sample: We will be surveying all members who have been disenrolled starting in March 2021. On a monthly basis, we receive documentation from IME (discontinuance data) about which members are being disenrolled in that month. We will include all disenrolled members in our survey. Surveys are mailed on a rolling monthly basis to members 3 months after a member is disenrolled. For example, surveys mailed in March will be sent to members who had been disenrolled in December. In some cases, surveys will be sent to multiple members in one household. The monthly groups will vary in size as the monthly number of disenrolled members change.

Survey packets will be initially mailed to each group on the second Wednesday of the month. The packets will include the survey and a cover letter, which describes the survey, states that participation is completely voluntary, and provides a phone number to ask questions or opt out of the study. Respondents will be 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 pre-paid incentive and post-paid incentive be used: each initial packet will include a $2 bill (pre-paid incentive), and respondents who return a completed the survey will be sent a $20 gift card (post-paid incentive). One week after the initial survey packets are mailed, a postcard reminder will be sent. Four weeks after the initial mailing, a reminder survey packet will be sent to those who have not returned a completed survey. We will continue these first monthly surveys until 6 months before the end of

the waiver. We will follow up completed surveys with surveys at 6 and 12 months to understand how disenrollment has impacted people long term.

Survey measures: We will be modifying our existing disenrollment survey to capture members awareness and knowledge of their disenrollment, their experiences with the disenrollment process, consequences to disenrollment, and their awareness and knowledge of the HBI. See the Supplement to the Proposal for examples of past surveys. The table below illustrates the basic measures and domains of the disenrollment survey (Table 11).

Table 11. Survey Measures for Healthy Behavior Incentive Program Evaluation Disenrollment Survey

Measure	Measure description	Sources	Previous use
Experience with disenrollment	Members experiencing with the disenrollment process	Original items, based on qualitative interviews	2017 and 2019
MCO	Which Managed Care Organization member is enrolled in	Original item	2017 and 2019
Members understanding of insurance	Members understanding of insurance coverage and benefits, insurance plan's premiums, and what is needed to do to prevent being disenrolled form insurance coverage	Original items	2019
Members knowledge of payment process	Premium/Hardship waiver awareness	Original items, based on qualitative interviews	2017 and 2019
Members experience with premium payments	Online premium payment	Original items	2019
Members experience with premium payments	Barriers to premium payment	Original items, based on qualitative interviews	2017 and 2019
Knowledge of program requirements	Members knowledge of program requirements	Original items, based on qualitative interviews	2017 and 2019
Completion of healthy behavior	Whether a member completed a healthy behavior (medical wellness exam, dental wellness exam, medical health risk assessment)	Original items, based on qualitative interviews	2017 and 2019
Members assessment of the cost, barriers, and benefits to program participation	Members indicate barriers	Original items, based on qualitative interviews	2017 and 2019
Experience with the health system	Did member have a period without health insurance and impact of not having health insurance	Original items, based on qualitative interviews	2017 and 2019
Access to and unmet needs for emergency care	Rating of timely access to urgent care	CAHPS 5.0	2017 and 2019
Access to and unmet needs for routine care	Rating of timely access to routine care	CAHPS 5.0	2017 and 2019

Measure	Measure description	Sources	Previous use
Regular source of care-personal doctor	Personal Doctor	CAHPS 5.0	2017 and 2019
Members use of Federally Qualified Health Centers	Whether member received care from Federally Qualified Health clinics	Original items	2017 and 2019
Food insecurity	Hunger Vital Signs	Hager, E. R., Quigg, A. M., Black, M. M., Coleman, S. M., Heeren, T., Rose-Jacobs, R., ... & Cutts, D. B. (2010). Development and validity of a 2-item screen to identify families at risk for food insecurity. *Pediatrics*, *126*(1), e26-e32.	2017 and 2019
Members use of government assistance programs	Whether member participated in government assistance programs	Original item	2017 and 2019
Self-rated health	How members rated their overall and mental and emotional health	Health and Performance Questionnaire	2017 and 2019
Health since disenrollment	Member's perceived change in health since being disenrolled	Original item, based on qualitative interviews	2017 and 2019
Chronic physical and mental health conditions	Whether members had 16 physical and 9 mental chronic health conditions for at least 3 months	Items taken from IowaCare Evaluation; modified CAHPS	2017 and 2019
Members assessment of the value of the program to them	Members indicate value	Original items, based on qualitative interviews	2017 and 2019
Reason for applying for insurance	Member indicates reason for applying for IWP	Original items, based on qualitative interviews	2017 and 2019
Health literacy	Single Item Literacy Screener	Morris, N. S., MacLean, C. D., Chew, L. D., & Littenberg, B. (2006). The Single Item Literacy Screener: evaluation of a brief instrument to identify limited reading ability. *BMC family practice*, *7*(1), 21.	2017 and 2019
Demographics	Age, gender, employment status, education, and race or ethnicity	Standard measures	2017 and 2019

Analysis: Because the number of people being disenrolled varies by month and can range from small numbers of disenrolled people (for example 40) to larger numbers (for example 300), we are only able to propose descriptive analyses at 3 months following disenrollment, 6 months following disenrollment, and 12 months following disenrollment. We will be examining the data for trends over time both as members are further away from their original disenrollment, as well as how disenrollment at 3 months, 6 months, and 12 months changes over time. The table below outlines the hypotheses and corresponding measures.

Limitations/Challenges: Locating people who have been disenrolled from the program can be difficult. We will be exploring more options to find contact information for people who may be transient. Without these efforts, our sample may only include those who are less mobile and are qualitatively different than others. This limitation will be recognized in all reports and in the dissemination of the findings.

HBI Disenrollment interviews

To better understand how members experience disenrollment and the consequences of disenrollment, we have planned a qualitative data collection that will provide in-depth, rich information. Our previous 1115 Waiver evaluation activities included in-depth interviews. The data gathered from these interviews were valuable in understanding how the HBI program functioned, how members understood the program, and member experiences.

Study Design: We will interview disenrolled members at 6 and 12 months after their disenrollment.

Sample: The sample will be drawn randomly from those who have completed the first disenrollment survey. We will interview approximately 60 disenrolled members at 6 months and follow up with them at 12 months.

Interview protocol: Those who completed the 3-month post disenrollment survey will be sent a letter inviting them to participate in an in-depth interview. The letter will provide them with information for contacting researchers to participate in the interview. There will be 10 attempts to reach the potential respondent to schedule an interview. The interviewer will be specifically trained in qualitative interviewing and will have significant background knowledge about Medicaid and the 1115 Waiver. Interviews will last about 30 minutes, be conducted over the telephone, and be recorded. The recordings will be transcribed by a 3rd party service. Respondents will be provided with a gift card to compensate them for their time.

Interview questions: Our interview guide will be informed by the survey results from the previous years. We will ask open-ended questions to solicit the richest narrative possible. The interview will focus on disenrolled members' experiences since disenrollment, the consequences of disenrollment, and current insurance status. The interview guide will be pilot tested to ensure that the questions are appropriate for the target population.

Analysis: The interviews will be transcribed. We will develop a codebook based on the interview guide and the research questions listed below. Trained coders will code a selection of the transcripts to develop intercoder reliability. Following coding, we will examine the codes for themes to answer the basic questions about disenrolled members' experiences. To understand how experiences vary across time from original disenrollment, we will compare 3 month, 6 month, and 12 month interviews. To examine how the disenrollment process maybe be changing over time, we will analyze across all disenrolled members at 3 months.

Limitations/Challenges: Locating disenrolled members after 6 and 12 months will be challenging. We will develop a retention system to encourage members to provide us with current contact information

HBI Limitations and Alternative Approaches

As with any study, our proposed analyses are subject to some limitations. First, we cannot adequately control for the temporal relationship between completing healthy behaviors and subsequent healthcare utilization and spending. That is, we will not know whether our outcomes of interest occurred before or after the completion of the healthy behavior(s). We will address this to the best of our ability by conducting sensitivity analyses with a lagged dependent variable such that we model a member's outcome in year t as a function of their HBI participation in year t-1. Similarly, to account for partial completion of the requirements and the cumulative effect of completing activities over time, we will rerun all of our multivariable models with HBI participation defined as a running count of the number of activities an individual has completed during the time they have been enrolled (measured as of the given year of the specific observation).

Second, despite employing rigorous analytic strategies to combat them (e.g., propensity score matching), our regression models may be limited by unobserved factors that differ between individuals (e.g., health status, severity of acute illness, health literacy, etc.), for which we are unable to adequately adjust our models. This may bias our results. However, the direction and magnitude of any such bias cannot be well predicted. To address this, we will employ member-level fixed effects where possible. Alternatively, we will construct a hypothetical variable associated with both HBI participation and our outcomes of interest and rerun our analyses to assess the robustness of our results to unobserved confounding. Finally, administrative data are collected for billing and tracking purposes and may not always accurately reflect the service provided.

Evaluation Methods Summary: HBI

Comparison Strategy	Outcome Measure(s)	Data Sources	Analytic Approach
Hypothesis 1: The proportion of members who complete a wellness exam, health risk assessment, or both will vary.			
Research Question 1.1: What proportion of members complete a wellness exam in a given year?			
N/A	Binary indicator for completion of wellness exam	DHS Data and Medicaid Enrollment Data, 2014 – present	Univariate analysis stratified by income group, using t-tests to compare the mean completion rate between income groups.
Research Question 1.2: What proportion of members complete an HRA in a given year?			
N/A	Binary indicator for completion of an HRA	DHS Data and Medicaid Enrollment Data, 2014 – present	Univariate analysis stratified by income group, using t-tests to compare the mean completion rate between income groups.
Research Question 1.3: What proportion of members complete both a wellness exam and an HRA in a given year?			
N/A	Binary indicator for completion of both a wellness exam and an HRA	DHS Data and Medicaid Enrollment Data, 2014 – present	Univariate analysis stratified by income group, using t-tests to compare the mean completion rate between income groups.
Hypothesis 2: The proportion of members completing a wellness exam, health risk assessment, or both will change over time and by income level.			
Research Question 2.1: Has the proportion of members completing a wellness exam decreased among lower-income members and increased among higher-income members?			
N/A	Binary indicator for completion of wellness exam	DHS Data and Medicaid Enrollment Data, 2014 – present	Univariate analysis stratified by year and income group, using t-tests to compare the mean completion rate between income groups and within income groups between years.
Research Question 2.2: Has the proportion of members completing an HRA decreased among lower-income members and increased among higher-income members?			
N/A	Binary indicator for completion of an HRA	DHS Data and Medicaid Enrollment Data, 2014 – present	Univariate analysis stratified by year and income group, using t-tests to compare the mean completion rate between income groups and within income groups between years.

Comparison Strategy	Outcome Measure(s)	Data Sources	Analytic Approach
Research Question 2.3: Has the proportion of members completing both required activities decreased among lower-income members and increased among higher-income members?			
N/A	Binary indicator for completion of both a wellness exam and an HRA	DHS Data and Medicaid Enrollment Data, 2014 – present	Univariate analysis stratified by year and income group, using t-tests to compare the mean completion rate between income groups and within income groups between years.
Hypothesis 3: Member characteristics are associated with the likelihood of completing both required HBI activities.			
Research Question 3.1: Are older, non-Hispanic white females living in metropolitan counties more likely to complete both required activities?			
N/A	Completion of both a wellness exam and an HRA	DHS Data, Medicaid Claims 2010 – present, Area Health Resources File, Area Deprivation Index, Census Data, American Community Survey	Multivariable modified Poisson regression model adjusting for member demographics and health status as well as social determinants of health and community-level factors. In sensitivity analyses, we will use county-level fixed effects.*
Research Question 3.2: Are members assigned to some MCOs more likely than members assigned to other MCOs to complete both required activities?			
N/A	Completion of both a wellness exam and an HRA	DHS Data, Medicaid Claims 2010 – present, Area Health Resources File, Area Deprivation Index, Census Data, American Community Survey	Multivariable modified Poisson regression model adjusting for member demographics and health status as well as social determinants of health and community-level factors. In sensitivity analyses, we will use county-level fixed effects.*
Research Question 3.3: Is the length of time in the program positively associated with the likelihood of completing both required activities?			
N/A	Completion of both a wellness exam and an HRA	DHS Data, Medicaid Claims 2010 – present, Area Health Resources File, Area Deprivation Index, Census Data, American Community Survey	Multivariable modified Poisson regression model adjusting for member demographics and health status as well as social determinants of health and community-level factors. In sensitivity analyses, we will use county-level fixed effects.*
Research Question 3.4: Are members with more negative social determinants of health (SDoH) less likely to complete both required activities?			
N/A	Completion of both a wellness exam and an HRA	DHS Data, Medicaid Claims 2010 – present, Area Health Resources File, Area Deprivation Index, Census Data, American Community Survey	Multivariable modified Poisson regression model adjusting for member demographics and health status as well as social determinants of health and community-level factors. In sensitivity analyses, we will use county-level fixed effects.*

Comparison Strategy	Outcome Measure(s)	Data Sources	Analytic Approach
Research Question 3.5: Is the highest income group most likely to complete both required activities?			
N/A	Completion of both a wellness exam and an HRA	DHS Data, Medicaid Claims 2010 – present, Area Health Resources File, Area Deprivation Index, Census Data, American Community Survey	Multivariable modified Poisson regression model adjusting for member demographics and health status as well as social determinants of health and community-level factors. In sensitivity analyses, we will use county-level fixed effects.*
Hypothesis 4: Completing HBI requirements is associated with a member's use of the emergency department (ED).			
Research Question 4.1: Are members who complete the HBI requirements equally likely to have an ED visit?			
Propensity score matching based on all-or-none completion of HBI requirements.†	Member's likelihood of having any ED visit	DHS Data and Medicaid Enrollment Data, Area Health Resources File, Area Deprivation Index, American Community Survey, DHS Social Determinants of Health data, 2014 – present	Bivariate analysis, comparing means of members who completed vs. did not complete required activities within each income group using t-tests. Multivariable modified Poisson model among our propensity score matched sample, adjusting for member demographics and health status as well as social determinants of health and community-level factors.^
Research Question 4.2: Do members who complete the HBI requirements have fewer total ED visits annually?			
Propensity score matching based on all-or-none completion of HBI requirements.†	Member's annual number of ED visits	DHS Data and Medicaid Enrollment Data, Area Health Resources File, Area Deprivation Index, American Community Survey, DHS Social Determinants of Health data, 2014 – present	Bivariate analysis, comparing means of members who completed vs. did not complete required activities within each income group using t-tests. Multivariable modified Poisson model among our propensity score matched sample, adjusting for member demographics and health status as well as social determinants of health and community-level factors. ^
Research Question 4.3: Are members who complete the HBI requirements less likely to have a non-emergent ED visit?			
Propensity score matching based on all-or-none completion of HBI requirements.†	Member's likelihood of having any non-emergent ED visit (NYU Algorithm)	DHS Data and Medicaid Enrollment Data, Area Health Resources File, Area Deprivation Index, American Community Survey, DHS Social Determinants of Health data, 2014 – present	Bivariate analysis, comparing means of members who completed vs. did not complete required activities within each income group using t-tests. Multivariable modified Poisson model among our propensity score matched sample, adjusting for member demographics and health status as well as social determinants of health and community-level factors.^

Comparison Strategy	Outcome Measure(s)	Data Sources	Analytic Approach
Research Question 4.4: Do members who complete the HBI requirements have fewer total non-emergent ED visits annually?			
Propensity score matching based on all-or-none completion of HBI requirements.†	Member's annual number of non-emergent ED visits (NYU Algorithm)	DHS Data and Medicaid Enrollment Data, Area Health Resources File, Area Deprivation Index, American Community Survey, DHS Social Determinants of Health data, 2014 – present	Bivariate analysis, comparing means of members who completed vs. did not complete required activities within each income group using t-tests. Multivariable modified Poisson model among our propensity score matched sample, adjusting for member demographics and health status as well as social determinants of health and community-level factors.^
Research Question 4.5: Are members who complete the HBI requirements less likely to have a 3-day, 7-day, or 30-day return ED visit?			
Propensity score matching based on all-or-none completion of HBI requirements.†	Member's likelihood of having a 3-day return ED visit, Member's likelihood of having a 7-day return ED visit, Member's likelihood of having a 30-day return ED visit	DHS Data and Medicaid Enrollment Data, Area Health Resources File, Area Deprivation Index, American Community Survey, DHS Social Determinants of Health data, 2014 – present	Bivariate analysis, comparing means of members who completed vs. did not complete required activities within each income group using t-tests. Multivariable modified Poisson model among our propensity score matched sample, adjusting for member demographics and health status as well as social determinants of health and community-level factors.^
Research Question 4.6: Do members who complete the HBI requirements have fewer total 3-day, 7-day, or 30-day return ED visits annually?			
Propensity score matching based on all-or-none completion of HBI requirements.†	Member's annual number of 3-day return ED visits, Member's annual number of 7-day return ED visits, Member's annual number of 30-day return ED visits	DHS Data and Medicaid Enrollment Data, Area Health Resources File, Area Deprivation Index, American Community Survey, DHS Social Determinants of Health data, 2014 – present	Bivariate analysis, comparing means of members who completed vs. did not complete required activities within each income group using t-tests. Multivariable modified Poisson model among our propensity score matched sample, adjusting for member demographics and health status as well as social determinants of health and community-level factors.^
Hypothesis 5: Completing HBI requirements is associated with a member's use of hospital observation stays.			
Research Question 5.1: Are members who complete the HBI requirements equally likely to have a hospital observation stay?			
Propensity score matching based on all-or-none completion of HBI requirements. †	Member's likelihood of having a hospital observation stay	DHS Data and Medicaid Enrollment Data, Area Health Resources File, Area Deprivation Index, American Community Survey, DHS Social Determinants of Health data, 2014 – present	Bivariate analysis, comparing means of members who completed vs. did not complete required activities within each income group using t-tests. Multivariable modified Poisson model among our propensity score matched sample, adjusting for member demographics and health status as well as social determinants of health and community-level factors.^

Comparison Strategy	Outcome Measure(s)	Data Sources	Analytic Approach
Research Question 5.2: Do members who complete the HBI requirements have fewer total hospital observation stays annually?			
Propensity score matching based on all-or-none completion of HBI requirements.†	Member's annual number of hospital observation stays	DHS Data and Medicaid Enrollment Data, Area Health Resources File, Area Deprivation Index, American Community Survey, DHS Social Determinants of Health data, 2014 – present	Bivariate analysis, comparing means of members who completed vs. did not complete required activities within each income group using t-tests. Multivariable modified Poisson model among our propensity score matched sample, adjusting for member demographics and health status as well as social determinants of health and community-level factors.^
Hypothesis 6: Completing HBI requirements is associated with a member's use of inpatient hospital care.			
Research Question 6.1: Are members who complete the HBI requirements equally likely to be hospitalized?			
Propensity score matching based on all-or-none completion of HBI requirements.†	Member's likelihood of being hospitalized	DHS Data and Medicaid Enrollment Data, Area Health Resources File, Area Deprivation Index, American Community Survey, DHS Social Determinants of Health data, 2014 – present	Bivariate analysis, comparing means of members who completed vs. did not complete required activities within each income group using t-tests. Multivariable modified Poisson model among our propensity score matched sample, adjusting for member demographics and health status as well as social determinants of health and community-level factors.^
Research Question 6.2: Do members who complete the HBI requirements have fewer total hospitalizations annually?			
Propensity score matching based on all-or-none completion of HBI requirements.†	Member's annual number of hospitalizations	DHS Data and Medicaid Enrollment Data, Area Health Resources File, Area Deprivation Index, American Community Survey, DHS Social Determinants of Health data, 2014 – present	Bivariate analysis, comparing means of members who completed vs. did not complete required activities within each income group using t-tests. Multivariable modified Poisson model among our propensity score matched sample, adjusting for member demographics and health status as well as social determinants of health and community-level factors.^
Research Question 6.3: Are members who complete the HBI requirements less likely to have a potentially preventable hospitalization?			
Propensity score matching based on all-or-none completion of HBI requirements.†	Member's likelihood of experiencing a potentially-preventable hospitalization	DHS Data and Medicaid Enrollment Data, Area Health Resources File, Area Deprivation Index, American Community Survey, DHS Social Determinants of Health data, 2014 – present	Bivariate analysis, comparing means of members who completed vs. did not complete required activities within each income group using t-tests. Multivariable modified Poisson model among our propensity score matched sample, adjusting for member demographics and health status as well as social determinants of health and community-level factors.^

Comparison Strategy	Outcome Measure(s)	Data Sources	Analytic Approach
Research Question 6.4: Do members who complete the HBI requirements have fewer total potentially preventable hospitalizations annually?			
Propensity score matching based on all-or-none completion of HBI requirements.†	Member's annual number of potentially-preventable hospitalizations	DHS Data and Medicaid Enrollment Data, Area Health Resources File, Area Deprivation Index, American Community Survey, DHS Social Determinants of Health data, 2014 – present	Bivariate analysis, comparing means of members who completed vs. did not complete required activities within each income group using t-tests. Multivariable modified Poisson model among our propensity score matched sample, adjusting for member demographics and health status as well as social determinants of health and community-level factors.^
Research Question 6.5: Are members who complete the HBI requirements less likely to have a 30-day all-cause readmission?			
Propensity score matching based on all-or-none completion of HBI requirements.†	Member's likelihood of experiencing a 30-day all-cause readmission	DHS Data and Medicaid Enrollment Data, Area Health Resources File, Area Deprivation Index, American Community Survey, DHS Social Determinants of Health data, 2014 – present	Bivariate analysis, comparing means of members who completed vs. did not complete required activities within each income group using t-tests. Multivariable modified Poisson model among our propensity score matched sample, adjusting for member demographics and health status as well as social determinants of health and community-level factors.^
Research Question 6.6: Do members who complete the HBI requirements have fewer total 30-day all-cause readmissions annually?			
Propensity score matching based on all-or-none completion of HBI requirements.†	Member's annual number of 30-day all-cause readmissions	DHS Data and Medicaid Enrollment Data, Area Health Resources File, Area Deprivation Index, American Community Survey, DHS Social Determinants of Health data, 2014 – present	Bivariate analysis, comparing means of members who completed vs. did not complete required activities within each income group using t-tests. Multivariable modified Poisson model among our propensity score matched sample, adjusting for member demographics and health status as well as social determinants of health and community-level factors.^
Hypothesis 7: Completing HBI requirements is associated with shifts in patterns of member's health care utilization.			
Research Question 7.1: Do members who complete the HBI requirements have fewer potentially preventable hospitalizations as a proportion of total hospitalizations?			
Propensity score matching based on all-or-none completion of HBI requirements. †	Potentially-avoidable hospitalizations as a proportion of total hospitalizations	DHS Data and Medicaid Enrollment Data, Area Health Resources File, Area Deprivation Index, American Community Survey, DHS Social Determinants of Health data, 2014 – present	Bivariate analysis, comparing means of members who completed vs. did not complete required activities within each income group using t-tests. Multivariable modified Poisson model among our propensity score matched sample, adjusting for member demographics and health status as well as social determinants of health and community-level factors.^

Comparison Strategy	Outcome Measure(s)	Data Sources	Analytic Approach
Research Question 7.2: Do members who complete the HBI requirements have fewer non-emergent ED visits as a proportion of total ED visits?			
Propensity score matching based on all-or-none completion of HBI requirements.†	Non-emergent ED visits as a proportion of total ED visits	DHS Data and Medicaid Enrollment Data, Area Health Resources File, Area Deprivation Index, American Community Survey, DHS Social Determinants of Health data, 2014 – present	Bivariate analysis, comparing means of members who completed vs. did not complete required activities within each income group using t-tests. Multivariable modified Poisson model among our propensity score matched sample, adjusting for member demographics and health status as well as social determinants of health and community-level factors.^
Research Question 7.3: Do members who complete the HBI requirements have more primary care visits as a proportion of total outpatient visits?			
Propensity score matching based on all-or-none completion of HBI requirements. †	Primary care visits as a proportion of all outpatient visits	DHS Data and Medicaid Enrollment Data, Area Health Resources File, Area Deprivation Index, American Community Survey, DHS Social Determinants of Health data, 2014 – present	Bivariate analysis, comparing means of members who completed vs. did not complete required activities within each income group using t-tests. Multivariable modified Poisson model among our propensity score matched sample, adjusting for member demographics and health status as well as social determinants of health and community-level factors.^
Hypothesis 8: Completing HBI requirements is associated with a member's health care expenditures.			
Research Question 8.1: Do members who complete the HBI requirements have lower spending in all categories?			
Propensity score matching based on all-or-none completion of HBI requirements.†	Total health care expenditures Inpatient health care expenditures Potentially-preventable hospitalization expenditures Outpatient health care expenditures Primary care expenditures ED health care expenditures Non-emergent ED health care expenditures Pharmacy expenditures	DHS Data and Medicaid Enrollment Data, Area Health Resources File, Area Deprivation Index, American Community Survey, DHS Social Determinants of Health data, 2014 – present	Bivariate analysis, comparing means of members who completed vs. did not complete required activities within each income group using t-tests. Multivariable modified Poisson model among our propensity score matched sample, adjusting for member demographics and health status as well as social determinants of health and community-level factors.^

Comparison Strategy	Outcome Measure(s)	Data Sources	Analytic Approach
Hypothesis 9: We will identify disparities in the relationships between HBI completion and outcomes.			
Research Question 9.1: Do disparities exist in the following populations- high utilizers, individuals with multiple chronic conditions, individuals with OUD, individuals from racial and ethnic groups, rural individuals, and by sex?			
Propensity score matching based on all-or-none completion of HBI requirements.†	As defined above for research questions 4.1 - 4.6, 5.1 – 5.2, 6.1 – 6.6, 7.1 – 7.3, and 8.1	DHS Data and Medicaid Enrollment Data, Area Health Resources File, Area Deprivation Index, American Community Survey, DHS Social Determinants of Health data, 2014 – present	We will repeat the analyses outlined for research questions 4.1-4.6, 5.1-5.2, 6.1-6.6, 7.1-7.3, and 8.1, using interaction terms and/or running stratified models to identify differences in the association between HBI participation and outcomes among the following groups of members: High utilizers (those in the top quintile for number of outpatient, ED, and/or hospital visits) Individuals with multiple chronic conditions (defined categorically as 0/1, 2-3, 4+) Individuals with opioid use disorder Race/Ethnicity, Rurality, Sex
Hypothesis 10: Members who have been enrolled longer are more aware of the HBI program than those who have been enrolled a shorter period of time.			
Research Question 10.1: What is the level of awareness about the HBI program among members?			
Members with awareness of the HBI program and those without awareness	Existing survey items on awareness	HBI Phone Survey	T-test
Research Question 10.2: How long are members enrolled in the program?			
Members with awareness of the HBI program and those without awareness	Length of enrollment	Eligibility data	T-test
Research Question 10.3: Is there a relationship between length of enrollment and awareness of the HBI program?			
Members with awareness of the HBI program and those without awareness	Length of enrollment	Eligibility data	T-test

Comparison Strategy	Outcome Measure(s)	Data Sources	Analytic Approach
Hypothesis 11: Members who have been enrolled longer have more knowledge about the HBI program than those who have been enrolled a shorter period of time.			
Research Question 11.1: What specific knowledge about the HBI program do members report?			
Members with knowledge of the HBI program and those without	Existing survey items on knowledge	HBI Phone Survey	T-test
Research Question 11.2: Do members understand the incentive/disincentive part of the HBI program?			
Members with knowledge of the HBI program and those without	Existing survey items on knowledge	HBI Phone Survey	T-test
Research Question 11.3: Do members know they need to pay a premium monthly?			
Members with knowledge of the HBI program and those without	Existing survey items on knowledge	HBI Phone Survey	T-test
Research Question 11.4: Do members know about the hardship waiver?			
Members with knowledge of the HBI program and those without	Existing survey items on knowledge	HBI Phone Survey	T-test
Research Question 11.5: How long have members been enrolled?			
Members with knowledge of the HBI program and those without	Length of enrollment	Eligibility data	T-test
Hypothesis 12: Those who are aware of the HBI program are more likely to complete the behaviors (HRA and well exam) compared to those who were not aware.			
Research Question 12.1: What is the level of awareness of the HBI program?			
Completion of behaviors of members with awareness will be compared to completion for those without awareness	Existing survey items on awareness	HBI Phone Survey	Chi square, Modified Poisson regression
Research Question 12.2: What is the level of completion of the HRA and well exam?			
Completion of behaviors of members with awareness will be compared to completion for those without awareness	Binary indicator of completing both a wellness exam and HRA	DHS claims data	Chi square, Modified Poisson regression

Comparison Strategy	Outcome Measure(s)	Data Sources	Analytic Approach
Hypothesis 13: Those who have more knowledge about the HBI program are more likely to complete the behaviors (HRA and well exam) compared to those with less knowledge.			
Research Question 13.1: What is the level of knowledge about the HBI program?			
Completion of the behaviors of members with knowledge about the program will be compared to completion of behaviors for those without knowledge of the program	Existing survey items on program knowledge	HBI Phone Survey	Chi square, Modified Poisson regression
Research Question 13.2: What is the level of completion of the HRA and well exam?			
Completion of behaviors of members with awareness will be compared to completion for those without awareness	Binary indicator of completing both a wellness exam and HRA	DHS claims data	Chi square, Modified Poisson regression
Hypothesis 14: Members socio-demographic characteristic and perceptions/attitudes are associated with awareness of the HBI program.			
Research Question 14.1: What is the level of HBI program awareness?			
Members based on HBI program awareness	Existing survey items on awareness	HBI Phone Survey	Modified Poisson regression
Research Question 14.2: What socio-demographic characteristics (age, gender, income, education, employment, race, and ethnicity) of members?			
Members based on HBI program awareness	Existing demographic survey items	HBI Phone Survey	Modified Poisson regression
Research Question 14.3: What are the perceptions/attitudes (self-efficacy, response efficacy, perceived susceptibility, perceived severity, and perceived benefit) of members?			
Members based on HBI program awareness	Existing survey items on perceptions and attitudes	HBI Phone Survey	Modified Poisson regression
Hypothesis 15: Members socio-demographic characteristic and perceptions/attitudes are associated with knowledge of the HBI program.			
Research Question 15.1: What is the level of HBI program knowledge?			
Members based on HBI program knowledge	Existing survey items on program knowledge	HBI Phone Survey	Modified Poisson regression
Research Question 15.2: What socio-demographic characteristics (age, gender, income, education, employment, race, and ethnicity) of members?			
Members based on HBI program awareness	Existing demographic survey items	HBI Phone Survey	Modified Poisson regression

Comparison Strategy	Outcome Measure(s)	Data Sources	Analytic Approach
Research Question 15.3: What are the perceptions/attitudes (self-efficacy, response efficacy, perceived susceptibility, perceived severity, and perceived benefit) of members?			
Members based on HBI program awareness	Existing survey items on perceptions and attitudes	HBI Phone Survey	Modified Poisson regression
Hypothesis 16: Members socio-demographic characteristic and perceptions/attitudes are associated with completion of the HRA and well exam.			
Research Question 16.1: What is the level of completion of the HRA and well exam?			
Members based on completion of HRA and well exam	Existing survey items on HRA and well exam completion	HBI Phone Survey	Modified Poisson regression
Research Question 16.2: What are the socio-demographic characteristics (age, gender, income, education, employment, race, and ethnicity) of members?			
Members based on completion of HRA and well exam	Existing demographic survey items	HBI Phone Survey	Modified Poisson regression
Research Question 16.3: What are the perceptions/attitudes (self-efficacy, response efficacy, perceived susceptibility, perceived severity, and perceived benefit) of members?			
Members based on completion of HRA and well exam	Existing survey items on perceptions and attitudes	HBI Phone Survey	Modified Poisson regression
Hypothesis 17: Members are most likely to hear about the HBI program from their MCO.			
Research Question 17.1: Where are members learning about the HBI program and program components?			
Compare sources of information	Existing survey items on where members learn about HBI program	HBI Phone Survey	Descriptive
Hypothesis 18: Members report difficult in using hardship waiver.			
Research Question 18.1: What are the perceptions of the ease of use of the hardship waiver?			
n/a	Existing survey items on perception of hardship waiver and barriers to using hardship waiver	HBI Phone Survey	Descriptive
Research Question 18.2: What are the challenges members reporting in using the hardship waiver?			
n/a	Existing survey items on perception of hardship waiver and barriers to using hardship waiver	HBI Phone Survey	Descriptive
Hypothesis 19: Members who do not complete the HRA and well exam report barriers to completing the behaviors.			
Research Question 19.1: What are the barriers to completing the HRA and wellness exam as reported by the members?			
n/a	Existing measure of barriers to completion of HRA and well exam	HBI Phone Survey	Descriptive

Comparison Strategy	Outcome Measure(s)	Data Sources	Analytic Approach
Hypothesis 20: Disenrolled members report no knowledge of the HBI program.			
Research Question 20.1: What is the level of HBI program knowledge among disenrolled members?			
n/a	Existing survey measures on HBI program knowledge	Disenrollment Survey	Descriptive
Hypothesis 21: Disenrolled members describe confusion around the disenrollment process.			
Research Question 21.1: How do disenrolled members describe the process of learning about the disenrollment?			
n/a	Qualitative questions	Interviews	Descriptive/Thematic analysis
Hypothesis 22: Disenrolled members report consequences to their disenrollment.			
Research Question 22.1: What happened after members are disenrolled for non-payment?			
n/a	Qualitative questions	Interviews	Descriptive/Thematic analysis
Research Question 22.2: Will disenrolled members be able to reenroll to health insurance coverage?			
n/a	Existing survey questions on disenrollment experience	Disenrollment survey	Descriptive/Thematic analysis
Research Question 22.3: Do the consequences change over time?			
n/a	Existing survey questions on disenrollment experience	Disenrollment survey	Descriptive/Thematic analysis

†In analyses designed to test the relationship between completion of HBI requirements and various health care utilization and spending outcomes, we will use propensity score matching to reduce unobserved confounding between members who do and do not complete the requirements. Specifically, we will model the likelihood of completing the HBI requirements and will match individuals who completed both required activities to individuals who completed none of the required activities based on their propensity scores using nearest neighbor matching. Individuals who completed only one of the two required activities will be excluded. After matching, we will visually inspect the covariates to confirm that our target and control groups are balanced with respect to observed covariates.

*We will estimate either modified Poisson or ordinary least squares regression models (depending on whether our outcomes are binary, count, or continuous). In some cases, there will be no comparison group. In other cases, we will estimate our models among our propensity score matched sample as described above and earlier in the table that presents our analytic approach. All models will adjust for member demographics including age, gender, race/ethnicity, rurality, and income-group. All models will also adjust for members' health status using both a mental health indicator and a substance abuse indicator derived from diagnosis codes in the claims data, as well as annual counts of the total number of outpatient visits, the total number of prescription medications, and the total number of chronic conditions with which a member has been diagnosed. We will also adjust for other factors that may be associated with the likelihood of a member completing the HBI requirements or the outcomes of interest, including the number of times during the year that a member's residence changes, an indicator of the MCO in which the member is enrolled, the member's total years of enrollment (as a running count of cohorts), and a cohort fixed effect. Finally, we will adjust for social determinants of health, community health care resources, and other contextual factors drawn from the Area Health Resources File, Area Deprivation Index, the American Community Survey, and data collected by the MCOs and provided to DHS.

^We will also conduct sensitivity analyses. For example, in lieu of the specific community-level factors described in the preceding factors, we will adjust for all observed and unobserved variation at the county level using fixed effects. This has the advantage of better controlling for omitted variables but results in a limited ability to identify specific factors. Where feasible, we will also explore the use of individual-level fixed effects for the same reason. Finally, to assess the extent to which there is a dose-response relationship between completing the HBI requirements and our outcomes of interest, we will define our key independent variable in those models as a running count of the number of HBI requirements completed during the period in which a member was enrolled.

Logic Model: HBI

2020 HBI EVALUATION LOGIC MODEL

NEED(s): The Iowa Health and Wellness Plan (IHAWP), Iowa's version of Medicaid expansion, provides comprehensive health coverage at low or no cost to low-income Iowans between the ages of 19 and 64. A feature of the IHAWP is the Healthy Behaviors Program (HBP), where members can waive paying monthly premiums if they participate in the following healthy behaviors annually: receive a wellness exam (WE) from their health care provider or a dental exam from their dental provider; and completing a health risk assessment (HRA).

THEORY OF CHANGE: The IHAWP seeks to increase access for low-income Iowans to quality, affordable health care services and coverage. The HBI program is designed to empower members to take specific steps (i.e., obtaining a WE and completing an HRA) to make healthy behavior changes and take ownership in managing their own health. Using a financial incentive, members are encouraged to complete their healthy behaviors. Ideally, by engaging in these healthy behaviors and maintaining their health insurance coverage, members will see improved health outcomes and financial stability.

YOUR PLANNED WORK			YOUR INTENDED RESULTS		
Inputs	Activities	Participation	Short-Term Outcomes	Medium-Term Outcomes	Long-Term Outcomes

IHAWP Members
• Adults ages 19-64
• Income up to 138% FPL
Stakeholder Collaboration
• CMS – federal government
• Iowa Department of Human Services
• Iowa Medicaid Enterprise
• MCOs
  • Amerigroup
  • Iowa Total Care
• State Provider Associations
• Advocacy groups
IHAWP Components
• Funding
• Program staff
• Program infrastructure
Providers
• Primary Care Providers
• Dental providers
• Hospitals
	Overall HBP Activities
	• Yearly wellness exam (WE)
	  • Preventive exam from a plan-enrolled physician
	  • Dental well exam from a plan-enrolled dental provider
	• Health risk assessment survey tool
	
	HBP Contribution Activities by Income
	• 0-50% FPL
	  • No monthly contribution
	• 51-100% FPL
	  • $5 monthly contribution starting in second year of enrollment if WE and HRA are not completed
	• 101-138% FPL
	  • $10 monthly contribution starting in second year of enrollment if WE and HRA are not completed
	
	Additional Activities:
	• HBP education and promotion by MCOs, DHS, & providers
	• Financial hardship waiver
		• Completion of WE
		• Completion of HRA
		• Completion of both: WE and HRA
		
		• Association of member demographics with the likelihood of completing either (WE or HRA) or both required activities
			• Increased awareness about the program among members
			• Increased knowledge of the program among members
			• Increased utilization of preventive health care services
			
			• Change over time: Proportion of members that complete a WE
			• Change over time: Proportion of members that complete an HRA
			• Change over time: Proportion of members that complete both required activities (WE & HRA)
			
			• Proportion of members who are disenrolled from the IHAWP
			• Proportion of members who re-apply for benefits following disenrollment and successfully re-enroll
				• Reduced use of the emergency department (ED)
				  • Reduced likelihood of having an ED visit
				  • Reduced # of ED visits
				  • Reduced likelihood of a non-emergent ED visit
				  • Reduced annual # of non-emergent ED visits
				  • Reduced likelihood of having a 3-day return ED visit
				  • Reduced annual # of 3-day return ED visits
				  • Reduced likelihood of having a 7-day return ED visit
				  • Reduced annual # of 7-day return ED visits
				  • Reduced likelihood of having a 30-day return ED visit
				  • Reduced annual # of 30-day return ED visits
				
				• Reduced use of hospital observation stays
				  • Reduced likelihood of having a hospital observation stay
				  • Reduced annual number of hospital observation stays
				
				• Reduced use of inpatient hospital care
				  • Reduced likelihood of being hospitalized
				  • Reduced annual # of hospitalizations
				  • Reduced likelihood of experiencing a potentially-preventable hospitalization
				  • Reduced annual # of potentially preventable hospitalizations
				  • Reduced likelihood of experiencing a 30-day all-cause readmission
				  • Reduced annual # of 30-day all-cause readmissions
				
				• Shift in patterns of member's health care utilization
				  • Fewer potentially avoidable hospitalizations as a proportion of total hospitalizations
				  • Fewer non-emergent ED visits as a proportion of total ED visits
				  • More primary care visits as a proportion of all outpatient visits
				
				• Reduction in health care expenditures
				  • Total health care expenditures
				  • Inpatient health care expenditures
				  • Outpatient health care expenditures
				  • Primary care expenditures
				  • ED health care expenditure
				  • Non-emergent ED health care expenditures
				  • Pharmacy expenditures
					• Improved financial stability
					• Reduction in health disparities
					• Improved health status for members
					• Improved quality of life
					• Reduced mortality from underlying health conditions

ASSUMPTIONS	EXTERNAL FACTORS
• IHAWP members are aware of HBP requirements • IHAWP members can complete the HBP requirements • IHAWP members have knowledge about the HBP (i.e., incentive/disincentive components, information on premiums, availability of the hardship waiver) • IHAWP members value preventive health services • IHAWP members value health insurance coverage	• MCO changes within the state • Willingness and availability of medical and dental providers to participate as plan-enrolled providers for exams • Underlying health status of members • Barriers to compliance (access to health care services, health literacy, taking time off work, lacking a current provider, lack of perceived need for a WE)

2) Dental Wellness Plan: Healthy Behaviors, Premiums, and Dental Benefits

Background

Beginning in May 2014, CMS approved Iowa's request to offer dental benefits to Iowa Health and Wellness Plan (IHAWP) members through the Dental Wellness Plan (DWP), Section 1115 Demonstration Amendment. Iowa Wellness Plan. Project #11-W-00289/5. State of Iowa Department of Human Services. May 1, 2017, https://dhs.iowa.gov/sites/default/files/Iowa_DWP_Draft_1115_Final_05.1.17.pdf.

Originally, DWP offered tiered dental benefits to the state's Medicaid expansion population (ages 19 to 64), allowing members to earn enhanced benefits by returning for regular periodic recall exams every 6-12 months. Three years later, on May 1, 2017, the State of Iowa proposed a waiver amendment, to be effective July 1, 2017. Prior to July 1, 2017, Iowa provided dental benefits to adult enrollees via two different benefit packages and management strategies, which varied by eligibility group. Individuals eligible through the Medicaid expansion were enrolled in the original DWP. All other Medicaid-enrolled adults received State Plan dental benefits via the traditional, fee-for-service delivery system. With the amendment, the State proposed to offer a single, unified adult dental program – DWP 2.0 – for most Medicaid populations. This unified dental program is intended to ensure continuity of care as members transition between Medicaid eligibility categories.

Healthy Behavior Requirements

Along with merging adult dental benefits into a single program, the 1115 waiver amendment also modified the DWP benefit structure. The DWP 2.0 structure eliminated the tiered benefits in response to concerns that too few members had become eligible for higher benefit tiers. Instead, the 1115 waiver amendment allowed members to be eligible for comprehensive dental benefits during their first year of enrollment. However, the modified earned benefit structure in DWP 2.0 requires members to complete State-designated **healthy dental behaviors** annually to maintain comprehensive dental benefits after the first year of enrollment. Healthy dental behaviors include (1) completion of an oral health self-assessment and (2) a preventive dental visit.

Monthly Premiums

Members over 50% of the Federal Poverty Level (FPL) who do not complete required healthy behaviors during year one of enrollment have a **premium obligation** beginning in year two. If members fail to make the monthly $3.00 premium payments, benefits are reduced to basic coverage benefits only, which mainly includes problem-focused oral exams and tooth extractions.

Annual Benefit Maximum

Consistent with the previous Medicaid State Plan and DWP 1.0, originally there was no annual benefit maximum (ABM) with DWP 2.0. However, beginning September 1, 2018, a $1,000 ABM was implemented. This maximum applies to all members except ages 19-20, who are excluded per EPSDT requirements. Individual members with unique circumstances may apply for an Exception to Policy to be eligible for a higher benefit amount.

Certain DWP members are excluded from premium obligations and reduced benefits for failure to complete the healthy behaviors. This includes the following groups:

1. Pregnant women
2. Individuals whose medical assistance for services furnished in an institution is reduced by amounts reflecting available income other than required for personal needs
3. 1915(c) home and community-based waiver enrollees
4. Individuals receiving hospice care
5. Indians eligible to receive services through Indian health care providers or under contract health services
6. Breast and cervical cancer treatment program enrollees
7. Medically frail (i.e., medically exempt) enrollees
8. Enrollees who attest to a financial hardship
9. Members with income <50% FPL
10. 19 and 20-year-olds receive EPSDT coverage regardless of healthy behaviors completion or premium payments.

DWP Policy Goals

The overall goal of the Iowa Wellness Plan is to "provide access to healthcare for low-income Iowans by employing a benefit design that was intended to improve outcomes, increase personal responsibility, and ultimately lower costs" (Letter to CMS Director Brian Neale from Iowa Medicaid Director Mikki Stier, May 1, 2017). Additionally, the goals of Iowa's Section 1115 Waiver Amendment for the DWP are to "encourage utilization of preventive dental services and compliance with treatment plans by requiring members to complete a State designated "healthy behavior" annually. Enrollees who complete their healthy behavior, including an oral health self-assessment and preventive dental exam, within their first year of enrollment will maintain full dental benefits, while those who do not complete the healthy behaviors will be required to make monthly premium payments to maintain full dental benefits." Thus, goals can be summarized as follows:

1. Provide access to dental care
2. Improve oral health outcomes
3. Encourage utilization of preventive dental services
4. Encourage compliance with dental treatment plans
5. Complete annual healthy dental behaviors
6. Maintain full dental benefits annually

DWP Adjustments for the impact of the COVID-19 pandemic

All analyses and comparisons will need to account for effects of the COVID-19 pandemic in Iowa. Specifically, the evaluation will need to consider effects on access to dental care beginning in March 2020. On March 17, 2020, the Iowa Dental Association and the Iowa Dental Board issued guidance that recommended adherence to American Dental Association (ADA) guidelines to cease elective dental care. On March 27, 2020, Governor Reynolds mandated cessation of non-emergency dental care. Beginning May 8, 2020, Iowa permitted dentists to begin providing routine dental care. However, guidance from the CDC and OSHA at that time recommended against resuming elective dental treatment.

At least three impacts of the pandemic are immediately apparent for DWP members.

1. For a period of no less than seven weeks during SFY 2020, DWP members were unable to complete the health dental behavior requirement for an annual dental visit.
    → Expected effect on DWP evaluation: Analyses will need to account for reduced time available to complete an annual dental visit.
2. DWP members – like the rest of the population – may have had difficulty obtaining emergency dental care for a substantial period of time during SFY 2020. In a survey conducted by the ADA[2] during the week of April 20, 17% of dental offices nationally were closed and not seeing any patients.
    → Expected effect on DWP evaluation: Analyses will need to consider impact on member access to emergency care and use of emergency departments (EDs) for non-traumatic dental conditions.
3. Teledentistry expanded rapidly in Iowa during the pandemic.
    → Expected effect on DWP evaluation: Analyses will need to consider whether teledentistry resulted in any substitution effects after May 8th and how Iowa Medicaid Enterprise and the PAHPs responded to teledentistry visits.

The evaluation will also explore whether dentist participation in DWP was affected by the pandemic and the impact of waiving premiums during the pandemic public health emergency.

Potential adjustments to analyses include use of monthly indicators related to specific proclamations by the state and dental organizations, along with trends in the prevalence of COVID-19.

Hypotheses and Research Questions

Topic 1: Member perceptions of HDB requirements and associated disincentives.

Hypothesis 1: Higher levels of awareness and perceived ability to comply with requirements will be associated with favorable attitudes towards the DWP benefit structure.

Research Question 1A: What level of awareness do members have of the DWP program (including HDB requirements, monthly premiums, annual benefit maximum, and benefit structure)?

Subsidiary Hypothesis 1A.1: Members who have been enrolled longer will have higher levels of awareness than new enrollees.

Subsidiary Hypothesis 1A.2: DWP 2.0 enrollees will have higher levels of awareness than DWP 1.0 enrollees.

Research Question 1B: Do members view HDB requirements as a favorable alternative to monthly premiums?

Subsidiary Hypothesis 1B.1: HDBs will be preferred over monthly premiums.

Subsidiary Hypothesis 1B.2: A majority of members will maintain full benefits via completing HDBs rather than via paying premiums.

[2] https://www.ada.org/en/publications/ada-news/2020-archive/april/third-wave-of-hpi-polling-shows-dentists-response-to-covid-19

Research Question 1C: Do members view expanded dental benefits as preferable over basic benefits?

Subsidiary Hypothesis 1C.1: Members with full benefits will be more likely to prefer expanded dental benefits over basic benefits compared to members with basic benefits.

Research Question 1D: What are the barriers to completing HDBs?

Subsidiary Hypothesis 1D.1: DWP members who are exempt from HDBs will have equal access to dental care to those with the HDBs.

Subsidiary Hypothesis 1D.2: Barriers to care in DWP 2.0 will be lower than pre-DWP 2.0.

Subsidiary Hypothesis 1D.3: Members with full benefits will report fewer barriers than members with basic benefits.

Research Question 1E: What are the characteristics of members with awareness of the program?

Subsidiary Hypothesis 1E.1: Demographic, socioeconomic, eligibility, length of enrollment, and health-related characteristics will be associated with awareness.

Research Question 1F: How are members learning about the program?

Subsidiary Hypothesis 1F.1: Members will report receiving information about DWP from multiple sources.

Subsidiary Hypothesis 1F.2: Members will report that information from their PAHP helped them understand their dental benefits.

Research Question 1G: What are members' experiences applying for the financial hardship waiver?

Subsidiary Hypothesis 1G.1: Members will report low levels of awareness of the financial hardship waiver.

Subsidiary Hypothesis 1G.2: The percentage of members with hardship waivers will increase over time.

Research Question 1H: How satisfied are members with basic benefit levels?

Subsidiary Hypothesis 1H.1: Members will have high levels of satisfaction with basic dental benefits.

Topic 2: Impact of member attitudes and experiences with the DWP benefit structure on completion of HDBs

Hypothesis 2: Completion of HDBs will be positively associated with awareness, ability to comply with requirements, and attitudes.

Research Question 2A: What proportion of DWP members complete HDBs annually?

Subsidiary Hypothesis 2A.1: Members with longer lengths of enrollment are more likely to complete HDBs

Subsidiary Hypothesis 2A.2: IWP-eligible members are more likely to complete HDBs than MSP-FMAP-eligible members.

Subsidiary Hypothesis 2A.3: DWP 2.0 members will have higher rates of preventive dental visits compared to pre-DWP 2.0

Research Question 2B: Are members with hardship exemptions less likely to complete HDBs?

Subsidiary Hypothesis 2B.1: Members with hardship exemptions will be less likely to complete HDBs.

Research Question 2C: How does HDB completion relate to awareness, ability to comply with requirements, and attitudes?

Subsidiary Hypothesis 2C.1: Completion of HDBs will be associated with awareness, ability to comply with requirements, and attitudes.

Topic 3: Impact of DWP benefit structure on members' care-seeking behavior

Hypothesis 3: DWP members who complete HDBs will be more likely to receive needed preventive care and treatment in a dental office.

Research Question 3A: Are the HDB requirements associated with increased use of preventive care?

Subsidiary Hypothesis 3A.1: Members who are not exempt from HDBs will be more likely to have a preventive dental visit than members who are exempt.

Research Question 3B: Are members able to find a dental home?

Subsidiary Hypothesis 3B.1: Likelihood of having a regular source of dental care will increase with length of enrollment.

Subsidiary Hypothesis 3B.2: Newly enrolled members will be able to find a participating dental provider.

Subsidiary Hypothesis 3B.3: DWP 2.0 members will be more likely to have a dental home compared to pre-DWP 1.0.

Research Question 3C: Is completion of HDBs associated with members' use of the emergency department (ED) for non-traumatic dental conditions (NDTCs)?

Subsidiary Hypothesis 3C.1: Members who complete the HDBs will have fewer ED visits for NTDCs annually.

Subsidiary Hypothesis 3C.2: Members who complete the HDBs will be more likely to follow-up with a dentist after an ED visit for a NTDC.

Research Question 3D: Did the introduction of an annual benefit maximum (ABM) influence the types of care members receive?

Subsidiary Hypothesis 3D.1: Members post-ABM will be less likely to receive fixed and removable prosthodontic procedures (excluding complete dentures).

Research Question 3E: How does DWP change dental utilization?

Subsidiary Hypothesis 3E.1: Dental utilization within the DWP population will be as high or higher than utilization in other states.

Topic 4: Impact of DWP benefit structure on members' oral health

Hypothesis 4: DWP members' oral health will improve over time.

Research Question 4A: How do members rate their oral health?

Subsidiary Hypothesis 4A.1: Self-rated oral health will improve over time.

Research Question 4B: Do members with basic benefits have similar unmet treatment needs compared to those with full benefits?

Subsidiary Hypothesis 4B.1: Members with basic benefits will have similar levels of unmet dental need compared to individuals with full benefits.

Research Question 4C: Do the two benefit levels exacerbate health disparities?

Subsidiary Hypothesis 4C.1: Members with basic benefits will not have significantly lower self-rated oral health than individuals with full benefits.

Topic 5: Impact of the COVID-19 pandemic on DWP member service utilization and provider service provision

Hypothesis 5: DWP member service utilization and provider service provision will change due to system changes associated with COVID-19 over time.

Research Question 5A: Have DWP members' ability to access services changed during the COVID-19 pandemic?

Subsidiary Hypothesis 5A.1: Members will be less likely to have diagnostic or preventative dental visits during the COVID-19 pandemic.

Subsidiary Hypothesis 5A.2: Members will be more likely to have an unmet need for dental care during the COVID-19 pandemic.

Research Question 5B: Is the COVID-19 pandemic associated with members' use of the emergency department (ED) for non-traumatic dental conditions (NDTCs)?

Subsidiary Hypothesis 5B.1: Members will be more likely to have ED visits for NTDCs during the COVID-19 pandemic.

Research Question 5C: Did the COVID-19 pandemic impact provider participation in DWP?

Subsidiary Hypothesis 5C.1: Providers will be less likely to accept new DWP members during and after the COVID-19 pandemic

Subsidiary Hypothesis 5C.2: Dental providers will be more likely to offer tele-dentistry services during the COVID-19 pandemic.

Research Question 5D: Have DWP members' barriers to care changed during the COVID-19 pandemic?

Subsidiary Hypothesis 5D.1: Members will be more likely to avoid dental care due to perceived risk of COVID-19.

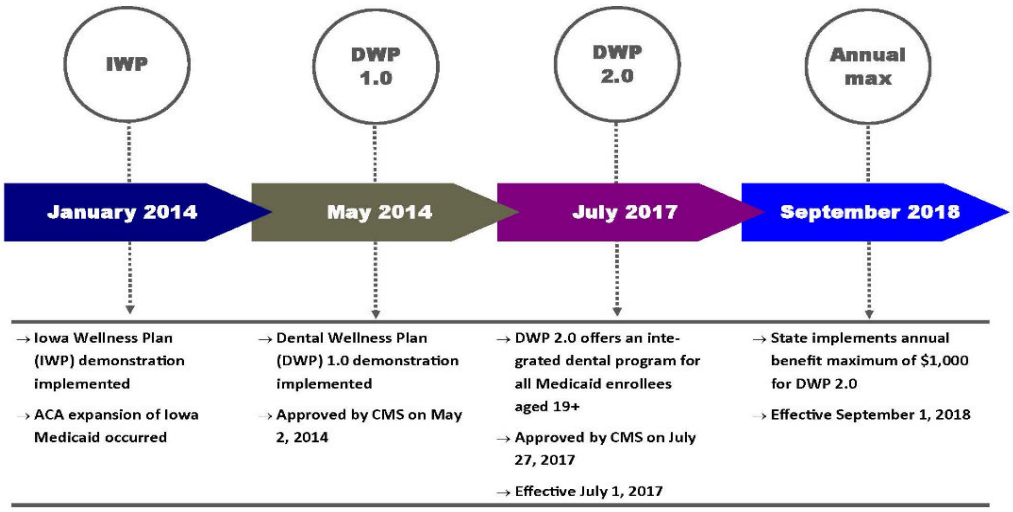
Subsidiary Hypothesis 5D.2: Members will be more likely to utilize teledentistry during the COVID-19 pandemic.

Evaluation Periods

For this evaluation of DWP 2.0, the "pre" period includes SFY 2017 and prior years (Figure 1); the "post" period includes SFY 2018 through the present. Certain hypotheses and measurements will examine pre-post effects related to the September 2018 implementation of the annual benefit max.

State fiscal years will be used to delineate most evaluation periods because most policy changes have been implemented using this timeline.

Figure 1. Dental Wellness Plan policy timeline



Data Sources, Analysis Methods, and Measures

Data sources

Member survey: Member survey-based outcomes will use data from cross-sectional member surveys that are fielded every 1.5 years throughout the evaluation period to track changes in outcomes over time.

Surveys are administered to a stratified random sample of DWP members, including stratification by benefit level, length of enrollment, and PAHP carrier. Samples are drawn from Medicaid eligibility data. Members must have been enrolled in DWP for at least the previous six months to be eligible to receive the survey. Surveys are conducted by mail with an option to complete online. Reminder postcards are sent 2 weeks after the initial fielding date, and a second survey by mail 4 weeks later. A $2 bill will be included in the first mailing as an incentive, and respondents who return their survey within the first two weeks will be entered into a drawing for one of ten $100 gift cards. The sample frame excludes women eligible due to pregnancy and only allows one person per household to be selected. Many survey items have remained constant since pre-DWP 2.0, which will allow us to examine comparisons over time p DWP 2.0 pre- and post- DWP 2.0 implementation. Based on previous surveys, we anticipate a 20-30% response rate.

Provider survey: Provider survey-based outcomes will use data from cross-sectional surveys of private practice dentists fielded every 1.5 years throughout the evaluation period. Surveys are

administered to all private practice dentists in Iowa (~n=1300) drawn from the Iowa Health Professions tracking system housed in the University of Iowa College of Medicine. Surveys are conducted by mail with an option to complete online, and the reminder schedule is the same as the member survey. No incentives are used. Based on previous surveys, we anticipate a response rate of 40-45%.

Consumer in-depth interviews: In-depth telephone interviews will be conducted with a random sample of DWP members, targeting equal representation of members with full and with basic benefits. Key interview topics will include awareness, experiences, and barriers to HDB completion, as well as the perceptions of premiums as an alternative to HDB completion. Interviews will be conducted until saturation is reached.

Administrative claims data: This evaluation will use claim, encounter, and enrollment data to evaluate administrative outcomes. For most administrative measures, the sample includes IWP and MSP-FMAP eligibility categories.

Analyses

Descriptive statistics: Simple univariate statistics, including frequencies, percentages, measures of central tendency, and percentiles will be used to describe measures and characteristics of members in each study population.

Trends over time: Where data are available, we will compare trends in measures over time. This will allow us to examine changes that occurred after major policy changes (e.g., change from DWP 1.0 to DWP 2.0 benefit structure) or other events (e.g., COVID-19 pandemic). Alluvial charts, or Sankey diagrams, will also be used to visualize changes over time. These diagrams are especially useful to see how the member population flows into and out of the program and across benefit levels (e.g., from full to basic benefits). Outcomes from 2018 will provide DWP 2.0 baseline data as available, while DWP 1.0 data from 2017 will provide pre-DWP 2.0 comparisons. Overall, outcomes from 2017-2019 are available to examine trends for several measures. Comparative interrupted time series (CITS) will use a Difference in Difference (DID) estimation to examine the effect of a policy by comparing the pre- and post-program means in the study population using the means in comparison population as the counterfactuals.

Bivariate analysis: Chi-square tests, t-tests (or non-parametric alternatives), and ANOVA will be used to identify associations between outcomes and predictor variables (e.g., measures and demographic characteristics, or measure outcomes across years). Bivariate analyses are frequently used 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 regression analyses.

Multivariable regression: multivariable analysis to identify factors associated with binary outcomes (e.g., having a dental visit in the previous 12 months) will be performed using demographic and other individual-level characteristics as predictors. Based on previous years' evaluation, we anticipate that zero-inflated regression (e.g., zero-inflated Poisson or zero-inflated negative binomial models) will be the most appropriate choice to model data. In the 2018 DWP 2.0 evaluation, we used difference-in-differences analysis to test the effects of DWP 2.0 implementation. In subsequent years, 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., completion of healthy dental behaviors). We will use difference-in-difference analysis (using modified Poisson regression and OLS as appropriate based on the outcome) to model the use of the emergency department (ED) for nontraumatic dental conditions (NTDCs). The control group is

defined as members who never completed any HBI requirements in any year in which they were enrolled. The full treatment group is defined as members who completed all HDB requirements in all years in which they were enrolled. There will also be three partial treatment groups defined as follows: (1) members who completed BOTH HDB requirements, but only in SOME years in which they were enrolled; (2) completed SOME requirements in ALL years in which they were enrolled; (3) members who completed SOME requirements, but only in SOME years in which they were enrolled. The models will also adjust for other demographic characteristics of members and the communities in which they live. Depending on sample sizes and other aspects of the data, we may ultimately collapse the three partial treatment groups into a single partial treatment group. We will also explore the use of individual-level fixed effects in sensitivity analyses. Based on tests of the parallel trends assumption, we will use propensity score matching and inverse probability of treatment weights as needed.

Cross-state comparisons. We will explore various sources of aggregate cross-state data in order to provide descriptive comparisons of state-level results and offer context for Iowa-specific outcomes relative to other states. States will be categorized based on (1) whether they expanded Medicaid and (2) whether they offer comprehensive adult dental benefits to the Medicaid/Medicaid-expansion populations. Comparisons will be made across these categories. Possible sources of comparison data include the Behavioral Risk Factor Surveillance System (BRFSS) and the National Health and Nutrition Examination Survey (NHANES). Several limitations must be noted. First, BRFSS does not ask a question about dental utilization every year. For example, the 2019 BRFSS does not include this survey item, however 2018 does as "how long has it been since you last visited a dentist or a dental clinic for any reason". Second, cross-state comparisons are limited by potential release of recent data. For example, as of May 2020, the most recent NHANES oral health data release is 2017-2018.

We will compare BRFSS responses that indicate dental visits within the past year to our responses from the Iowa Consumer Survey. Where possible, trends by year will be explored.

NHANES also includes an oral health questionnaire component with an item that asks when someone last visited a dentist. The NHANES oral health questionnaire also asks about unmet need, cost barriers, and other barriers to care (e.g., transportation, distance, office hours, or fear of the dentist). As described above, we can potentially compare rates of dental utilization within the past year and barriers to care with Iowa Consumer Survey data. The PPC surveys of DWP enrollees have included items about utilization and barriers to care since 2014, allowing us to also explore comparisons over time. We will confirm that we are replicating item wording on Iowa DWP Consumer Survey questionnaires to match regularly repeated national surveys.

Evaluation Methods Summary: Member perceptions of HDB requirements and associated disincentives.

Comparison Strategy	Outcomes measures(s)	Data sources	Analytic approach
Hypothesis 1: Higher levels of awareness and perceived ability to comply with requirements will be associated with favorable attitudes towards the DWP benefit structure.			
Research Question 1A: What level of awareness do members have of the DWP program (including HDB requirements, monthly premiums, annual benefit maximum, and benefit structure)?			
Subsidiary Hypothesis 1A.1: Members who have been enrolled longer will have higher levels of awareness than new enrollees.			
Newly enrolled members vs. longer-term enrollees	Member awareness of self-risk assessment HDB requirement	DWP Member Survey	Descriptive, Bivariate
Newly enrolled members vs. longer-term enrollees	Member awareness of annual exam HDB requirement	DWP Member Survey	Descriptive, Bivariate
Newly enrolled members vs. longer-term enrollees	Member awareness of benefit levels	DWP Member Survey	Descriptive, Bivariate
Newly enrolled members vs. longer-term enrollees	Member awareness of monthly premiums	DWP Member Survey	Descriptive, Bivariate
Newly enrolled members vs. longer-term enrollees	Member awareness of annual benefit maximum	DWP Member Survey	Descriptive, Bivariate
Subsidiary Hypothesis 1A.2: DWP 2.0 enrollees will have higher levels of awareness than DWP 1.0 enrollees.			
DWP 2.0 members vs. DWP 1.0 and MSP members pre-DWP 2.0	Member awareness of plan structure	DWP Member Survey	Descriptive, Bivariate
Research Question 1B: Do members view HDB requirements as a favorable alternative to monthly premiums?			
Subsidiary Hypothesis 1B.1: HDBs will be preferred over monthly premiums.			
Full benefits vs. basic benefits	Member preference for how to maintain of full dental benefits - quantitative	DWP Member survey	Descriptive, Bivariate
Full benefits vs. basic benefits	Member preference for how to maintain of full dental benefits - qualitative	DWP Member in-depth interviews	Qualitative thematic coding

Comparison Strategy	Outcomes measures(s)	Data sources	Analytic approach
Subsidiary Hypothesis 1B.2: A majority of members will maintain full benefits via completing HDBs rather than via paying premiums.			
Eligible for full benefits via HDB completion vs. premium payments vs. exemptions, by year of eligibility	Member maintenance of full benefits, HDB vs. premium	Administrative data	Descriptive
Research Question 1C: Do members view expanded dental benefits as preferable over basic benefits?			
Subsidiary Hypothesis 1C.1: Members with full benefits will be more likely to prefer expanded dental benefits over basic benefits compared to members with basic benefits.			
Full benefits vs. basic benefits	Member preference for how to maintain of full dental benefits - quantitative	DWP Member survey	Descriptive, Bivariate
Full benefits vs. basic benefits	Member preference for how to maintain of full dental benefits - qualitative	DWP Member in-depth interviews	Qualitative thematic coding
Research Question 1D: What are the barriers to completing HDBs?			
Subsidiary Hypothesis 1D.1: DWP members who are exempt from HDBs will have equal access to dental care to those with the HDBs			
Exempt vs. non-exempt from HDBs	Barriers to HDB completion - quantitative	DWP Member survey	Descriptive, Bivariate
None	Barriers to HDB completion - qualitative	DWP Member in-depth interviews	Qualitative thematic coding
Subsidiary Hypothesis 1D.2: Barriers to care in DWP 2.0 will be lower than pre-DWP 2.0.			
DWP 2.0 members vs. DWP 1.0 and MSP members pre-DWP 2.0	Barriers to HDB completion	DWP Member survey	Descriptive, Bivariate
Subsidiary Hypothesis 1D.3: Members with full benefits will report fewer barriers than members with basic benefits. Subsidiary Hypothesis 1D.1: DWP members who are exempt from HDBs will have equal or lower barriers to care.			
Full benefits vs. basic benefits	Barriers to HDB completion	DWP Member survey	Descriptive, Bivariate
Research Question 1E: What are the characteristics of members with awareness of the program?			
Subsidiary Hypothesis 1E.1: Demographic, socioeconomic, eligibility, length of enrollment, and health-related characteristics will be associated with awareness.			
Independent variables include demographic and health-related survey items, and program eligibility and enrollment factors	Member awareness scale	DWP Member survey	Bivariate, Multivariable regression analysis

Comparison Strategy	Outcomes measures(s)	Data sources	Analytic approach
Research Question 1F: How are members learning about the program?			
Subsidiary Hypothesis 1F.1: Members will report receiving information about DWP from multiple sources.			
None	Member source of program information	DWP Member survey	Descriptive
Subsidiary Hypothesis 1F.2: Members will report that information from their PAHP helped them understand their dental benefits.			
None	Impact of PAHP outreach on member knowledge	DWP Member survey	Descriptive
Research Question 1G: What are members' experiences applying for the financial hardship waiver?			
Subsidiary Hypothesis 1G.1: Members will report low levels of awareness of the financial hardship waiver.			
None	Member awareness of financial hardship waiver	DWP Member survey	Descriptive
Subsidiary Hypothesis 1G.2: The percentage of members with financial hardship waivers will increase over time.			
None	Member use of financial hardship waiver	Administrative data	Descriptive
Research Question 1H: How satisfied are members with basic benefit levels?			
Subsidiary Hypothesis 1H.1: Members will have high levels of satisfaction with basic dental benefits.			
Members with basic benefits	Member satisfaction with basic dental benefits	DWP Member survey	Descriptive
Members with basic benefits vs. full benefits	Plan satisfaction	DWP Member survey	Descriptive, Bivariate

Evaluation Methods Summary: Impact of member attitudes and experiences with the DWP benefit structure on completion of HDBs

Comparison Strategy	Outcomes measures(s)	Data sources	Analytic approach
Hypothesis 2: Completion of HDBs will be positively associated with awareness, ability to comply with requirements, and attitudes.			
Research Question 2A: What proportion of DWP members complete HDBs annually?			
Subsidiary Hypothesis 2A.1: Members with longer lengths of enrollment are more likely to complete HDBs.			
Newly enrolled members vs. longer-term enrollees	Preventive dental visit (HDB requirement)	Administrative data	Descriptive; Chi-square test of homogeneity

Comparison Strategy	Outcomes measures(s)	Data sources	Analytic approach
Newly enrolled members vs. longer-term enrollees	Completion of self-risk assessment	Administrative data	Descriptive; Chi-square test of homogeneity
Full population Trend over time (FY2018 onward)	Preventive dental utilization	Administrative data	Descriptive
Full population Trend over time (FY2018 onward)	Preventive dental visit (HDB requirement)	Administrative data	Descriptive
Full population Trend over time (FY2018 onward)	Completion of self-risk assessment	Administrative data	Descriptive
Members enrolled in DWP for >12 months, categorized by length of enrollment (e.g., 2 years, 3 years, etc); exclude members with waivers and excluded from HDB requirements Trend over time (FY2019 onward)	Retention of full benefits as a result of completing HDBs	Administrative data	Alluvial chart
Subsidiary Hypothesis 2A.2: IWP-eligible members are more likely to complete HDBs than MSP-FMAP-eligible members.			
IWP and MSP-FMAP	Preventive dental visit (HDB requirement)	Administrative data	Descriptive; Chi-square test of homogeneity
IWP and MSP-FMAP	Completion of self-risk assessment	Administrative data	Descriptive; Chi-square test of homogeneity
Subsidiary Hypothesis 2A.3: DWP 2.0 members will have higher rates of preventive dental visits compared to pre-DWP 2.0			
DWP 2.0 members vs. DWP 1.0 and MSP members pre-DWP 2.0 (FY2017) Trend over time (FY2017 onward)	Preventive dental visit (HDB requirement)	Administrative data	Descriptive; Chi-square test of homogeneity
Research Question 2B: Are members with hardship exemptions less likely to complete HDBs?			
Subsidiary Hypothesis 2B.1: Members with hardship exemptions will be less likely to complete HDBs.			
Members with hardship exemption vs. members without hardship exemption	Completion of both HDBs	Administrative data	Descriptive; Chi-square test of homogeneity

Comparison Strategy	Outcomes measures(s)	Data sources	Analytic approach
Research Question 2C: How does HDB completion relate to awareness, ability to comply with requirements, and attitudes?			
Subsidiary Hypothesis 2C.1: Completion of HDBs will be associated with awareness, ability to comply with requirements, and attitudes.			
Independent variables include demographic and health-related survey items, and plan awareness, ability to complete requirements, and program attitudes	Predictors of HDB completion	Administrative data (HDBs); DWP Member survey	Bivariate; Multivariable logistic regression analysis

Evaluation Methods Summary: Impact of DWP benefit structure on members' care-seeking behavior

Comparison Strategy	Outcomes measures(s)	Data sources	Analytic approach
Hypothesis 3: DWP members who complete HDBs will be more likely to receive needed preventive care and treatment in a dental office.			
Research Question 3A: Are the HDB requirements associated with increased use of routine dental care, including preventive care?			
Subsidiary Hypothesis 3A.1: Members who are not exempt from HDBs will be more likely to have a preventive dental visit than members who are exempt.			
Members who are exempt from HDBs vs. members who are not (including categorically eligible and hardship waivers)	Preventive dental visit (HDB requirement) by member exemption	Administrative data	Multivariable logistic regression
Members who are exempt from HDBs vs. members who are not (including categorically eligible and hardship waivers)	Any dental visit by member exemption	Administrative data	Multivariable logistic regression
Research Question 3B: Are members able to find a dental home?			
Subsidiary Hypothesis 3B.1: Likelihood of having a regular source of dental care will increase with length of enrollment.			
Newly enrolled members vs. longer-term enrollees	Regular dentist: Percent of members who report that they currently have a regular dentist	DWP Member survey	Descriptive, Bivariate

Comparison Strategy	Outcomes measures(s)	Data sources	Analytic approach
None	Care continuity: Among members with 2 or more years of enrollment, percent of members with a preventive dental visit (HDB requirement) in each year	Administrative data	Descriptive
None	Usual source of care: Percent of members from previous measure who saw the same provider for both visits	Administrative data	Descriptive
Subsidiary Hypothesis 3B.2: Newly enrolled members will be able to find a participating dental provider.			
Newly enrolled members	Ability to find a dentist	DWP Member survey	Descriptive
None	Dentist participation in DWP	DWP Provider survey	Descriptive
None	Dentist attitudes toward DWP	DWP Provider survey	Descriptive; Bivariate; Trends over time
None	Dental visit in first year of enrollment	DWP Administrative data	Descriptive; Trends over time
Subsidiary Hypothesis 3B.3: DWP 2.0 members will be more likely to have a dental home compared to pre-DWP 1.0.			
DWP 2.0 members vs. DWP 1.0 and MSP members pre-DWP 2.0	Regular dentist: Percent of members who report that they currently have a regular dentist	DWP Member survey	Descriptive, Bivariate, Trends over time
DWP 2.0 members vs. DWP 1.0 and MSP members pre-DWP 2.0	Timeliness of emergency dental care: Percent of members who needed to see a dentist right away because of a dental emergency and were able to see a dentist as soon as they wanted	DWP Member survey	Descriptive, Bivariate, Trends over time
DWP 2.0 members vs. DWP 1.0 and MSP members pre-DWP 2.0	Timeliness of specialty dental care: Percent of members who report that they received specialty dental care as soon as wanted	DWP Member survey	Descriptive, Bivariate, Trends over time
DWP 2.0 members vs. DWP 1.0 and MSP members pre-DWP 2.0	Timeliness of routine dental care: Percent of members who report that they received routine dental care as soon as wanted	DWP Member survey	Descriptive, Bivariate, Trends over time

Comparison Strategy	Outcomes measures(s)	Data sources	Analytic approach
Research Question 3C: Is completion of HDBs associated with members' use of the emergency department (ED) for non-traumatic dental conditions (NDTCs)?			
Subsidiary Hypothesis 3C.1: Members who complete the HDBs will have fewer ED visits for NTDCs annually.			
Two comparison groups: 1:DWP members who complete the HDBs 2:DWP members who do not complete HDBs	ED utilization for NTDCs	Administrative data	Comparative interrupted time series Pre:SFY2014-2017 Post:SFY2018-2021
Subsidiary Hypothesis 3C.2: Members who complete the HDBs will be more likely to follow-up with a dentist after an ED visit for a NTDC.			
Two comparison groups: 1:DWP members who complete the HDBs 2:DWP members who do not complete HDBs	Follow-up after ED visit: Percent of members who were seen in the ED for non-traumatic dental related reasons within the reporting year and visited a dentist for treatment services within 60 days following the ED visit	Administrative data	Comparative interrupted time series Pre:SFY2014-2017 Post:SFY2018-2021
Research Question 3D: Did the introduction of an annual benefit maximum (ABM) influence the types of care members receive?			
Subsidiary Hypothesis 3D.1: Members post-ABM will be less likely to receive fixed and removable prosthodontic procedures (excluding complete dentures).			
Two comparison groups: 1:DWP members who are subject to ABM 2:DWP members exempt from ABM	Utilization of specialty dental services	Administrative data	Comparative interrupted time series Pre:SFY2014-2017 Post:SFY2018-2021
DWP members pre- and post- ABM implementation	Unmet need for care	DWP Member survey	Descriptive, Bivariate
DWP members pre- and post- ABM implementation	Out-of-pocket costs	DWP Member survey	Descriptive, Bivariate
Research Question 3E: How does DWP change dental utilization?			
Subsidiary Hypothesis 3E.1: Dental utilization within the DWP population will be as high or higher than utilization in other states.			
Comparable expansion and non-expansion states	Dental utilization: Percent of the adult statewide population who had a dental visit within the last year	National survey data (e.g., BRFSS)	Comparison of rates

Evaluation Methods Summary: Impact of DWP benefit structure on members' oral health

Comparison Strategy	Outcomes measures(s)	Data sources	Analytic approach
Hypothesis 4: DWP members' oral health will improve over time.			
Research Question 4A: How do members rate their oral health?			
Subsidiary Hypothesis 4A.1: Self-rated oral health will improve over time.			
DWP 2.0 members vs. DWP 1.0 and MSP members pre-DWP 2.0	Self-rated oral health	DWP Member survey	Descriptive Bivariate
Research Question 4B: Do members with basic benefits have similar unmet treatment needs compared to those with full benefits?			
Subsidiary Hypothesis 4B.1: Members with basic benefits will have similar levels of unmet dental need compared to individuals with full benefits.			
Full benefits vs. basic benefits	Unmet treatment needs	DWP Member survey	Multivariable logistic regression (adjusted for length of enrollment and other potential confounders)
Research Question 4C: Do the two benefit levels exacerbate health disparities?			
Subsidiary Hypothesis 4C.1: Members with basic benefits will not have significantly lower self-rated oral health than individuals with full benefits.			
Full benefits vs. basic benefits Examine differences based on HDB-exemption IWP and MSP-FMAP	Self-rated oral health	DWP Member survey	Multivariable analysis – adjust for length of enrollment and other potential confounders

Evaluation Methods Summary: Impact of the COVID-19 pandemic on DWP members' and providers' service utilization and provision

Comparison Strategy	Outcomes measures(s)	Data sources	Analytic approach
Hypothesis 5: DWP members' and providers' utilization and provision of services will change due to system changes associated with COVID-19 over time.			
Research Question 5A: Have DWP members' ability to access services changed during the COVID-19 pandemic?			
Subsidiary Hypothesis 5A.1: Members will be less likely to have diagnostic or preventive dental visits during the COVID-19 pandemic.			
Newly enrolled members (<11 months) vs. members with at least 1 year of eligibility	Preventive dental visit (HDB requirement)	Administrative data	Descriptive; McNemar test; Trend over time
Newly enrolled members (<11 months) vs. members with at least 1 year of eligibility	Any dental visit	Administrative data	Descriptive; Trend over time
Subsidiary Hypothesis 5A.2: Members will be more likely to have an unmet need for dental care during the COVID-19 pandemic.			
Members pre- and post-COVID	Unmet treatment needs	DWP Member survey	Descriptive, Bivariate, Trends over time
Research Question 5B: Is the COVID-19 pandemic associated with members' use of the emergency department (ED) for non-traumatic dental conditions (NDTCs)?			
Subsidiary Hypothesis 5B.1: Members will be more likely to have ED visits for NTDCs during the COVID-19 pandemic.			
IWP and MSP-FMAP pre and post COVID-19; IWP and MSP-FMAP time series ongoing during COVID-19	ED utilization for NTDCs	Administrative data	Descriptive; Trend over time
IWP and MSP-FMAP pre and post COVID-19; IWP and MSP-FMAP time series ongoing during COVID-19	Emergency dental appointments	DWP Member survey	Descriptive, Bivariate, Trends over time
Research Question 5C: Did the COVID-19 pandemic impact provider participation in DWP?			
Subsidiary Hypothesis 5C.1: Providers will be less likely to accept new DWP members during and after the COVID-19 pandemic			
Pre- and post-COVID	New patient acceptance	DWP Provider survey	Descriptive, Bivariate, Trends over time
Subsidiary Hypothesis 5C.2: Dental providers will be more likely to offer teledentistry services during the COVID-19 pandemic.			
None	Use of teledentistry	DWP Provider survey	Descriptive, Bivariate, Trends over time

Comparison Strategy	Outcomes measures(s)	Data sources	Analytic approach
Research Question 5D: Have DWP members' barriers to care changed during the COVID-19 pandemic?			
Subsidiary Hypothesis 5D.1: Members will be more likely to avoid dental care due to perceived risk of COVID-19.			
None	Percent of members who have avoided a dental visit due to the COVID pandemic	DWP Member Survey	Descriptive, Bivariate, Trends over time
Subsidiary Hypothesis 5D.2: Members will be more likely to utilize teledentistry during the COVID-19 pandemic.			
None	Teledentistry utilization	Administrative data	Descriptive; McNemar test; Trend over time (PMPM)

Logic Model: Dental Wellness Plan

Process			Outcomes		
Policy	**PAHP Activity**	**Dental utilization**	**Short-term** (Knowledge/attitudes)	**Intermediate** (Behavior/normative change)	**Long-term** (Desired results of DWP)
Requirement for members to obtain an annual preventive dental exam AND complete a self-risk assessment in order to retain full benefits and avoid monthly premium requirements	Member outreach [Survey]	• Annual rates of dental exams [Outcomes, Survey] • Self-risk assessment completion as identified by the PAHP's (codes not required)	• Member awareness/ knowledge of HDB requirement for annual exam [Survey] • Member awareness/ knowledge of HDB requirement for self-risk assessment [Survey] • Member awareness/ knowledge of impact of HDBs on benefit levels [Survey] • Member awareness/ knowledge of premium requirements [Survey] • Member awareness/ knowledge of hardship exemptions from premiums [Survey]	• Established regular source of dental care [Survey] • Reduced utilization of ED for non-traumatic dental conditions [Outcomes] • Proportion of members paying monthly premiums (excluding hardship exemptions) [Outcomes] • Annually, increased rates of preventive dental examinations [Survey, Outcomes] • Increased utilization of urgent treatment services by new members [Outcomes]	• Regular utilization of annual dental exams by individuals – i.e. repeated behavior over time [Outcomes] • Member self-rated oral health increases over time [Survey] • Reduced utilization of urgent treatment services by members over time [Outcomes] • Members retain full benefits as a result of completing HDBs • Reduced unmet dental need over time • Basic benefit levels will not increase disparities in unmet dental need among DWP members
Contextual Factors: (1) Members can apply for premium exemptions due to material hardship. (2) Several populations are excluded from monthly premium requirements. (3) Dental benefits have an annual maximum of $1,000. (3) Previous enrollment in Medicaid or DWP 1.0. (4) Length of enrollment in DWP 2.0. (5) Dentist participation in DWP 2.0 and acceptance of new patients. (6) Member completion of other IWP Healthy Behaviors (e.g., wellness visit or health risk assessment). (7) COVID-19 pandemic effects on dentist workforce availability and patient care-seeking behaviors.					

3) Retroactive Eligibility

Background

The state of Iowa requested a waiver of retroactive eligibility to remove the federally mandated 3-month retroactive eligibility period for Medicaid members. Groups affected by the original waiver included newly enrolling children 1-18 years of age in Medicaid and adult parents/caretaker relatives of children in Medicaid, those newly enrolling in Iowa Wellness Plan, newly enrolling in Medicaid due to a disability determination or newly enrolling through a separate waiver program such as Home and Community-Based Services (HCBS). The amendment requesting the waiver was filed with CMS on August 2, 2017 and approved to begin November 1, 2017. This waiver was amended as of July 1, 2018 for nursing home residents who had been in the nursing facility for any three months prior to Medicaid application granting them access to 3 months of retroactive eligibility. It was again amended as of January 1, 2020 as part of the 1115 renewal to exempt children 1-19 years of age granting them access to 3 months of retroactive eligibility.

The state provided the following rationale for this action in the original amendment:

> "The State's rationale for this amendment request is founded on the fact that the commercial market does not allow for retroactive health coverage, and if CMS grants this request to waive Section 1902(a)(34), sufficient protections will still remain in place for individuals to receive necessary care.
>
> As mentioned above, the State seeks to more closely align Medicaid policy with that of the commercial market, which does not allow for an individual to apply for retroactive health insurance coverage. Eliminating Medicaid retroactivity encourages individuals to obtain and maintain health insurance coverage, even when healthy. With the availability of Medicaid expansion and premium tax credits, affordable coverage options have been available in Iowa for those complying with the individual mandate, thus eliminating the need for retroactive coverage. Further, by more closely aligning Iowa Medicaid policy with policy in the commercial insurance market, members will be better prepared if they are eventually able to transition to commercial health insurance."

Goals

In the most recent amendment, November 2019, the state provided a table of goals and questions as shown below.

Table 12. State waiver goals – Waiver of Retroactive Eligibility

Waiver Policy: Waiver of Retroactive Eligibility	
Goal: **Encourages individuals to obtain and maintain health insurance coverage, even when healthy.**	
Eliminating retroactive eligibility will increase the likelihood of enrollment and enrollment continuity.	Do eligible people subject to retroactive eligibility waivers enroll in Medicaid at the same rates as other eligible people who have access to retroactive eligibility?
	What is the likelihood of enrollment continuity for those subject to a retroactive eligibility waiver compared to other Medicaid beneficiaries who have access to retroactive eligibility?
	Do beneficiaries subject to retroactive eligibility waivers who disenroll from Medicaid have shorter enrollment gaps than other beneficiaries who have access to retroactive eligibility?

The State also proposed the following hypotheses and research questions.

Table 13. Table of state-specified hypotheses and research questions – Waiver of Retroactive Eligibility

Hypothesis	Research Question(s)
Eliminating retroactive eligibility will increase enrollment of eligible people when they are healthy relative to those eligible people who have the option of retroactive eligibility.	Do newly enrolled beneficiaries subject to the waiver of retroactive eligibility have higher self-assessed health status than other newly enrolled beneficiaries who have access to retroactive eligibility?
Through greater continuity of coverage, health outcomes will be better for those subject to retroactive eligibility waivers compared to other Medicaid beneficiaries who have access to retroactive eligibility.	Do beneficiaries subject to the retroactive eligibility waiver have better health outcomes than other beneficiaries who have access to retroactive eligibility?
Elimination or reduction of retroactive coverage eligibility will not have adverse financial impacts on consumers.	Does the retroactive eligibility waiver lead to changes in the incidence of beneficiary medical debt?

The logic model below is drawn from the State's amendment and CMS's approval letter to the state granting the 1115 renewal dated November 15, 2019. Additionally, in the original amendment the waiver of retroactive eligibility is proposed to reduce annual costs in excess of $36M with the federal share topping $26M due to a reduction in total member months.

Logic Model: Waiver of Retroactive Eligibility

Process		**Outcomes**		
Policy	**Process**	**Short-term outcomes**	**Intermediate outcomes**	**Long-term outcomes**
Waiver of Retroactive Eligibility	Provider communication Member communication	Increase likelihood of enrollment Increase enrollment continuity There will be no adverse financial impact on consumers Increase in provider-initiated applications	Increase enrollment of healthy beneficiaries Lower PMPM costs Increase use of preventive care No change in rates of uncompensated care No change in member medical/dental debt Reduction total member months	Improved self-ratings of physical/mental health Reduced avoidable inpatient admissions Program wide cost reductions
Moderating factors: Existing chronic conditions, presence of enrolled Medicaid beneficiaries in the household, previous Medicaid enrollment, demographic characteristics				

Hypotheses and research questions

Hypothesis 1: Eliminating retroactive eligibility will increase the likelihood of enrollment and enrollment continuity.

Primary Research Question 1.1: Are people subject to the waiver of retroactive eligibility more likely to enroll in Medicaid relative to members in the same programs prior to the waiver?

Subsidiary Research Question 1.1a: Are people subject to the waiver of retroactive eligibility more likely to enroll while still healthy relative to members in the same programs prior to the waiver?

Subsidiary Research Question 1.1b: Are people subject to the waiver of retroactive eligibility more likely to enroll earlier?

Primary Research Question 1.2: Do people subject to the waiver of retroactive eligibility have increased enrollment continuity relative to members in the same programs prior to the waiver?

Subsidiary Research Question 1.2a: Do people subject to the waiver of retroactive eligibility understand that they will not be covered during enrollment gaps?

Subsidiary Research Question 1.2b: What are the barriers to timely renewal for those subject to the waiver of retroactive eligibility?

Subsidiary Research Question 1.2c: Among members subject to the retroactive eligibility waiver, is timely renewal more likely by those who might be expected to value coverage highly, relative to those who might value coverage less?

Subsidiary Research Question 1.2d: Are people subject to the waiver of retroactive eligibility more likely to remain continuously enrolled relative to members in the same programs prior to the waiver?

Subsidiary Research Question 1.2e: Are people subject to the waiver of retroactive eligibility more likely to re-enroll relative to members in the same programs prior to the waiver?

Hypothesis 2: Eliminating retroactive eligibility will not increase negative financial impacts on members.

Primary Research Question 2.1: Are there any negative financial impacts on consumers because of the waiver of retroactive eligibility relative to members in the same programs prior to the waiver?

Subsidiary Research Question 2.1a: Do beneficiaries subject to the waiver of retroactive eligibility experience greater 'medical debt' relative to members in the same programs prior to the waiver?

Subsidiary Research Question 2.1b:Do hospitals experience higher rates of uncompensated care after the enactment of the waiver of retroactive eligibility?

Hypothesis 3: Eliminating retroactive eligibility will improve member health.

Primary Research Question 3.1: Do people who are subject to waiver of retroactive eligibility have better health outcomes?

Hypothesis 4: Eliminating retroactive eligibility will reduce the annual Medicaid services budget.

Primary Research Question 4.1: What are the effects on the Medicaid services budget?

Hypothesis 5: Providers will increase initiation of Medicaid applications for eligible patients/clients

Primary Research Question 5.1: Have health care providers increased the initiation of Medicaid applications for eligible patients/clients?

Evaluation Methods Summary: Waiver of Retroactive Eligibility

Comparison Strategy	Outcomes measures(s)	Data sources	Analytic approach
Hypothesis 1: Eliminating retroactive eligibility will increase the likelihood of enrollment and enrollment continuity.			
Primary Research Question 1.1: Are people subject to the waiver of retroactive eligibility more likely to enroll in Medicaid relative to members in the same programs prior to the waiver?			
Subsidiary Research Question 1.1a: Are people subject to the waiver of retroactive eligibility more likely to enroll while still healthy relative to members in the same programs prior to the waiver?			
Study group: Medicaid members subject to waiver – IWP, FMAP, SSI Comparison group: Medicaid members not subject to the waiver – Parents of children as proxy	In general, how would you rate your overall health now? Excellent; Very good; Good; Fair; Poor	Enrollment survey	DID May 2021-April 2022
Study group: Adults in IWP, FMAP, SSI CY 2018-2021 and children in Medicaid CY 2018-2019 Comparison group: Adults in IWP, FMAP, SSI CY 2014-2017 and children in Medicaid CY 2014-2017 and 2020-2021	Hospitalizations per 1,000 member per month ED visits per 1,000 member per month Ambulatory care visits per 1,000 member per month Average number of prescriptions per member per month	Medicaid claims	ITS Pre-RE waiver CY 2014-2017 Post-RE waiver CY 2018-2021
Study group: Adults in IWP, FMAP, SSI CY 2018-2021 and children in Medicaid CY 2018-2019 Comparison group: Adults in IWP, FMAP, SSI CY 2014-2017 and children in Medicaid CY 2014-2017 and 2020-2021	Per member per month Medicaid reimbursement in first 3 months of enrollment	Medicaid claims	CITS Pre-RE waiver CY 2014-2017 Post-RE waiver CY 2018-2021
Subsidiary Research Question 1.1b: Are people subject to the waiver of retroactive eligibility more likely to enroll earlier?			
Study group: Medicaid members subject to waiver – IWP, FMAP, SSI Comparison group: Medicaid members not subject to the waiver – Parents of children as proxy	Beneficiary estimate of gap between considering enrollment and completing application process (Under development) How long ago did you start thinking about applying for Medicaid/state help/etc.	Enrollment survey	Means test May 2021-April 2022

Comparison Strategy	Outcomes measures(s)	Data sources	Analytic approach
Primary Research Question 1.2: Do people subject to the waiver of retroactive eligibility have increased enrollment continuity relative to members in the same programs prior to the waiver?			
Subsidiary Research Question 1.2a: Do people subject to the waiver of retroactive eligibility understand that they will not be covered during enrollment gaps?			
Study group: Medicaid members subject to waiver – IWP, FMAP, SSI Comparison group: Medicaid members not subject to the waiver – Parents of children as proxy	Understanding of coverage (Under development) When you applied for Medicaid did you believe that the program would pay for some of the care you received before being enrolled? If yes, how far back did you expect that coverage to go?	Enrollment survey Member survey	Means tests and descriptive analyses May 2021-April 2022
Subsidiary Research Question 1.2b: What are the barriers to timely renewal for those subject to the waiver of retroactive eligibility?			
Study group: Medicaid members subject to waiver – IWP, FMAP, SSI Comparison group: Medicaid members not subject to the waiver – Parents of children as proxy	Barriers to enrollment (Under development) Did you have any problems trying to enroll for Medicaid/IWP, etc.? If yes, what were they? Couldn't understand the forms, process too complicated, had no transportation to appointment, did not know where to go to get help, did not have all the documents I needed, had no one to help me fill out the forms	Enrollment survey Member survey	Descriptive analyses May 2021-April 2022
Subsidiary Research Question 1.2c: Among members subject to the retroactive eligibility waiver, is timely renewal more likely by those who might be expected to value coverage highly, relative to those who might value coverage less?			
Study group: Adults in IWP, FMAP, SSI CY 2018-2021 Comparison group: Adults in IWP, FMAP, SSI CY 2014-2017	Number of enrollment gaps over 2 months within the calendar year Average length of enrollment gap in the calendar year Risk stratified by prescription use and presence of chronic conditions as measured by CCS	Medicaid enrollment files	CITS Pre-RE waiver CY 2014-2017 Post-RE waiver CY 2018-2021 We will also analyze without risk stratification to allow short-enrollment members into the analytic
Study group: Medicaid members subject to waiver – IWP, FMAP, SSI Comparison group: Medicaid members not subject to the waiver – Parents of children as proxy	Value of renewal (Under development) How important is it for you to keep your health coverage? Very important, important, neither important nor not important, not important, not important at all	Member survey	Descriptive analyses

Comparison Strategy	Outcomes measures(s)	Data sources	Analytic approach
Study group: Adults in IWP, FMAP, SSI CY 2018-2021 Comparison group: Adults in IWP, FMAP, SSI CY 2014-2017	Length of enrollment period Total months of enrollment from first enrollment in period to end of enrollment or end of period, whichever comes first, adjusted for months remaining in period at enrollment.	Medicaid enrollment files	CITS Pre-RE waiver CY 2014-2017 Post-RE waiver CY 2018-2021
Subsidiary Research Question 1.2d: Are people subject to the waiver of retroactive eligibility more likely to remain continuously enrolled relative to members in the same programs prior to the waiver?			
Study group: Adults in IWP, FMAP, SSI CY 2018-2021 and children in Medicaid CY 2018-2019 Comparison group: Adults in IWP, FMAP, SSI CY 2014-2017 and children in Medicaid CY 2014-2017 and 2020-2021	Longer periods of continuous enrollment Average months of continuous enrollment, adjusted for months remaining in period at enrollment	Medicaid enrollment files	CITS Pre-RE waiver CY 2014-2017 Post-RE waiver CY 2018-2022
Study group: Adults in IWP, FMAP, SSI CY 2018-2021 and children in Medicaid CY 2018-2019 Comparison group: Adults in IWP, FMAP, SSI CY 2014-2017 and children in Medicaid CY 2014-2017 and 2020-2021	Time to first enrollment gap	Medicaid enrollment files	Survival analysis CY 2014-2022 Time dependent covariates including RE waiver implementation
Subsidiary Research Question 1.2e: Are people subject to the waiver of retroactive eligibility more likely to re-enroll following a voluntary or administrative disenrollment relative to members in the same programs prior to the waiver?			
Study group: Adults in IWP, FMAP, SSI CY 2018-2021 and children in Medicaid CY 2018-2019 Comparison group: Adults in IWP, FMAP, SSI CY 2014-2017 and children in Medicaid CY 2014-2017 and 2020-2021	Length of enrollment gap Number of months between disenrollment (forced or voluntary) and re-enrollment	Medicaid enrollment files	CITS Pre-RE waiver CY 2014-2017 Post-RE waiver CY 2018-2022
Study group: Adults in IWP, FMAP, SSI CY 2018-2021 and children in Medicaid CY 2018-2019 Comparison group: Adults in IWP, FMAP, SSI CY 2014-2017 and children in Medicaid CY 2014-2017 and 2020-2021	Rates of re-enrollment Proportion of members disenrolled (forced or voluntary) who re-enroll within 1 year	Medicaid enrollment files	Descriptive analyses CY 2014-2022

Comparison Strategy	Outcomes measures(s)	Data sources	Analytic approach
Hypothesis 2: Eliminating retroactive eligibility will not increase the likelihood of negative financial impacts on members.			
Primary Research Question 2.1: Are there any negative financial impacts on consumers because of the waiver of retroactive eligibility relative to members in the same programs prior to the waiver?			
Subsidiary Research Question 2.1a: Do beneficiaries subject to the waiver of retroactive eligibility experience greater 'medical debt' relative to members in the same programs prior to the waiver?			
Study group: Medicaid members subject to waiver – IWP, FMAP, SSI Comparison group: Medicaid members not subject to the waiver – Parents of children as proxy	Whether member reports medical or dental debt. (Under development) Do you currently owe money for health care you (your children) have gotten in the past? If yes, is this for medical care? Is this for dental care?	Enrollment survey	DID May 2021-April 2022
Study group: Medicaid members subject to waiver – IWP, FMAP, SSI Comparison group: Medicaid members not subject to the waiver – Parents of children as proxy	Amount of medical/dental debt reported at enrollment (Under development) How much do you owe for medical care you (your children) have gotten? How much do you owe for dental care you (your children) have gotten?	Enrollment survey	DID May 2021-April 2022
Subsidiary Research Question 2.1b:Do hospitals experience higher rates of uncompensated care after the enactment of the waiver of retroactive eligibility?			
Iowa Hospitals before and after the waiver	Reported rate of uncompensated care	HCRIS	ITS Pre-RE waiver CY 2014-2017 Post-RE waiver CY 2018-2021
Hospitals in comparison states without waivers	Reported rates of uncompensated care	HCRIS	CITS Pre-RE waiver CY 2014-2017 Post-RE waiver CY 2018-2021
Hypothesis 3: Eliminating retroactive eligibility will improve member health.			
Primary Research Question 3.1: Do people who are subject to waiver of retroactive eligibility have better health outcomes?			
Study group: Surveyed adults in IWP, FMAP, SSI CY 2021 Comparison group: Surveyed adults in IWP, FMAP, SSI CY 2017 and 2018	Self-ratings of physical and mental health	Member survey	Descriptive analyses Survey 2017, 2018 and 2021

Comparison Strategy	Outcomes measures(s)	Data sources	Analytic approach
Study group: Adults in IWP, FMAP, SSI CY 2018-2021 Comparison group: Adults in IWP, FMAP, SSI CY 2014-2017	Avoidable inpatient admissions	Medicaid claims files	Descriptive analyses Pre-RE waiver CY 2014-2017 Post-RE waiver CY 2018-2021
Hypothesis 4: Eliminating retroactive eligibility will reduce the annual Medicaid services budget.			
Primary Research Question 4.1: What are the effects on the Medicaid services budget?			
Study group: Iowa Medicaid CY 2013-2017 Comparison group: Iowa Medicaid CY 2018-2022	Total annual Medicaid health care services expenditures	Medicaid claims	ITS Pre-RE waiver CY 2013-2017 Post-RE waiver CY 2018-2022
Study group: Iowa Medicaid CY 2013-2017 Comparison group: Iowa Medicaid CY 2018-2022	Total number of months Medicaid eligibility	Enrollment files	Descriptive analyses Pre-RE waiver CY 2013-2017 Post-RE waiver CY 2018-2022
Hypothesis 5: Providers will increase initiation of Medicaid applications for eligible patients/clients.			
Primary Research Question 5.1: Have health care providers increased the initiation of Medicaid application for eligible patients/clients?			
Providers at the individual, MCO, ACO level	Provider reports of Medicaid application initiation process and follow-up	Key stakeholder interviews	Descriptive analyses July 2021-June 2022

Data Sources, Analysis Methods, and Measures

Evaluating the waiver of retroactive eligibility requires a variety of analytics and data collection strategies. This evaluation will be composed of 2 phases. Phase 1 is oriented to process measures and Phase 2 is oriented to outcome measures.

Phase 1: Process

Phase 1 focuses on understanding the implementation of the waiver from the perspectives of IME, health care provider entities, and members. Understanding and documenting implementation provides the background for developing survey questions and the context for interpreting outcome results. We will use qualitative methods to conduct this portion of the evaluation, including document analysis and in-depth interviews. The document analysis will be ongoing, as the program is implemented, while interviews will be during the first year of the evaluation period.

Policy Definition

Through a series of telephone interviews with IME staff, we will translate the past and current policies into a visual representation identifying the application and enrollment process. With special investigation of application process changes, we will utilize enrollment files to understand the groups that are affected by this policy change.

Policy Communication

The state's primary mechanism for communicating the policy change to provider entities and members was through brochures, informational letters and website posting. We will collect historical communication documents (2014-2017) related to retroactive eligibility to determine what provider entities and members were told regarding the 3-month retroactive eligibility period prior to the waiver. We will try to understand how members were informed regarding the availability of retroactive eligibility prior to waiver implementation and how the elimination of retroactive eligibility was communicated. We will also collect communications related to the current and ongoing eligibility determination and maintenance including letters, brochures and web postings related to the waiver of retroactive eligibility. Historical documents will need to be accessed through IME personnel charged with eligibility determination and maintenance.

Policy Understanding

The outcome measures rely, at least partially, on stakeholders, including enrollees, understanding the policy change. As part of Phase 1, we will interview members and provider entities to determine whether they are aware of the policy change, how they identified the change and its relationship to their activities. The information gathered in these interviews will also inform the development of survey questions specific to this waiver. In order for the survey questions to have face validity, we will need to better understand the language provider entities and members use to describe the waiver. For example, though 'retroactive eligibility' is a familiar term to those in government, it is unclear that members can identify this or understand how it worked.

Phase 1 provides the contextual information to guide measure development, understand the policy implementation and determine contextual characteristics that may influence the results of hypothesis testing.

Phase 2: Outcomes

Phase 2 focuses on the testing of hypotheses relative to specific and measurable outcomes.

Populations

Study populations

November 1, 2017 through December 31, 2019

Children and adults who were subject to the waiver of retroactive eligibility including all adults in IWP, FMAP and SSI and children in the Children's Medicaid Assistance Program (CMAP). Although members receiving LTSS were subject to the waiver during this time, their eligibility pattern varies significantly from any other group within Medicaid precluding their use in these analyses.

January 1, 2020 through December 31, 2024

Adults subject to the waiver of retroactive eligibility including all adults in IWP, FMAP and SSI. Children were no longer subject to the waiver during this time frame.

Comparison populations

January 2011 through October 31, 2017

Pre-waiver population of adults and children in groups that are later subject to retroactive eligibility including all adults in IWP, FMAP and SSI and children in the CMAP.

January 1, 2020 through December 31, 2024

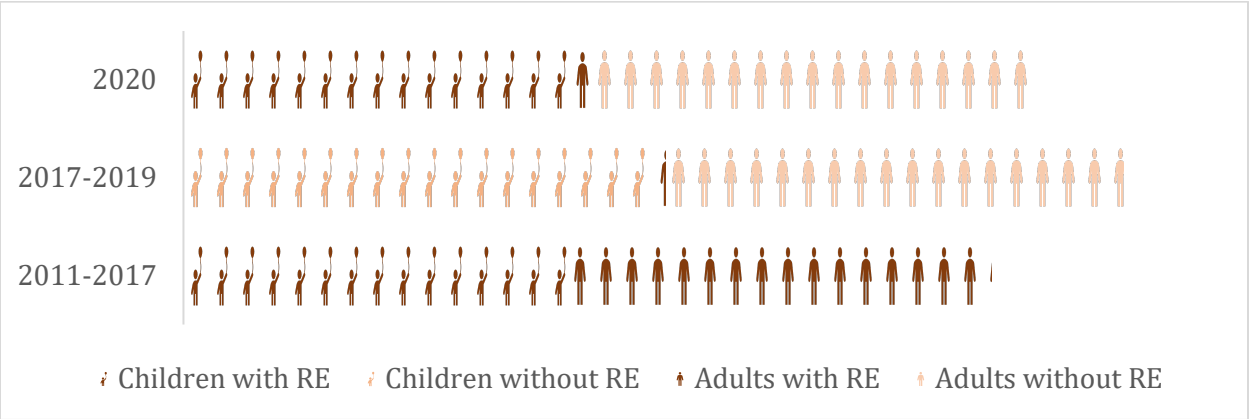
Children in the CMAP no longer subject to the waiver of retroactive eligibility at this time.

Figure 2 provides a visualization of the number of adults and children subject to the waiver of retroactive eligibility within three key time periods: prior to the waiver, during the first 2 years of the waiver and following adjustments to the waiver on January 1, 2020. Each figure represents 15,000 members.

Provider entities

Provider entities such as medical offices, public health offices, hospitals and long-term care facilities help patients/clients who may be eligible for Medicaid apply for benefits by initiating and, in some cases, following-up to make certain the application was filed in an effort to improve their ability to get paid for services. These activities may be performed by front office staff, billing and claim staff, discharge planners, care coordinators, outreach workers, peer counselors and a host of other staff. Additionally, service providers such as physicians, pharmacists, therapists, ARNPs, and PAs may act to trigger application assistance or may direct patients/clients to apply directly when application assistance is not available at their entity. Information from these sources is critical to understand entity/facility changes that may have occurred due to the waiver of retroactive eligibility. We will utilize process measures to understand and assess the effects of the waiver of retroactive eligibility on health care providers.

Figure 2. Visualization of study groups



Empirical strategy

The empirical strategy we adopt is to approach causal inference. For this purpose, we will conduct two steps in our empirical strategy: 1) pre-process our data by matching target study populations with comparison population groups (e.g., finding matched individuals for members subject to the retroactive eligibility waiver) and 2) employ econometric modeling techniques, namely, difference-in-difference (DID), comparative interrupted time series (CITS) with control variables on the matched data. Pre-processing data before regression adjustment provides multiple benefits, including reductions in model dependence, estimation error and bias (Iacus et al., 2019). As recommended in King and Nielsen (2019), we will combine propensity score matching (PSM) with coarsened exact matching (CEM) using multiple covariates (including indicators of health condition, income and disability status). We will show post-matching covariate balances. We have experience in using matching methods including CEM and PSM in previous studies and will incorporate the latest evidence-based recommended matching practices in our future estimations of this evaluation.

The DID model is appropriate for survey data when individuals are observed in at least two periods. We will therefore apply the DID model for research questions that rely on enrollment surveys. The DID model will capture the effect of a health policy, namely the retroactive eligibility waiver, by comparing the pre- and post-program means in a study population (namely, study population 1 or 2) using the pre- and post-policy means in comparison populations 1 and 2 as counterfactuals.

When units of analysis (e.g., individuals, hospital-level rates of uncompensated care) are observed more frequently, a CITS specification is more appropriate. Under this specification, we analyze means and slopes of pre-waiver values to determine changes in both means and in during-waiver linear and non-linear trends, using comparison populations as counterfactuals.

References

Iacus, Stefano M., Gary King, and Giuseppe Porro. 2019. “A Theory of Statistical Inference for Matching Methods in Causal Research.” Political Analysis 27 (1): 46–68.

King, Gary, and Richard Nielsen. 2019. “Why Propensity Scores Should Not Be Used for Matching.” Political Analysis 27 (4): 435–54.

Data sources

Medicaid claims and enrollment files

The PPC is home to a Medicaid Data Repository encompassing over 100 million claims, encounter and eligibility records for all Iowa Medicaid enrollees for the period October 2010 through the present. Data are assimilated into the repository on a monthly basis. 95% of medical and pharmaceutical claims are completely adjudicated within 3 months of the first date of service, while the adjudication timing' for institutional claims is 6 months. The PPC staff also have extensive experience with these files as well as extensive experience with CMS adult core measures and HEDIS measures. In addition, the database allows members to be followed for long periods of time over both consecutive enrollment months and periods before and after gaps in coverage. When the enrollment database was started in 1965 Iowa made a commitment to retain a member number for at least 3 years and to never reuse the same Medicaid ID number. This allows long-term linkage of member information including enrollment, cost and utilization even if they change plans.

Enrollment surveys

Telephone surveys for newly enrolled members will be performed for a 1 year period to collect information related to enrollment, understanding of retroactive eligibility, reasons for enrollment, medical and dental debt on enrollment, health status and estimated time between recognition of need for coverage and application. Approximately 480 adults (19-64 years old) and 300 children (1-18 years old) are enrolled each month. With one telephone survey per household and a 30% response rate we would expect to obtain 100 telephone surveys of adults and 40 surveys of children per month, resulting in approximately 1,200 adult surveys and 480 child surveys over the year-long collection period.

Member surveys

The PPC has worked with the developers of the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) survey and utilized CAHPS survey measures for over 15 years to conduct enrollee surveys for the Iowa Medicaid Enterprise (IME). This background will provide us with access to CAHPS enrollee survey results for both IowaCare enrollees and Medicaid enrollees for several years prior to the beginning of Iowa Wellness Plan. Surveys are completed every 18 months for a representative sample of Medicaid enrollees.

Content analysis

Existing documents produced for IWP implementation will be monitored, compiled and synthesized by PPC staff to track progress and modifications from original program description and objectives. These information sources will inform the interpretation of outcome data and be used to alter the outcome evaluation to parallel changes, if needed. The content of these documents will provide the PPC with evidence to identify and recruit stakeholders for structured interviews included in the process evaluation. In addition, any information unable to be gathered from the content analysis will determine which outcome areas need to be included in qualitative data collection.

Content analysis data sources might include:

- Waiver documents
- Quarterly progress reports
- Meeting minutes
- Supplemental materials from relevant advisory groups or committees
- Informational letters

- Contract and RFP documents
- Internal planning documents

Structured key stakeholder interviews

Interviews with key IWP stakeholders will be conducted annually and staggered at different times for different stakeholder groups. Interviews will be 60 minutes long and topics for the structured interviews will be developed to reflect the content of each program and target any areas which were not covered in the content analysis or could benefit from elaboration from a primary source as needed to provide context for data collection activities, outline the availability of key pieces of information and outline adjustments to IWP. Stakeholder interviews may occur at varying times as needed to inform the evaluation portions of the policy components.

Interviews will be audio recorded and professionally transcribed. The interview transcripts will be uploaded into qualitative analysis software and coded into themes. Some themes will be pre-determined according to the structured script, and some will be emergent and reflect the natural flow of conversations and provide additional context for the structured conversation.

Healthcare Provider Cost Reporting Information System (HCRIS)

HCRIS provide uncompensated claims information for all hospitals that accept Medicare reimbursement and are available through HCRIS. PPC purchases access to the RAND web tool to access and download assimilated, corrected datasets for analysis. RAND provides additional calculated data points such as rates of uncompensated care based on algorithms to minimize missing data and weight existing information to allow state-level comparisons. These methods are available on the website or by request.

National survey options

Though previous work at the PPC, we have found that national survey, such as the Medical Expenditure Panel Survey (MEPS) and the National Financial Capability Survey, do not recruit Iowans in sufficient numbers to allow for state-level comparisons. However, we may be able to utilize the American Community Survey (ACS) and/or the Behavioral Risk Factor Surveillance System (BRFSS) to assess some state level effects.

Covid-19 adjustments

It is unclear how the COVID-19 pandemic and its ensuing economic effects will alter the enrollment for state Medicaid programs. Some unemployed workers may be able to keep their health insurance, while other may lose their insurance but will not qualify for Medicaid immediately. We will utilize enrollment surveys to determine the magnitude of the effect that COVID-19 has on enrollment.

4) Cost sharing

Background

Within the IWP, cost sharing consists primarily of an $8 copayment for emergency department (ED) services utilized for non-emergent reasons. IME provides a listing of the diagnosis codes that qualify as an emergency visit on the Medicaid 'Provider Claims and Billing' webpage. This page is updated at least annually but may be updated more frequently, for example, it was updated on April 1, 2020 to reflect emergency diagnoses related to COVID-19.

In a letter to the State Medicaid Director, Michael Randol, dated November 15, 2019, CMS outlined the following expectations/goals for the $8 ED copay.

> Iowa believes this policy will help beneficiaries learn about the importance of choosing appropriate care in the appropriate setting-which is generally not the ED-by educating beneficiaries about the direct cost of health care services and the importance of seeking preventive services and similar care in the most appropriate setting. Receiving preventive and similar care in non-emergency settings can improve the health of beneficiaries, because they can build and maintain relationships with their regular treating providers. Over time, this may lead to the prevention and/or controlled maintenance of chronic disease, as prevention and health promotion are difficult to achieve and sustain through episodic ED visits. Additionally, this policy will improve the ability of beneficiaries who truly need emergency care to access it, by preserving ED and state fiscal resources for those who are truly in need of timely emergency care.

Goals

1. Educate members the ED is not the appropriate place for all care
2. Educate members about the cost of emergency department care
3. Build relationships with primary care providers improving preventive and chronic care
4. Increase the availability of emergency departments for those who need them

The manifestation of the goals and the short and long-term effects of the $8 ED copayment on utilization and cost are reflected in the logic model.

Logic Model: Cost sharing

Process		Outcomes		
Policy	**Process**	**Short term (Goals)**	**Intermediate**	**Long-term**
$8 copayment for non-emergent ED visit	Member understanding of $8 copayment (PRQ1) Communication and implementation of non-emergent conditions (Process eval) $8 Copayment billing and collection process (Process eval) Provider understanding and implementation of $8 copayment (Process eval)	Understanding ER is not the appropriate place for all care (PRQ2.1) Realization of cost for ER services (PRQ2.2) Establishment of primary care regular source of care (PRQ3.1)	Increased primary care utilization for non-emergent acute care (PRQ2.4) Increased utilization of prevention/monitoring care (PRQ3.2) Decreased ER utilization for non-emergent acute care (PRQ2.3) Increase in beneficiary regular source of care (PRQ3.1)	Improved self-ratings of physical/mental health (PRQ4) Reduced avoidable inpatient admissions (PRQ4) Improved ED availability for emergent care (Process eval)
Moderating factors: Existing chronic conditions, regular source of care, distance to providers, previous use of ED, demographic characteristics				

Hypotheses and research questions

Hypothesis 1: Members understand the $8 copayment for non-emergent use of the ER.

Research question 1: Do members understand the $8 copayment for non-emergent use of the ER?

Hypothesis 2: Cost sharing improves member understanding of appropriate ER use.

Research Question 2.1: Do members subject to an $8 copayment understand appropriate use of the ER better than members who are not subject to the copay?

Research Question 2.2: Do members subject to an $8 copayment understand cost of the ER better than members who are not subject to the copay?

Research Question 2.3: Are members subject to an $8 copayment for non-emergent use of the ER less likely to use the ER for non-emergent care?

Research Question 2.4: Are members subject to an $8 copayment for non-emergent use of the ER more likely to use the primary care providers for non-emergent care?

Hypothesis 3: Members subject to cost sharing are more likely to establish and utilize a regular source of care as compared to members not subject to cost sharing.

Research Question 3.1: Are members who are subject to the $8 copayment for non-emergent ER use more likely to have a regular source of care than those not subject to the copayment?

Research Question 3.2: Are members who are subject to the $8 copayment for non-emergent ER use more likely to receive preventive care and chronic care monitoring than those not subject to the copayment?

Hypothesis 4: Cost sharing improves long-term health care outcomes.

Research Question 4.1: Do members who are subject to the $8 copayment for non-emergent ER use have more favorable long-term health care outcomes?

The hypotheses, research questions and methods to address the goals and outcomes provided in the logic model above. Further explanations of the methods follow the table.

Evaluation Methods Summary: Cost Sharing

Comparison Strategy	Outcomes measures(s)	Data sources	Analytic approach
Hypothesis 1: Members understand the $8 copayment for non-emergent use of the ER.			
Research Question 1: Do members understand the $8 copayment for non-emergent use of the ER?			
Study group: IWP members completing the consumer survey Two comparison groups: 1: FMAP adult members completing the consumer survey 2: SSI adult members completing the consumer survey	Sometimes health plans require members to pay part of cost when they use the emergency room. This is considered a copayment. Are you required to pay any part of the cost when you use the emergency room? If yes, do you know how much you will need to pay? If yes, are there any reasons why you might not have to pay? What are these reasons?	Consumer survey	DID 2017 and 2021 consumer survey

Comparison Strategy	Outcomes measures(s)	Data sources	Analytic approach
Hypothesis 2: Cost sharing improves member understanding of appropriate ER use.			
Research Question 2.1: Do members subject to an $8 copayment understand appropriate use of the ER better than members who are not subject to the copay?			
Study group: IWP members completing the consumer survey Two comparison groups: 1: FMAP adult members completing the consumer survey 2: SSI adult members completing the consumer survey	In the last 6 months, have you used the ED In the last 6 months, how many times did you go to an emergency room (ER) to get care for yourself? Do you think the care you received at your most recent visit to the ER could have been provided in a doctor's office? What was the main reason you did not go to a doctor's office or clinic for the care you received at your most recent visit to the ER? Choose only one response. I did not have a doctor or clinic to go to My insurance plan would not cover the care I needed if I went to a doctor's office or clinic My doctor, nurse, or other health care provider told me to go to an ER for this care My doctor's office or clinic was open, but I could not get an appointment My doctor's office or clinic was not open when I needed care I had transportation problems getting to a doctor's office or clinic My health problem was too serious for the doctor's office or clinic	Consumer survey	Descriptive analyses 2017 and 2021 consumer surveys

Comparison Strategy	Outcomes measures(s)	Data sources	Analytic approach
Research Question 2.2: Do members subject to an $8 copayment understand cost of the ER better than members who are not subject to the copay?			
For those indicating they had an ER visit in the last 6 months. Study group: IWP members completing the consumer survey indicating they understand the $8 copayment Comparison group: IWP members who said they did not understand the $8 copayment on the 2017 consumer survey	[Measure under development] Thinking back to the last time you went to the emergency room: How much did the care cost you? How much did the emergency room charge your insurance?	Consumer survey	Descriptive analyses 2021 Consumer survey
Research Question 2.3: Are members subject to an $8 copayment for non-emergent use of the ER less likely to use the ER for non-emergent care?			
Study group: IWP members who indicated they understood the $8 copayment on the 2017 consumer survey Comparison group: IWP members who said they did not understand the $8 copayment on the 2017 consumer survey This measure will be repeated following the 2021 consumer survey.	Member probability of a non-emergency ED visit Newly developed measure indicating whether there was a claim in measurement period for a non-emergent diagnosis which is defined as NOT on the list of emergency diagnoses provided by IDHS	2017 Consumer survey Medicaid claims	DID 2-year period surrounding the 2017 survey
Study group: IWP members Two comparison groups 1: FMAP adult members 2: SSI adult members	Rate of a non-emergency ED claims Newly developed measure indicating number of ED visits for a non-emergent diagnosis (see above) during the measurement period	Medicaid claims	CITS Pre-COVID PHE $8 copay present, COVID PHE $8 copay suspended, Post-COVID PHE $8 copay reinstated

Comparison Strategy	Outcomes measures(s)	Data sources	Analytic approach
Study group: IWP members Two comparison groups 1: FMAP adult members 2: SSI adult members	Rate of ER readmission 7 days and 30 days This measure has been used in other studies at the PPC. It is based upon the hospital readmission measure in HEDIS but substitutes ED visit for hospitalization throughout.	Medicaid claims	CITS Pre-COVID PHE $8 copay present, COVID PHE $8 copay suspended, Post-COVID PHE $8 copay reinstated
Comparable states with no copayment required (will need to explore state options)	Rate of ER readmission 7 days and 30 days See above	HCUP ER files	Comparison of rates
Comparable states with no copayment required (will need to explore state options)	Rate of ER use for non-emergent acute care See above	HCUP ER files	Comparison of rates CY 2013 and CY 2014
Research Question 2.4: Are members subject to an $8 copayment for non-emergent use of the ER more likely to use the primary care providers for non-emergent care?			
Study group: IWP members Two comparison groups 1: FMAP adult members 2: SSI adult members	Rate of primary care provider office use for non-emergent acute care Newly developed measure indicating proportion of population that utilized an MD, DO, ARNP, PA, rural health clinic, FQHC or otherwise identified primary care clinic during the measurement year for non-emergent care.	Medicaid claims	CITS Pre-COVID PHE $8 copay present, COVID PHE $8 copay suspended, Post-COVID PHE $8 copay reinstated
Hypothesis 3: Members subject to cost sharing are more likely to establish and utilize of a regular source of care as compared to members not subject to cost sharing.			
Research Question 3.1: Are members who are subject to the $8 copayment for non-emergent ER use more likely to have a regular source of care than those not subject to the copayment?			
Study group: IWP members completing the consumer survey indicating they understand the $8 copayment Three comparison groups 1: FMAP adult members 2: SSI adult members 3: IWP members who said they did not understand the $8 copayment on the consumer survey	A personal doctor is the person you would see if you need a check-up, want advice about a health problem, or get sick or hurt. Do you have a personal doctor? (The answer to this question will focus on individuals who did not have a personal doctor in a 2017 survey.)	Consumer survey	DID 2017 and 2021 consumer surveys

Comparison Strategy	Outcomes measures(s)	Data sources	Analytic approach
Study group: IWP members Two comparison groups 1: FMAP adult members 2: SSI adult members	Utilization of a regular source of care New developed measure one visit to an MD, DO, ARNP, PA, rural health clinic, FQHC or otherwise identified primary care clinic during the measurement year for preventive care or 2 or more visits for acute care.	Medicaid claims	Means tests CY 2014-2022
Research Question 3.2: Are members who are subject to the $8 copayment for non-emergent ER use more likely to receive preventive care and chronic care monitoring than those not subject to the copayment?			
Study group: IWP members 3 comparison groups 1: FMAP adult members 2: SSI adult members 3:IowaCare members	Rates of annual well-person visit Based on HEDIS Adult Access to Ambulatory/Preventive Care (utilize the preventive codes only)	Medicaid claims	CITS Pre-IWP CY 2012-2013 Post-IWP CY 2014-2022
For those identified as having diabetes Study group: IWP members Three comparison groups 1: FMAP adult members 2: SSI adult members 4:IowaCare members	Rates of HbA1c monitoring for persons with Diabetes HEDIS Comprehensive Diabetes Care measure component	Medicaid claims	DID CY 2014-2022
Study group: IWP members Three comparison groups 1: FMAP adult members 2: SSI adult members 3:IowaCare members	Rates of primary care follow-up visit within 7 days of ER use Based on HEDIS Follow-up After Emergency Department Visit for Mental Illness and Emergency Department Utilization measures	Medicaid claims	DID CY 2014-2022

Comparison Strategy	Outcomes measures(s)	Data sources	Analytic approach
Hypothesis 4: Cost sharing improves long-term health care outcomes.			
Research Question 4.1: Do members who are subject to the $8 copayment for non-emergent ER use have more favorable long-term health care outcomes?			
Study group: IWP members Two comparison groups 1: FMAP adult members 2: SSI adult members	In general, how would you rate your overall health now? Excellent; Very good; Good; Fair; Poor	Consumer surveys	DID 2017 and 2021 consumer surveys
Study group: IWP members Two comparison groups 1: FMAP adult members 2: SSI adult members	In general, how would you rate your overall mental and emotional health now? Excellent; Very good; Good; Fair; Poor	Consumer surveys	Means tests 2017 and 2021 consumer surveys
Study group: IWP members Two comparison groups 1: FMAP adult members 2: SSI adult members	Rates of avoidable inpatient admissions AHRQ measure incorporating Ambulatory Care-Sensitive Condition	Medicaid claims	DID CY 2014-2022
Comparable states with no copayment required	Rates of avoidable inpatient admissions See above	HCUP ER files	Descriptive analyses CY 2012-2015

Data Sources, Analysis Methods and Methods

Known implementation issues

The $8 copayment for non-emergent ED use has been in place since January 1, 2014. We originally began to assess this component during the first evaluation period. Previous analyses were halted when we discovered that there was a disconnect between the ED visit and the application of the copayment. We anticipated, at that time, that Iowa Medicaid would apply the copayment to the claims, however within the first 2 years we found less than 10 claims that had an $8 copayment attached. Consumer surveys indicated that members had a poor understanding of what constitutes emergent care and that they may be driven to the ED through providers such as nurse triage programs and physicians on-call for practices. Since April 2016, the MCOs have been responsible for enforcing this $8 copayment within the claims/encounter process. We anticipate that we will see more claims with the $8 copayment attached. Additionally, we are working to integrate the diagnosis codes for non-emergent visits into existing algorithms to better estimate the degree of ED use for 'non-emergent' care as defined by Iowa Medicaid.

Empirical strategy

The empirical strategy we adopt is to approach causal inference. For this purpose, we will conduct two steps in our empirical strategy: 1) pre-process our data by matching target study populations with comparison population groups (e.g., finding matched individuals for IWP members subject to the $8 copayment) and 2) employ econometric modeling techniques, namely, difference-in-difference (DID), comparative interrupted time series (CITS) with control variables on the matched data. Pre-processing data before regression adjustment provides multiple benefits, including reductions in model dependence, estimation error and bias (Iacus et al., 2019). As recommended in King and Nielsen (2019), we will combine propensity score matching (PSM) with coarsened exact matching (CEM) using multiple covariates (including indicators of health condition, income and disability status). We will show post-matching covariate balances. We have experience in using matching methods including CEM and PSM in previous studies and will incorporate the latest evidence-based recommended matching practices in our future estimations of this evaluation.

The DID model is appropriate for survey data when individuals are observed in at least two periods. We will therefore apply the DID model for research questions that rely on consumer surveys. The DID model will capture the effect of a health policy, namely the 8% copayment, by comparing the pre- and post-program means in a study population (namely, IWP members) using the pre- and post-policy means in comparison populations (namely, SSI and FMAP) as counterfactuals.

When units of analysis (e.g., individuals, county-level or service-area rates of ER readmission) are observed more frequently, a CITS specification is more appropriate. Under this specification, we analyze means and slopes of pre-policy values to determine changes in both means and in post-IWP linear and non-linear trends, using comparison populations as counterfactuals. The interruptions in these analyses vary with the question but are of two types 1) the point at which the $8 copayment was suspended due to the COVID PHE (March 1, 2020) and again at the point which the $8 copayment is reinstated (TBD) at the close of the COVID PHE and 2) the point at which the IWP begins (January 1, 2014).

References

Iacus, Stefano M., Gary King, and Giuseppe Porro. 2019. “A Theory of Statistical Inference for Matching Methods in Causal Research.” Political Analysis 27 (1): 46–68.

King, Gary, and Richard Nielsen. 2019. “Why Propensity Scores Should Not Be Used for Matching.” Political Analysis 27 (4): 435–54.

Policy communication/implementation

We will conduct a retrospective process evaluation to assess methods used to communicate the $8 copayment to members and providers. We will also interview selected emergency department administrators and/or hospital administrators to determine how this policy was implemented on the ground. Previous conversations with administrations indicated that this policy was rarely enforced. Ongoing work looking at the effects of ACA on hospitals, particularly CAH hospitals, indicates a significant reduction in bad debt and charity care. There appears to be little incentive for hospitals to collect the $8 copayment.

Though this work is not directed at a specific hypothesis it does provide the context to understand findings related to this policy and why goals may, or may not, be met.

Target populations

IWP members

The population of adults in IWP January 1, 2014 through December 31, 2023. These adults were split into two plan options from January 2014 through December 2015 with those from 0-100% FPL being offered a modified Medicaid expansion and those from 101-138% FPL being offered a private option utilizing Qualified Health Plans. All members were placed into the traditional Medicaid program from January-March 2016 and then all were placed into a Medicaid managed care program that began with three Managed Care Organizations (MCO). Currently, two MCOs provide care for Iowa Medicaid members.

Comparison populations

Medicaid members in FMAP

Medicaid members enrolled through FMAP are adult parents/guardians of children in Medicaid in families with incomes less than 50% FPL.

Medicaid members in SSI

Medicaid members enrolled through the SSI Program are adults with a determination of disability. Those who are dually eligible for Medicare are not included in the analyses.

Other states

HCUP data for states that do and do not utilize an ED copayment will be compared to Iowa for the period CY 2014-2022.

Data sources

Administrative data

The PPC is home to a Medicaid Data Repository encompassing over 100 million claims, encounter and eligibility records for all Iowa Medicaid enrollees for the period October 2010 through the present. Data are assimilated into the repository on a monthly basis. 95% of medical and pharmaceutical claims are completely adjudicated within 3 months of the first date of service, while the adjudication timing' for institutional claims is 6 months. The PPC staff also have extensive experience with these files as well as extensive experience with CMS adult core measures and HEDIS measures. In addition, the database allows members to be followed for long periods of time over both consecutive enrollment months and periods before and after gaps in coverage. When the enrollment database was started in 1965 Iowa made a commitment to retain a member number for at least 3 years and to never reuse the same Medicaid ID number. This allows long-term linkage of member information including enrollment, cost and utilization even if they change plans.

Iowa Hospital Association files

The Iowa Hospital Association collects claims data for all patients in all Iowa hospitals. These data provide information regarding cost and utilization for inpatient and outpatient visits including emergency room use. Hospitals indicate the expected payor on these files providing an opportunity to assess uncompensated care. Though these data are not utilized in the analyses directly, the data may be useful for establishing population-based trends in ED use before, during and after COVID-19.

Key Stakeholder Interviews

Process measures including key stakeholder interviews will be collected by a specialized team within the IWP evaluation tasked with collecting, organizing and interpreting process information. Coordinating with this team, information will be captured regarding policy changes and translation related to the $8 copayment and its alteration during COVID-19.

Healthcare Cost and Utilization Project – HCUP

HCUP encompasses data for 37 states, including Iowa. The data includes inpatient stays, emergency department visits and ambulatory care. Data is readily available through a user-friendly web-based reporting tool. In addition, data can be downloaded for analysis. Free data does not include locational information beyond a state indicator, however, datasets with more refined locational information can be purchased.

Member surveys

The PPC has worked with the developers of the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) survey and utilized CAHPS survey measures for over 15 years to conduct enrollee surveys for the Iowa Medicaid Enterprise (IME). This background will provide us with access to CAHPS enrollee survey results for both IowaCare enrollees and Medicaid enrollees for several years prior to the beginning of Iowa Wellness Plan. Surveys are completed every 18 months for a representative sample of Medicaid enrollees. In the past, specific questions related to ED use and beliefs around ED use have been included. These will be refined and include in future surveys.

Emergency department use survey

The PPC survey team is developing a telephone survey to be administered to members who utilize the ED for non-emergent diagnoses. We anticipate recruiting 50 members per month for 1 year.

This should yield 300 completed surveys (100 per group) with sufficient power to detect moderate differences at .05.

Evaluation periods

Pre- post-implementation period (CY 2012-2022)

Analyses involving state-level data will be conducted for the period CY 2012-2022. For the Annual Wellness Visit measure we will be able to take advantage of the pre-IWP IowaCare program to provide data on IWP members prior to CY 2014.

Post-implementation period (CY 2014-2022)

The post-implementation period provides a very interesting opportunity to assess the effect of the $8 copayment. The copayment was in place from January 2014-March 2020, then waived due to COVID-19 from March 2020 through end of PHE when it will be reinstated.

COVID-19 adjustments

During the COVID-19 pandemic Iowa Medicaid waived the $8 copayment for inappropriate ED use and updated the ICD-10 diagnosis codes that could be used to determine appropriate use to reflect COVID-related visits. Additionally, health care utilization, in particular ED use, was affected by a general avoidance of the ED to help hospitals preserve much needed PPE and lessen individuals' exposure to COVID-19. We will continue to monitor policies and activities, utilize the data to try to account for COVID-19 effects and monitor best practices as other researchers also adjust analyses for these effects.

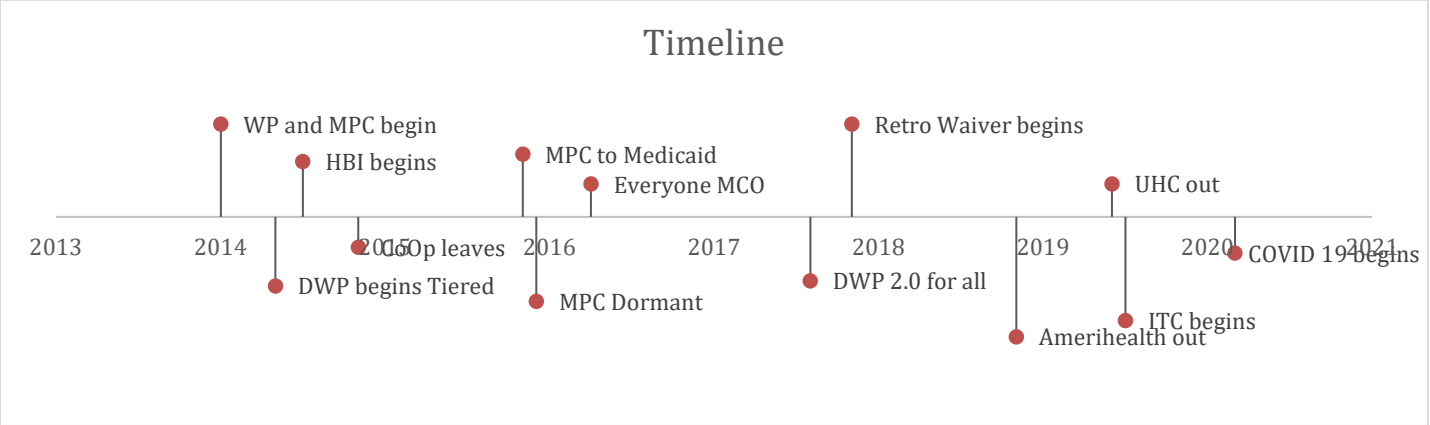
5) Cost and Sustainability

Background

The most recent guidance from CMS indicates that evaluation questions regarding cost should focus on sustainability. In the past, the IWP evaluation has estimated cost effects, but without addressing whether the cost effects are sustainable for the state. Sustainability requires information on costs, but also information on revenue streams.

IWP costs and revenues will need to be separated from the costs and revenues of other Medicaid program components. As can be seen from the timeline below, some state-level changes such as implementation of the MCOs, may be difficult to separate from IWP administrative costs. Additionally, the costs of MCO movement into and out of the program may result in additional administrative costs for IWP. The determination of what proportion of change costs should be accounted to IWP will be driven through our conversations with the key IME staff and estimates of the proportion of the affected population in IWP. Figure 3 provides a timeline of the changes that occurred within the IWP over time. These changes will be documented and addressed within the analyses.

Figure 3. Timeline of IWP changes



WP=Wellness Plan, MPC=Marketplace Choice, DWP=Dental Wellness Plan, HBI=Healthy Behavior Initiative, UHC=UnitedHealthcare, ITC=Iowa Total Care

Goals

The goals of the IWP program as they pertain to cost are likely going to impact the following:

1. Short term-increase FMAP payments and reduce bankruptcies
2. Intermediate term- Increased preventive care use, Decreased ED cost/use, Decreased inpatient admissions/cost, Decreased uncompensated care
3. Longer term-Statewide cost reductions

CMS guidance outlines the following key questions for investigation. (https://www.medicaid.gov/medicaid/section-1115-demo/downloads/evaluation-reports/ce-evaluation-design-guidance-sustainability-appendix.pdf)

1. What are the administrative costs operate the demonstration?

2. What are the short- and long-term effects of eligibility and coverage policies on health service expenditures?
3. What are the impacts of eligibility and coverage policies on provider uncompensated care costs?

The model below provides a visual representation of Medicaid state costs and the results from the expansion. Though health care costs at the state level may be reduced through the expansion of health care coverage to additional Iowans, the effect on the Medicaid program will result in increased costs. To establish the sustainability of the change we have a few options: 1) determine whether the state revenues for the general fund are rising proportionally to program costs, 2) determine whether state per adult health care costs are declining in comparison to anticipated increases due to additional coverage, 3) compare the increase in specific health care service costs in Iowa to other states.

Logic Model: Cost and sustainability

Process		Outcomes		
Policy	**Process**	**Short-term outcomes**	**Intermediate outcomes**	**Long-term outcomes**
Medicaid Expansion	Enabling legislation Increase in Administrative capacity Infrastructure changes Addition of contractors	Increased FMAP payments No change in proportion of general fund for Medicaid Decreased bankruptcies	Increased preventive care use Decreased ED cost/use Decreased inpatient admissions/cost Decreased uncompensated care	State-side Improvement of self-ratings of physical/mental health State-wide cost reductions Increases in private insurance coverage Increases in employment/job seekers
Moderating factors: Existing chronic conditions, communication regarding eligibility options and process, presence of Medicaid beneficiaries in the household				

Hypotheses and research questions

Hypothesis 1: Ongoing administrative costs will increase due to implementation of IWP.

Primary Research Question 1.1: What are the administrative costs associated with IWP?

Subsidiary Research Question 1.1a: How did the Medicaid program administrative costs change with implementation and ongoing support of IWP?

Subsidiary Research Question 1.1b: How do the contractor/agency/provider costs change after implementation of IWP?

Hypothesis 2: IWP will result in short-term outcomes supporting a sustainable program.

Primary Research Question 2.1: What are the changes in revenue streams as a result of IWP?

Subsidiary Research Question2.1a: How do Federal Medical Assistance Percentage (FMAP) payments change as a result of IWP?

Subsidiary Research Question 2.1b: How does the rate of individual bankruptcies in the state change with implementation of IWP?

Hypothesis 3: IWP results in intermediate outcomes supporting a sustainable program.

Primary Research Question 3.1: How does IWP change healthcare expenditures?

Subsidiary Research Question 3.1a: How does IWP change healthcare expenditures in the Medicaid program?

Subsidiary Research Question 3.1b: How does IWP change state-wide healthcare expenditures?

Primary Research Question 3.2: How does IWP change healthcare utilization?

Subsidiary Research Question 3.2a: How does IWP change healthcare utilization in the Medicaid program?

Subsidiary Research Question 3.2b: How does IWP change healthcare utilization in Iowa?

Hypothesis 4: IWP results in long-term outcomes supporting a sustainable program.

Primary Research Question 4.1: What are the long-term, state-wide changes resulting from IWP?

Evaluation Methods Summary: Cost and Sustainability

Comparison Strategy	Outcomes measures(s)	Data sources	Analytic approach
Hypothesis 1: Ongoing administrative costs will increase due to implementation of IWP			
Primary Research Question 1.1: What are the administrative costs associated with IWP?			
Subsidiary Research Question 1.1a: How did the Medicaid program administrative costs change with implementation and ongoing support of IWP?			
Pre and post IWP state fiscal years	Administrative costs	MCO capitation payments/budget documents	Descriptive analyses SFY 2011-2021
Subsidiary Research Question 1.1b: How do the contractor/agency/provider costs change after implementation of IWP?			
Study group: MCOs, service providers, and contractors	Ongoing costs to contractors/agencies and providers due to IWP	Key stakeholder interviews	Descriptive analyses SFY 2011-2021
Hypothesis 2.1: IWP will result in short-term outcomes supporting a sustainable program.			
Primary Research Question 2.1: What are the changes in revenue streams as a result of IWP?			
Subsidiary Research Question 2.1a: How do Federal Medical Assistance Percentage (FMAP) payments change as a result of IWP?			
Pre and post IWP state fiscal years	Federal payments	IME reports	Descriptive analyses SFY 2011-2021
Pre and post IWP state fiscal years	Proportion of Medicaid budget covered through FMAP payments	IME reports	Descriptive analyses SFY 2011-2021
Subsidiary Research Question 2.1b: How does the rate of individual bankruptcies in the state change with implementation of IWP?			
Pre and post IWP state fiscal years	Bankruptcy rates	State fiscal reports	Descriptive analyses SFY 2011-2021
Hypothesis 3: IWP results in intermediate outcomes supporting a sustainable program.			
Primary Research Question 3.1: How does IWP change healthcare expenditures?			
Subsidiary Research Question 3.1a: How does IWP change healthcare expenditures in the Medicaid program?			
Study group: IWP members Three comparison groups 1: FMAP adult members 2: SSI adult members 3: IowaCare members	Per member per year (PMPY) expenditures on preventive care Total Medicaid reimbursement per person per year for services considered preventive such as annul well visit, monitoring labs, and vaccines.	Medicaid claims	CITS Pre-IWP CY 2012-2013 Post-IWP CY 2014-2021
Study group: IWP members Two comparison groups 1: FMAP adult members 2: SSI adult members	PMPY expenditures on ED visits Total Medicaid reimbursement per person per year for emergency department use not resulting in hospitalization	Medicaid claims	DID CY 2014-2021

Comparison Strategy	Outcomes measures(s)	Data sources	Analytic approach
Study group: IWP members Two comparison groups 1: FMAP adult members 2: SSI adult members	PMPM expenditures on inpatient admissions Total Medicaid reimbursement per person per year for hospitalizations	Medicaid claims	DID CY 2014-2021
Study group: Iowa pre- and post-IWP implementation Comparison group: comparable non-expansion states pre- and post-IWP implementation	PMPY expenditures on ED visits Total Medicaid reimbursement per person per year for emergency department use not resulting in hospitalization	TMSIS	DID CY 2015-2021 (year limitations due to cutover dates)
Study group: Iowa pre- and post-IWP implementation Comparison group: comparable non-expansion states pre- and post-IWP implementation	PMPM expenditures on inpatient admissions Total Medicaid reimbursement per person per year for hospitalizations	TMSIS	DID CY 2015-2021 (year limitations due to cutover dates)
Subsidiary Research Question 3.1b: How does IWP change state-wide healthcare expenditures?			
Study group: Iowa pre- and post-IWP implementation Comparison group: comparable non-expansion states pre- and post-IWP implementation	Rate of self-pay/charity care	HCRIS	CITS Pre-IWP CY 2012-2013 Post-IWP CY 2014-2021
Study group: Iowa pre- and post-IWP implementation Comparison group: comparable non-expansion states pre- and post-IWP implementation	Reported rates of uncompensated care	HCRIS	CITS Pre-IWP CY 2012-2013 Post-IWP CY 2014-2021
Iowa Hospitals pre and post IWP	ED expenditures Total all-payor charges for ED care at Iowa hospitals	Iowa Hospital Association files	Descriptive analyses CY 2012-2021
Iowa Hospitals pre and post IWP	Inpatient expenditures Total all payor charges for hospitalizations at Iowa hospitals.	Iowa Hospital Association files	Descriptive analyses CY 2012-2021

Comparison Strategy	Outcomes measures(s)	Data sources	Analytic approach
Study group: Iowa pre- and post-IWP implementation Comparison group: comparable non-expansion states pre- and post-IWP implementation	ED expenditures Total all-payor charges for ED care at Iowa hospitals	HCUP	CITS Pre-IWP CY 2012-2013 Post-IWP CY 2014-2021
Study group: Iowa pre- and post-IWP implementation Comparison group: comparable non-expansion states pre- and post-IWP implementation	Inpatient expenditures Total all payor charges for hospitalizations at Iowa hospitals.	HCUP	CITS Pre-IWP CY 2012-2013 Post-IWP CY 2014-2021
Primary Research Question 3.2: How does IWP change healthcare utilization?			
Subsidiary Research Question 3.2a: How does IWP change healthcare utilization in the Medicaid program?			
Study group: IWP members Three comparison groups 1: FMAP adult members 2: SSI adult members 3. IowaCare members	Preventive care utilization Whether or not member obtain an annual wellness exam.	Medicaid claims	CITS Pre-IWP CY 2012-2013 Post-IWP CY 2014-2021
Members who used the ED during the calendar year Study group: IWP members Two comparison groups 1: FMAP adult members 2: SSI adult members	Non-emergent ED use Whether or not ED visit was for a non-emergent reason as defined by the IDHS.	Medicaid claims	DID
Study group: IWP members Two comparison groups 1: FMAP adult members 2: SSI adult members	Avoidable hospitalizations	Medicaid claims	CITS

Comparison Strategy	Outcomes measures(s)	Data sources	Analytic approach
Study group: Iowa pre- and post-IWP implementation Comparison group: comparable non-expansion states pre- and post-IWP implementation	Non-emergent ED use	TMSIS	DID
Study group: Iowa pre- and post-IWP implementation Comparison group: comparable non-expansion states pre- and post-IWP implementation	Avoidable hospitalizations	TMSIS/HCUP	DID
Subsidiary Research Question 3.2b: How does IWP change healthcare utilization in Iowa?			
Study group: Iowa pre- and post-IWP implementation Comparison group: comparable non-expansion states pre- and post-IWP implementation	Preventive care utilization	BRFSS	CITS
Iowa Hospitals pre and post IWP	Non-emergent ED use	Iowa Hospital Association Files	CITS
Iowa Hospitals pre and post IWP	Avoidable hospitalizations	Iowa Hospital Association Files	CITS
Study group: Iowa pre- and post-IWP implementation Comparison group: comparable non-expansion states pre- and post-IWP implementation	Non-emergent ED use	HCUP	DID
Study group: Iowa pre- and post-IWP implementation Comparison group: comparable non-expansion states pre- and post-IWP implementation	Avoidable hospitalizations	HCUP	DID

Comparison Strategy	Outcomes measures(s)	Data sources	Analytic approach
Hypothesis 4: IWP results in long-term outcomes supporting a sustainable program.			
Primary Research Question 4.1: What are the long-term, state-wide changes resulting from IWP?			
Study group: Iowa pre- and post-IWP implementation Comparison group: comparable non-expansion states pre- and post-IWP implementation	Self-ratings of physical health	BRFSS	CITS
Study group: Iowa pre- and post-IWP implementation Comparison group: comparable non-expansion states pre- and post-IWP implementation	Self-ratings of mental health	BRFSS	CITS
Study group: Iowa pre- and post-IWP implementation Comparison group: comparable non-expansion states pre- and post-IWP implementation	Annual average (median) per person healthcare expenditures	ACS	CITS
Study group: Iowa pre- and post-IWP implementation Comparison group: comparable non-expansion states pre- and post-IWP implementation	Rate of private insurance coverage	ACS	CITS
Study group: Iowa pre- and post-IWP implementation Comparison group: comparable non-expansion states pre- and post-IWP implementation	Rates of unemployment	ACS	CITS

Data Sources, Analysis Methods and Measures

Methods

Quantifying and evaluating the cost and sustainability of the Iowa Wellness plan is being expanded for this waiver period to include state-level sustainability. Two phases of data collection will be utilized: Phase 1 to gather process information that will inform the analytical strategies (Phase 2).

Phase 1: Process

Phase 1 focuses on understanding the cost and revenue streams associated with the Medicaid program in general and IWP in particular. We will use qualitative methods to conduct this portion of the evaluation, including document analysis and in-depth interviews. The document analysis will be ongoing, as we monitor program developments and adjustments for the evaluation as a whole, while interviews will be during the first year of the evaluation period to identify and define data collection strategies for cost and revenue data at the state and program level.

Policy Definition

Through a series of telephone interviews with IME staff, we will translate the past and current policies into a visual representation identifying the policy changes that might affect cost and revenues. Documents related to policy changes and adjustments will be collected and reviewed. Special attention will be paid to the timing of changes so that we are able to include these in cost modelling as appropriate.

Policy Translation

Policy changes and adaptations are translated into programs in unique and variable ways as administrative rules are written and interpreted the program leadership and staff. The timing of policy change and implementation is also variable. Our efforts will be focused on understanding the policy changes and adjustments and when they are fully implemented in the program. A good example of a policy change that we need to understand fully for this evaluation is the telehealth legislation and timing. Though legislation expanded telehealth in March, this policy would not be considered fully implemented until we can establish a steady state for utilization of telehealth visits.

Phase 1 provides the contextual information to guide measure development, understand the policy implementation and determine contextual characteristics that may influence the results of hypothesis testing.

Phase 2: Qualitative analyses

Phase 2 focuses on the testing of hypotheses relative to specific and measurable outcomes.

Populations-state level

Iowa

Iowa has over 3 million residents with 36% living in rural areas. Prior to COVID-19 the unemployment rate hovered around 3.6% with the primary industries being manufacturing, finance and insurance, real estate, and health care. Farming ranks 8th in economic contribution in Iowa, though much of the manufacturing in the state is centered on meat processing (chickens, hogs) and the primary exports are farm related. 50% of the population is female, 90% are white, and 23% of the population is under 18 years of age, while 17% are 65 and over. Iowa Medicaid provides dental coverage for adults and has a Medicaid Buy-in program for people with disabilities. The state allowed the Family Planning waiver to lapse in 2016.

Comparison states

We will assess comparison states on demographic characteristics, Medicaid program/expansion characteristics, and COVID-19 response. In previous work, it has been difficult to find states that have expanded or not expanded to match Iowa, particularly due to the coverage of adult dental services. Additionally, COVID-19 will make this even more difficult. We continue to research data sources and methods to allow for state-to-state comparisons over time for Iowa.

Populations-member level

Member study population: Adults in IWP January 1, 2014 through December 31, 2021. These adults were split into two plan options from January 2014 through December 2015 with those from 0-100% FPL being offered a modified Medicaid expansion and those from 101-138% FPL being offered a private option utilizing Qualified Health Plans. All members were placed into the traditional Medicaid program from January-March 2016 and then all were placed into a Medicaid managed care program that began with three Managed Care Organizations (MCO). Currently, two MCOs provide care for Iowa Medicaid members.

Member comparison population 1: Adults in the Family Medical Assistance Program and Transitional Program January 1, 2014 through December 31, 2021. FMAP and Transitional adults were provided coverage through the traditional Medicaid program from January 1, 2014 through March 31, 2016 when they were placed into the Medicaid managed care program that began with three Managed Care Organizations (MCO). Currently, two MCOs provide care for Iowa Medicaid members.

Data sources

Medicaid claims and enrollment files

The PPC is home to a Medicaid Data Repository encompassing over 100 million claims, encounter and eligibility records for all Iowa Medicaid enrollees for the period October 2010 through the present. Data are assimilated into the repository on a monthly basis. 95% of medical and pharmaceutical claims are completely adjudicated within 3 months of the first date of service, while the adjudication timing' for institutional claims is 6 months. The PPC staff also have extensive experience with these files as well as extensive experience with CMS adult core measures and HEDIS measures. In addition, the database allows members to be followed for long periods of time over both consecutive enrollment months and periods before and after gaps in coverage. When the enrollment database was started in 1965 Iowa made a commitment to retain a member number for at least 3 years and to never reuse the same Medicaid ID number. This allows long-term linkage of member information including enrollment, cost and utilization even if they change plans.

Iowa Hospital Association files

The Iowa Hospital Association collects claims data for all patients in all Iowa hospitals. These data provide information regarding cost and utilization for inpatient and outpatient visits including emergency room use. Hospitals indicate the expected payor on these files providing an opportunity to assess uncompensated care.

HCRIS

HCRIS provide uncompensated claims information for all hospitals that accept Medicare reimbursement. Recent publications have made use of these files to analyze costs. We will purchase a cleaned and readied dataset from one of the national vendors.

Key Stakeholder Interviews

Process measures including key stakeholder interviews will be collected by a specialized team within the IWP evaluation tasked with collected, organizing and interpreting process information. Coordinating with this team, information will be captured regarding policy changes and translation related to cost and sustainability.

Transformed Medicaid Statistical Information System - TMSIS

TMSIS contains yearly information on member eligibility thought beneficiary files, provider enrollment, and service utilization through claims and encounter data with zip code and county level geographic indicators. Replacing the TMAX files, this data source was transformed for different states at different times. One of the challenges with this dataset is finding an adequate comparison state that was 'crossed over' at the same time as Iowa. This data is obtained through ResDAC. The Public Policy Center has worked with ResDAC to obtain Medicare data in the past and houses a secure data enclave available for this data.

Healthcare Cost and Utilization Project – HCUP

HCUP encompasses data for 37 states, including Iowa. The data includes inpatient stays, emergency department visits and ambulatory care. Data is readily available through a user-friendly web-based reporting tool. In addition, data can be downloaded for analysis. Free data does not include locational information beyond a state indicator, however, datasets with more refined locational information can be purchased.

Behavioral Risk Factor Surveillance System – BRFSS

The BRFSS is supported by the CDC and utilizes a sampling framework to collect individual level information from people in all 50 states annually capturing information on health care utilization, presence of disease, preventive behaviors, and risk factors. The sampling framework provides for an oversample in small states to allow states to utilize the data for health planning and monitoring.

American Community Survey – ACS

This ongoing survey supported through the US Census Bureau provides community level information on important areas including insurance coverage, housing, and education. Data tables are easily created on the website and data is available for download through FTP.

Service costs

Costs for health care services will increase for the program, however, there may be reduced costs for total health services in the state due to improved access to preventive care and reductions in ED use and inpatient admissions. Could look at estimates of total cost for the state of Iowa over time? This component of cost, once expanded to a statewide approach, would also encompass the effects on provider uncompensated care.

Program years (CY2012-CY2019)

Annual costs

CY2012-CY2013=program administration + service costs

CY2014=implementation costs + administration costs

CY2015= program administration + service costs

CY2016-CY2019= program administration + service costs (consider MCO related costs)

Annual revenues=general fund revenue sources

Medicaid annual revenues=allocation from the general fund + FMAP

Empirical strategy

The empirical strategy we adopt is to approach causal inference for many research questions. For this purpose, we will conduct two steps in our empirical strategy: 1) pre-process our data by matching target study populations with comparison population groups (e.g., finding matched individuals for IWP members) and 2) employ econometric modeling techniques, namely, comparative interrupted time series (CITS) with control variables on the matched data. Pre-processing data before regression adjustment provides multiple benefits, including reductions in model dependence, estimation error and bias (Iacus et al., 2019). As recommended in King and Nielsen (2019), we will combine propensity score matching (PSM) with coarsened exact matching (CEM) using multiple covariates (including indicators of health condition, income and disability status). We will show post-matching covariate balances. We have experience in using matching methods including CEM and PSM in previous studies and will incorporate the latest evidence-based recommended matching practices in our future estimations of this evaluation.

As a variant of difference-in-differences models, a CITS specification is more appropriate with frequently observed data. Under this specification, we analyze means and slopes of pre-waiver values to determine changes in both means and in during-waiver linear and non-linear trends, using comparison populations as counterfactuals.

References

Iacus, Stefano M., Gary King, and Giuseppe Porro. 2019. “A Theory of Statistical Inference for Matching Methods in Causal Research.” Political Analysis 27 (1): 46–68.

King, Gary, and Richard Nielsen. 2019. “Why Propensity Scores Should Not Be Used for Matching.” Political Analysis 27 (4): 435–54.

Covid-19 adjustments

All post-2019 analyses and comparisons will need to account for the COVID-19 pandemic. Cost data including expenses and revenues at the state and programmatic levels need to account for known reductions in care-seeking behavior as individuals self-isolated and an uptake of telehealth as individuals limited trip making. Though we are unsure at this time how these adjustments will be manifested, we will respond to best practices in research analyses as they are identified and developed. We do believe that any analytics involving monthly costs can be adjusted with specific monthly indicators related to the specific practices in the state and the prevalence of COVID-19. Additionally, we will utilize the Medicaid claims data to determine the rate of telehealth visits before, during and after the pandemic. Though we do not identify the investigation of telehealth as a key research question within the cost/sustainability area of emphasis, it will play a key role in helping to define how analytics in all research areas will be adapted to account for COVID-19.

6) NEMT

NEMT Background

The state of Iowa was originally approved by CMS for a waiver of the non-emergency medical transportation (NEMT) benefit to members of the Iowa Health and Wellness Plan in 2014. There were significant research studies conducted to evaluate the impact of waiving NEMT during the previous waiver period, with the results reported to CMS.

As of January 1, 2020, the waiver of NEMT was extended through December 2024 when the IWP 1115 waiver renewal was approved. Medically frail beneficiaries and those eligible for EPSDT services are exempt from this waiver.

NEMT Goals

The goals of the NEMT waiver as stated in the original "Iowa Wellness Plan 1115 Waiver Application" from August 2013 and the state's discussion in CMS's letter to the state granting the latest 1115 renewal are:

1. To align benefits with those specified by the enabling legislation and make the benefits consistent with those offered by commercial insurers
2. To help Iowa improve the fiscal sustainability of its Medicaid program, without significant negative effects on beneficiary access to services

NEMT Hypotheses and research questions

Hypothesis 1: Wellness Plan members without a non-emergency transportation benefit will have equal or lower barriers to care resulting from lack of transportation.

Research Question 1.1: Are adults in the IWP less likely to report barriers to care due to transportation than other adults in Medicaid?

Research Question 1.2: Are adults in the IWP less likely to report transportation-related barriers to complete HBI requirements than other adults in Medicaid who report awareness of the NEMT benefit?

Research Question 1.3: Are adults in the IWP less likely to report barriers to care for chronic condition management due to transportation than other adults in Medicaid who report awareness of the NEMT benefit?

Research Question 1.4: Are adults in the IWP less likely to report unmet need for transportation to health care visits than other adults in Medicaid who report awareness of the NEMT benefit?

Research Question 1.5: Are adults in the IWP less likely to report worry about the ability to pay for cost of transportation than other adults in Medicaid who report awareness of the NEMT benefit?

Hypothesis 2: Wellness Plan members without a non-emergency transportation benefit will have equal or lower rates of missed appointments due to access to transportation.

Research Question 2.1: Are adults in the IWP less likely to report transportation-related missed appointments than other adults in Medicaid who receive the NEMT benefit?

Hypothesis 3: Wellness Plan members without a non-emergency transportation benefit will report a lower awareness of the non-emergency transportation benefit as a part of their health care plan.

Research Question 3.1: Do adults in the IWP less frequently report that their health care plan provides non-emergency transportation than other adults in Medicaid who receive the NEMT benefit?

Hypothesis 4: Wellness plan members without a non-emergency transportation benefit will report similar experiences with health care-related transportation regardless of their location or disability status.

Research Question 4.1: Do adults in the IWP who live in rural areas report similar experiences with health-care related transportation as other adults in Medicaid who receive the NEMT benefit?

Research Question 4.2: Do adults in the IWP who have limitations to activities of daily living report similar experiences with health-care related transportation as other adults in Medicaid who receive the NEMT benefit?

NEMT Evaluation Periods

The process evaluation components of the NEMT waiver (Phase 1) will begin in the first quarter of the evaluation period-expected start date is spring 2021. This will include discussions with MCOs regarding implementation of transportation services and the waiver for IWP members, as well as any MCO-specific transportation policies.

The consumer data portion of the evaluation (Phase 2) of the waiver of NEMT will be collected during the 2021-2024 time period as part of the IWP consumer survey. The timing of the next consumer survey is expected to field in the fall of 2021, however, a flexible approach to the timeline is necessary in the context of COVID-19, where there are external confounding factors that mediate the way members access care in this time as well as programmatic differences due to the Public Health Emergency (PHE). The IWP consumer survey will be fielded every 18 months throughout the evaluation period.

NEMT Data Sources, Analysis Methods, and Measures

The evaluation of the waiver of NEMT will be composed of two phases and utilize several different analytics and data collection methods. The first phase of the evaluation will be process oriented and evaluate how the NEMT waiver is actually being implemented by the Managed Care Organizations (MCOs) under contract with the Iowa Medicaid Enterprise (IME). The second phase will assess the impact of the waiver of NEMT on Iowa Wellness Plan members.

Phase 1: Process

Policy Definition and Implementation

We will conduct key informant interviews with IME staff and the two MCOs to determine expectations and how they are implementing both transportation services for those who are eligible and the waiver of NEMT coverage for IWP members subject to the waiver.

This process evaluation will provide the contextual information to guide measure development, understand the policy implementation and determine contextual characteristics that may influence the results of hypothesis testing.

Data collection via Interviews

The PPC will conduct annual interviews with key stakeholders (IME staff and MCOs) to assist in the development of member survey and the interpretation of the results. Additionally, qualitative interviews with NEMT utilizers and non-utilizers will be conducted to identify barriers to preventive care appointment adherence.

Phase 2: Hypothesis testing of the impact on IWP members

Mail-back surveys will be conducted with IWP members every 1.5 years to understand the impact that the waiver of NEMT services.

Study population

Study population: The group subject to the waiver includes adults 19 to 64 eligible for IWP coverage who are not determined to be medically frail and/or eligible for EPSDT services.

Comparison population: The comparison population consists of Medicaid eligible adults aged 19 to 64 (who have NEMT benefits as part of their coverage and report awareness of the NEMT benefit).

Additionally, data about transportation access obtained from prior IWP and Medicaid member surveys (from 2014-2019) may be utilized.

Data source: Member surveys

Survey-based outcomes will use data from member surveys that are fielded every 18 months throughout the evaluation period.

The foundation for the IWP member survey instrument will be based on the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) survey. The PPC was involved in the development of the CAHPS survey and has used the instrument to evaluate issues from the perspective of Iowa Medicaid and IWP members for over 15 years for the evaluation of Medicaid waiver programs. During the last IWP waiver period, the PPC has developed and utilized NEMT-specific questions to assess transportation barriers and needs for those with and without NEMT coverage.

Surveys will be mailed to a stratified random sample of 1500 members in each of the following groups: IWP (Amerigroup), IWP (Iowa Total Care), and the traditional Medicaid State Plan. Members must have been enrolled in IWP for at least the previous six months to be eligible to receive the survey. An initial invitation and survey will be mailed to the entire sample along with a cash pre-incentive (nominal monetary pre-incentives are utilized to maximize response rates for mailed surveys). Respondents will have the option to complete the survey online or mail back the paper survey in the provided postage-paid envelope. A reminder postcard will be sent a week after the initial survey. A follow-up survey will be sent a month after the first mailing to those who have not responded, and a telephone follow up will be conducted for those who do have not completed a survey 2-3 weeks following the second survey mailing.

Error! Reference source not found. indicates the hypotheses, research questions and measures that will be utilized to evaluate the impact of waiver coverage for non-emergency Medical Transportation in Iowa during the next waiver period.

Evaluation Methods Summary: NEMT

Comparison Strategy	Outcome measures(s)	Data sources	Analytic approach
Hypothesis 1: Wellness Plan members without a non-emergency transportation benefit will have equal or lower barriers to care resulting from lack of transportation.			
Research Question 1.1: Are adults in the IWP less likely to report barriers to care due to transportation than other adults in Medicaid?			
Adults in Medicaid	Member experiences with transportation issues to and from health care visits	IWP Member Survey	Means tests
Research Question 1.2: Are adults in the IWP less likely to report transportation-related barriers to complete HBI requirements than other adults in Medicaid who report awareness of the NEMT benefit?			
Adults in Medicaid	Member experiences with completing HBI requirements to avoid premiums	IWP Member Survey	Means tests
Research Question 1.3: Are adults in the IWP less likely to report barriers to care for chronic condition management due to transportation than other adults in Medicaid who report awareness of the NEMT benefit?			
Adults in Medicaid	Member experience with transportation issues for chronic condition management	IWP Member Survey	Means tests
Research Question 1.4: Are adults in the IWP less likely to report unmet need for transportation to health care visits than other adults in Medicaid who report awareness of the NEMT benefit?			
Adults in Medicaid	Member experience with unmet need for transportation	IWP Member Survey	Means tests
Research Question 1.5: Are adults in the IWP less likely to report worry about the ability to pay for cost of transportation than other adults in Medicaid who report awareness of the NEMT benefit?			
Adults in Medicaid	Member experience with cost of transportation	IWP Member Survey	Means tests
Hypothesis 2: Wellness Plan members without a non-emergency transportation benefit will have equal or lower rates of missed appointments due to access to transportation.			
Research Question 2.1: Are adults in the IWP less likely to report transportation-related missed appointments than other adults in Medicaid who receive the NEMT benefit?			
Adults in Medicaid	Member reports of transportation-related missed appointments	IWP Member Survey	Means tests

Comparison Strategy	Outcome measures(s)	Data sources	Analytic approach
Hypothesis 3: Wellness Plan members without a non-emergency transportation benefit will report a lower awareness of the non-emergency transportation benefit as a part of their health care plan.			
Research Question 3.1: Do adults in the IWP less frequently report that their health care plan provides non-emergency transportation than other adults in Medicaid who receive the NEMT benefit?			
Adults in Medicaid	Member reports of health care plan providing NEMT	IWP Member Survey	Means tests
Hypothesis 4: Wellness plan members without a non-emergency transportation benefit will report similar experiences with health care-related transportation regardless of their location or disability status.			
Research Question 4.1: Do adults in the IWP who live in rural areas report similar experiences with health-care related transportation as other adults in Medicaid who receive the NEMT benefit?			
Adults in Medicaid	Subgroup analyses of 1-3 by rurality	IWP Member Survey	Means tests
Research Question 4.2: Do adults in the IWP who have limitations to activities of daily living (ADLs) report similar experiences with health-care related transportation as other adults in Medicaid who receive the NEMT benefit?			
Adults in Medicaid	Subgroup analyses of 1-3 by ADLs	IWP Member Survey	Means tests

Logic Model: NEMT

2020 NEMT WAIVER EVALUATION LOGIC MODEL

NEED(s): The Iowa Wellness Plan (IWP), provides comprehensive health coverage at low or no cost to low-income Iowans between the ages of 19 and 64. The IWP was designed to include a benefit structure more like commercial insurance than traditional Medicaid. Specifically, IWP benefits were based on the state of Iowa employees' commercial health insurance plan and therefore does not contain the extensive benefits traditionally associated with Medicaid under the State Plan; in particular, IWP does not include the non-emergency medical transportation (NEMT) benefit.

THEORY OF CHANGE: The IWP seeks to increase access for low-income Iowans to quality, affordable health care services and coverage. IWP members without a non-emergency transportation (NEMT) benefit will have equal or lower barriers to care resulting from lack of transportation. Thus, the state will continue testing the NEMT waiver because of implications that that the waiver might help Iowa to improve the fiscal sustainability of its Medicaid program, without significant negative effects on beneficiary access to services.

YOUR PLANNED WORK			YOUR INTENDED RESULTS		
Inputs	Activities	Outputs	Short-Term Outcomes	Medium-Term Outcomes	Long-Term Outcomes

IWP Members Subject to NEMT Waiver
• Adults ages 19-64
• Eligible for IWP coverage
• Income up to 138% FPL
• Not determined to be medically frail
• Not eligible for EPSDT services
 	
Stakeholder Collaboration
• CMS – federal government
• Iowa Department of Human Services
• Iowa Medicaid Enterprise (IME)
• Managed Care Organizations (MCOs)
  • Amerigroup
  • Iowa Total Care
• State Provider Associations
• Advocacy groups
 	
NEMT Service Broker
• TMS Management Group
 	
IWP Components
• Funding
• Program staff
• Program infrastructure
	Activities of NEMT Service Broker
	• Administered by TMS Management Group
	• Authorize transportation
	• Verify member and trip eligibility
	• Process transportation claims and reimbursements
	• Audit trips and claims
	
	Activities of IWP Members with NEMT Waiver
	• Contact MCO to determine eligibility for NEMT services
	• Obtain transportation to appointments without any support services
	
	Activities of IWP Members Eligible for NEMT benefit
	• Contact MCO to determine eligibility for NEMT services
	• Schedule NEMT trip reservation prior to appointment
	• Obtain care from providers in the state provider network
	• Obtain signature from provider to prove that the Member was at the appointment in order to get reimbursed
	• Submit a Mileage Reimbursement Trip Log and Claim Form by mail, fax or email
	• Wait for payment to be processed and issued to driver at the driver's address
	
	NEMT Waiver Evaluation Activities
	• Key Informant Interviews
	  • Annual interviews with key stakeholders
	  • Conducted w/ IME staff
	  • Conducted w/ MCOs
	• IWP Member Surveys
	  • Fielded every 18 months
	  • Includes NEMT-specific questions to assess transportation barriers and needs for those with and without NEMT coverage
		• Member awareness of NEMT benefit and NEMT waiver
		• Number of IWP members eligible for NEMT services
		• Number of IWP members ineligible for NEMT services
		• Member experiences with transportation access
		• Implementation of transportation services by MCOs and NEMT service broker
		• Educating members about available transportation for non-emergent medical services
		• Costs saved by Medicaid program related to NEMT waiver
			• No difference in access to covered services for those with/without NEMT benefit
			• No difference in access to the services beneficiaries must obtain to avoid premium
			• No difference in experience with transportation issues for chronic condition management
			• No difference in unmet need for transportation for those with/without NEMT benefit
				• Members without NEMT benefit will not report greater worry about ability to pay for cost of transportation to/from a health care visit	• Improved fiscal sustainability of Medicaid program without significant negative effects on beneficiary access to services

ASSUMPTIONS	EXTERNAL FACTORS
• IWP members are aware of NEMT • IWP members that do not qualify for NEMT can access transportation for preventative health appointments • IWP members value preventive health services • IWP members value health insurance coverage	• MCO changes within the state • Underlying health status of IWP members impacting non-emergent health needs • Barriers to transportation and other factors related to preventive appointment adherence (knowledge, access, ease of use, infrastructure, up-front cost, work or childcare coverage, reliability of service)

7) Iowa Wellness Plan Member Experiences from Increased Eligibility for Healthcare Coverage

Background

There are several important areas of the IWP member's experiences that should be included in an evaluation of the Iowa Wellness Plan, as mentioned in both the STCs and other CMS correspondence to IME. These areas include access to care, coverage gaps and churning, and quality of care. These are all areas that would be expected to improve as a result of gaining Medicaid coverage as a result of the inclusion of the IWP population in Medicaid in Iowa.

Specific indications of the importance of evaluating these impacts of the IWP are in a letter from CMS to IME Director Michael Randol and in the STCs provided to the IME:

From the CMS letter to IME Director Randol:

"Under the extended demonstration, Iowa and CMS will continue to evaluate the effectiveness of various policies that are designed to improve the health of Medicaid beneficiaries, and encourage them to make responsible decisions about their health and accessing health care. Promoting beneficiary health and responsible health care decisions advances the objectives of the Medicaid program."

CMS's interest in evaluating the impact of the demonstration in providing insurance coverage to beneficiaries and the uninsured population, as well as outcomes of care, quality and cost of care, and access to care was further reinforced in the STCs and in conversations between CMS, IME and Public Policy Center staff during the development of this evaluation plan.

Goals related to Member Experience

The goals being evaluated for this portion of the IWP evaluation derive from the expansion of eligibility to populations not previously eligible for Medicaid coverage, those between 0-138% FPL not categorically eligible for Medicaid. This increased coverage has the following goals:

Goal 1: IWP members will have increased access to covered services.

Goal 2: IWP members will experience consistent, reliable coverage.

Goal 3: IWP members will experience improved quality of care.

Hypotheses and Research Questions

Topic 1: Access to care

Hypothesis 1.1: Wellness Plan members will have equal or greater access to primary care and specialty services.

Research Question 1.1.1: Are adults in the IWP more likely to have had an ambulatory or preventive care visit than other adults in Medicaid?

Research Question 1.1.2: Are adults in the IWP more likely to report greater access to urgent care than other adults in national estimates from National CAHPS Benchmarking Database?

Research Question 1.1.3: Are adults in the IWP more likely to report greater access to routine care than other adults in national estimates from National CAHPS Benchmarking Database?

Research Question 1.1.4: Are adults in the IWP more likely to get timely appointments, answers to questions, and have less time in waiting room than other adults in national estimates from National CAHPS Benchmarking Database?

Research Question 1.1.5: Are adults in the IWP more likely to know what to do to obtain care after regular office hours than other adults in national estimates from National CAHPS Benchmarking Database?

Research Question 1.1.6: Are adults in the IWP more likely to report greater access to specialist care than other adults in national estimates from National CAHPS Benchmarking Database?

Research Question 1.1.7: Are adults in the IWP more likely to report greater access to prescription medication than other adults in national estimates from National CAHPS Benchmarking Database?

Hypothesis 1.2: Wellness Plan members will have equal or greater access to preventive care services.

Research Question 1.2.1: Are women aged 50-64 in the IWP more likely to have had a breast cancer screening than other adults in Medicaid?

Research Question 1.2.2: Are women aged 21-64 in the IWP more likely to have had a cervical cancer screening than other adults in Medicaid?

Research Question 1.2.3: Are adults in the IWP more likely to have had a flu shot in the past year than other adults in national estimates from National CAHPS Benchmarking Database?

Research Question 1.2.4: Are adults with diabetes in the IWP more likely to have had Hemoglobin A1c testing than other adults with diabetes in Medicaid?

Research Question 1.2.5: Are adults in the IWP more likely to report greater access to preventive care than other adults in national estimates from National CAHPS Benchmarking Database?

Hypothesis 1.3: Wellness Plan members will have equal or greater access to mental and behavioral health services.

Research Question 1.3.1: Are adults in IWP with major depressive disorder more likely to have higher anti-depressant medication management than other adults with major depressive disorder in Medicaid?

Research Question 1.3.2: Are adults in the IWP more likely to utilize mental health services than other adults in Medicaid?

Research Question 1.3.3: Are adults in the IWP more likely to have greater access to preventive care than other adults in national estimates from National CAHPS Benchmarking Database?

Hypothesis 1.4: Wellness Plan members will have equal or greater access to care, resulting in equal or lower use of emergency department services for non-emergent care.

Research Question 1.4.1: Are adults in the IWP more likely to have fewer non-emergent ED visits than other adults in Medicaid?

Research Question 1.4.2: Are adults in the IWP more likely to have fewer follow-up ED visits than other adults in Medicaid?

Research Question 1.4.3: Are adults in the IWP more likely to utilize ambulatory care than other adults in Medicaid?

Research Question 1.4.4: What other circumstances are associated with overutilization of ED?

Topic 2: Coverage continuity

Hypothesis 2.1: Wellness Plan members will experience equal or less churning.

Research Question 2.1.1: Are adults in the IWP less likely to have gaps in health insurance coverage over the past 12 months than other adults in Medicaid?

Research Question 2.1.2: Are adults in the IWP more likely to have higher rates of consecutive coverage than other adults in Medicaid?

Research Question 2.1.3: Are adults in the IWP less likely to change plans or lose eligibility during the year than other adults in Medicaid?

Hypothesis 2.2: Wellness Plan members will maintain continuous access to a regular source of care when their eligibility status changes.

Research Question 2.2.1: Are adults in the IWP more likely to have a personal doctor than other adults in national estimates from National CAHPS Benchmarking Database?

Research Question 2.2.2: Are adults in the IWP more likely to have a positive experience with changing personal doctor/PCP than other adults in Medicaid?

Topic 3: Quality of Care

Hypothesis 3.1: Wellness Plan members will have equal or better quality of care.

Research Question 3.1.1: Are adults in the IWP less likely to receive antibiotic treatment for acute bronchitis than other adults in Medicaid?

Research Question 3.1.2: Are adults aged 40-64 with COPD in IWP more likely to have pharmacotherapeutic management of COPD exacerbation than other adults in Medicaid?

Research Question 3.1.3: Are adults in the IWP more likely to self-report receipt of flu shot than other adults in Medicaid?

Research Question 3.1.4: Are adults in the IWP less likely to report visiting the ED for non-emergent care than other adults in Medicaid?

Hypothesis 3.2: Wellness Plan members will have equal or lower rates of hospital admissions.

Research Question 3.2.1: Are adults in the IWP less likely to have hospital admissions for COPD, diabetes short-term complications, CHF, or asthma than other adults in Medicaid?

Research Question 3.2.2: Are adults in the IWP less likely to utilize general hospital/acute care than other adults in Medicaid?

Research Question 3.2.3: Are adults in the IWP less likely to have an acute readmission within 30 days of being discharged for acute inpatient stay than other adults in Medicaid?

Research Question 3.2.4: Are adults in the IWP less likely to have a self-reported hospitalization in the previous 6 months than other adults in Medicaid?

Research Question 3.2.5: Are adults in the IWP less likely to have a self-reported 30-day hospital readmission in the previous 6 months than other adults in Medicaid?

Hypothesis 3.3: Wellness Plan members will report equal or greater satisfaction with the care provided.

Research Question 3.3.1: Are adults in the IWP more likely to report that their personal doctor communicated well with them during office visits than other adults in national estimates from National CAHPS Benchmarking Database?

Research Question 3.3.2: Are adults in the IWP more likely to report that their provider supported them in taking care of their own health than other adults in national estimates from National CAHPS Benchmarking Database?

Research Question 3.3.3: Are adults in the IWP more likely to report that their provider paid attention to their mental or emotional health than other adults in national estimates from National CAHPS Benchmarking Database?

Research Question 3.3.4: Are adults in the IWP more likely to report that their provider talked with them about their prescription medications than other adults in national estimates from National CAHPS Benchmarking Database?

Research Question 3.3.5: Are adults in the IWP more likely to report that their provider paid attention to the care they received from other providers than other adults in national estimates from National CAHPS Benchmarking Database?

Research Question 3.3.6: Are adults in the IWP more likely to report higher ratings of their personal doctor than other adults in national estimates from National CAHPS Benchmarking Database?

Research Question 3.3.7: Are adults in the IWP more likely to report higher ratings of their overall care than other adults in national estimates from National CAHPS Benchmarking Database?

Research Question 3.3.8: Are adults in the IWP more likely to report higher ratings of their health plan than other adults in national estimates from National CAHPS Benchmarking Database?

Evaluation Periods

Multiple evaluation periods exist for this data depending on the question and analyses. Below we attempt to provide some explanation of the evaluation periods.

Pre- post-implementation period (CY 2011-2022)

Medicaid comparison groups

For measures in which we are able to utilize data from the IowaCare population (either administrative or survey), we will be able to compare a pre-implementation period of CY 2011-2013 and a post-implementation period of CY 2014-2022. Due to the differences in coverage for IowaCare and Iowa Wellness Plan, these comparisons are limited to utilization that could occur at a primary care site. Emergency department and inpatient hospitalization data is not valid as IowaCare members were only allowed to access 2 hospitals in Iowa. The IowaCare population will be limited to those with incomes of 0-133% FPL to mirror the IWP population for our analyses. IowaCare/IWP members will be compared over time to Medicaid members enrolled through FMAP and/or SSI.

Post-implementation period (CY 2014-2022)

Surveys

Survey data collected approximately every 18 months from January 2014 through present. Survey sampling strategies vary over time, however, for those surveys in which we have similar sampling

strategies we will be able to compare the data over time for IWP and Medicaid members enrolled through FMAP and SSI.

Administrative data

Medicaid claims data are available for the post implementation period CY 2014-2022.

Data Sources, Analysis Methods, and Measures

Data sources

Member surveys

Survey-based outcomes will use data from IWP member surveys that are fielded every 18 months throughout the evaluation period.

The foundation for the IWP member survey instrument will be based on the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) survey. The PPC was involved in the development of the CAHPS survey and has used the instrument to evaluate issues from the perspective of Iowa Medicaid and IWP members for over 15 years for the evaluation of Medicaid waiver programs.

Surveys will be mailed to a stratified random sample of 1500 members in each of the following groups: IWP (Amerigroup), IWP (Iowa Total Care), and the traditional Medicaid State Plan. Members must have been enrolled in IWP for at least the previous six months to be eligible to receive the survey. An initial invitation and survey will be mailed to the entire sample along with a cash pre-incentive (nominal monetary pre-incentives are utilized to maximize response rates for mailed surveys). Respondents will have the option to complete the survey online or mail back the paper survey in the provided postage-paid envelope. A reminder postcard will be sent a week after the initial survey. A follow-up survey will be sent a month after the first mailing to those who have not responded, and a telephone follow up will be conducted for those who do have not completed a survey 2-3 weeks following the second survey mailing.

Members in each of the Medicaid coverage options are surveyed every 18 months using an instrument that includes questions from the most recent CAHPS survey instrument and additional supplemental items appropriate for evaluating specific demonstration activities. The consumer surveys will be conducted utilizing the best practices for health surveys, based on CAHPS guidance and current survey research recommendations. Initial consumer surveys will be mailed with a nominal cash pre-incentive (demonstrated to have a significant positive impact on response rates). A random ID number assigned to all sample members will be used to track survey responses and identify who receives follow-up contact. In addition to a postcard reminder and a second follow-up survey, a telephone follow-up will be administered for non-respondents 2-3 weeks after the second mailing. To maximize potential for contact with the sample, address information will be verified and updated through a national change-of-address database and alternative forms of contact will be investigated for sample members with survey mailings that are undeliverable.

Administrative data

The PPC is home to a Medicaid Data Repository encompassing over 100 million claims, encounter and eligibility records for all Iowa Medicaid enrollees for the period October 2010 through the present. Data are assimilated into the repository on a monthly basis. 95% of medical and pharmaceutical claims are completely adjudicated within 3 months of the first date of service, while the adjudication timing' for institutional claims is 6 months. The PPC staff also have extensive experience with these files as well as extensive experience with CMS adult core measures and HEDIS measures. In addition, the database allows members to be followed for long periods of time over both consecutive enrollment months and periods before and after gaps in coverage. When the

enrollment database was started in 1965 Iowa made a commitment to retain a member number for at least 3 years and to never reuse the same Medicaid ID number. This allows long-term linkage of member information including enrollment, cost and utilization even if they change plans.

National CAHPS benchmarking database

The PPC has purchased the NCQA Quality Compass CAHPS data for commercial and Medicaid providers in the past. These data are available at the state by plan level allowing us to compare both Medicaid and Commercial plans across the nation. We will not be able to compare at the individual level or control for group differences when making the comparisons. However, these results provide worthwhile comparisons to assess how the IWP population compares to others over time.

Emergency department use survey

The PPC survey team is developing a telephone survey to be administered to members who utilize the ED for non-emergent diagnoses. We anticipate recruiting 50 members per month for 1 year. This should yield 300 completed surveys (100 per group) with sufficient power to detect moderate differences at .05.

Structured key stakeholder interviews

Interviews with key IWP stakeholders will be conducted annually and staggered at different times for different stakeholder groups. Interviews will be 60 minutes long and topics for the structured interviews will be developed to reflect the experiences of IWP members and provide elaboration from a primary source as needed to provide context for data collection activities, outline the availability of key pieces of information and outline adjustments to IWP. Stakeholder interviews may occur at varying times as needed to inform the evaluation portions of the policy components.

Measures

Bivariate analyses

With the complexity of the evaluation and the many areas investigation, it is not possible to provide complex modelling for every measure. Additionally, some measure changes provide context around the more complex modelling. Bivariate analyses can provide an understanding of the changes, for example, that have occurred pre-and post-demonstration between the many target and comparison groups we have identified. Appropriate bivariate analytic approaches we use depend on data structures of two variables of our interest, their sample size and other associated assumptions.

Multivariate modelling

Many outcomes are population-based, however through modification of the protocols they will also be measured as individual outcomes. Individual outcomes can be measured as a dichotomous variable indicating whether or not the member had a service (e.g., person with type 1 or type 2 diabetes receiving a Hemoglobin A1c) or experienced an outcome (e.g., preventive visit) or a continuous variable (e.g., per member per month cost, or time to first enrollment gap)

Comparative Interrupted Time Series (CITS)

A simple comparative interrupted time series analysis (CITS) entails a Difference in Difference (DID) estimation in which the effect of a health program is determined by comparing the pre- and post-program means in the study population using the pre- and post-program means in the comparison population as the counterfactuals. In complex CITS analyses with more pre- and post-IWP data (as in the case of many of our hypotheses), we analyze means and slopes of pre-IWP values to determine changes both in means and in post-IWP linear and non-linear trends, as well as mean and trend heterogeneity among different sub-groups of population.

For programs where a readily identified comparison group exists, CITS methods are very useful. For program groups where no readily-identified comparisons exist, regression controlling for observed patient or area characteristics will be utilized. The specific analysis technique will depend on the distribution of the dependent variable (e.g., OLS for continuous variables and logistic regression for dichotomous variables with a skewed distribution). When appropriate, person, program or area fixed effects will be used to control for time-invariant individual (or program or area) effects and year effects. Each method has strengths and weaknesses but combined should offer a robust analysis of program effects on costs and outcomes.

Covariates

Payment structure - series of dichotomous variables that provide payment structure comparisons. The variables will indicate whether during the month a member was in the HMO (0,1), PCCM (0,1), or fee-for-service (0,0).

Age - calculated monthly

Age squared - to allow for a curvilinear relationship between age and costs

Gender

Race - within the Medicaid data 30% of enrollees/members do not identify a race. Previous analyses have indicated that this option does not appear to have a race-based bias or systematic component. We will perform the analyses with this group identified as race 'Undisclosed' and without this group.

Number of chronic conditions - The Health Home program in Iowa Medicaid utilizes seven diagnoses to establish member participation: mental health condition, substance use disorder, asthma, diabetes, heart disease, overweight, and hypertension. A count of these conditions will serve as the chronic conditions measure though the severity of impairment will be unattainable.

Risk adjustment - Risk stratification provides an adjustment for the model to determine whether there are high-risk groups of enrollees whose costs are more likely to be reduced through the Wellness Plan. We will develop risk stratification based on medical diagnoses, physical diseases and disorders. We will determine the exact method of stratifying the enrollees once we are able to analyze the data and determine whether we are able to construct risk stratification for each month and how we will provide a risk stratification mechanism for the control groups.

Rural/urban - Rural-urban continuum codes (RUCC) provided through the US Department of Agriculture will be included. We will also test the model with the county of residence as a covariate; however, past analyses indicate that the RUCC is sufficient.

Income - Percent poverty will be included as it appears on the enrollment files.

When needed, we will use maximum likelihood estimators (logit or probit) or a recently developed special regressor method. Dong and Lewbel (2015) show that the special regressor method has several advantages over maximum likelihood estimators including providing consistent estimates in cases of endogenous regressors.

We will also utilize modified Poisson regressions (Poisson regressions with a robust error variance). This method is used to answer research questions involving count dependent variables. Poisson regressions use a log link function to relate the expected value of an outcome of interest (Y) (E(Y)=μ) to a linear combination of X:

$\log(\mu)=X_{it}$, or $\mu=e^{X}$ (1)

In addition, we will pre-process the data for estimations using matching methods, including propensity score matching (with difference matching schemes, e.g., nearest neighbor, caliper) or coarsened exact matching methods. Alternatively, we may use propensity scores as inverse probability of treatment weights whenever appropriate. All these estimation techniques are intended to minimize bias and allow us to make causal inference between program interventions and outcomes of interest. In previous rounds of cost analyses, we did use matching techniques to pre-process data and there seemed to be enough common support across covariates.

Reference:

Dong, Y., & Lewbel, A. (2015). A Simple Estimator for Binary Choice Models with Endogenous Regressors. *Econometric Reviews*, *34*(1–2), 82–105.

Evaluation Methods Summary: Access to Care

Comparison Strategy	Outcome Measure(s)	Data Sources	Analytic Approach
Hypothesis 1.1: Wellness Plan members will have equal or greater access to primary care and specialty services.			
Research Question 1.1.1: Are adults in the IWP more likely to have had an ambulatory or preventive care visit than other adults in Medicaid?			
Study group: IWP members Comparison group: FMAP adult members	Percent of members who had an ambulatory care visit in the measurement year (HEDIS AAP)	Medicaid claims	Means tests CY 2014-2022
Study group: IWP members Comparison group: FMAP adult members	Whether a member had an ambulatory or preventive care visit (HEDIS AAP)	Medicaid claims	DID CY 2014-2022
Research Question 1.1.2: Are adults in the IWP more likely to report greater access to urgent care than other adults in national estimates from National CAHPS Benchmarking Database?			
Adults in national estimates from National CAHPS Benchmarking Database	Composite of two questions rating timely access to UC and unmet need for UC (CAHPS question)	Member Survey	Means tests
Research Question 1.1.3: Are adults in the IWP more likely to report greater access to routine care than other adults in national estimates from National CAHPS Benchmarking Database?			
Adults in national estimates from National CAHPS Benchmarking Database	Composite of two questions rating timely access to RC and unmet need for RC (CAHPS question)	Member Survey	Means tests
Research Question 1.1.4: Are adults in the IWP more likely to get timely appointments, answers to questions, and have less time in waiting room than other adults in national estimates from National CAHPS Benchmarking Database?			
Adults in national estimates from National CAHPS Benchmarking Database	Composite of three questions 1) member experience with getting appointments for care in a timely manner, 2) time spent waiting for their appointment, and 3) receiving timely answers to their questions. (CAHPS question)	Member Survey	DID
Research Question 1.1.5: Are adults in the IWP more likely to know what to do to obtain care after regular office hours than other adults in national estimates from National CAHPS Benchmarking Database?			
Adults in national estimates from National CAHPS Benchmarking Database	Member experience with knowing what to do to obtain care after regular office hours (CAHPS question)	Member Survey	DID

Comparison Strategy	Outcome Measure(s)	Data Sources	Analytic Approach
Research Question 1.1.6: Are adults in the IWP more likely to report greater access to specialist care than other adults in national estimates from National CAHPS Benchmarking Database?			
Adults in national estimates from National CAHPS Benchmarking Database	Composite of two questions rating access to and unmet need for care from a specialist (CAHPS question)	Member Survey	DID
Research Question 1.1.7: Are adults in the IWP more likely to report greater access to prescription medication than other adults in national estimates from National CAHPS Benchmarking Database?			
Adults in national estimates from National CAHPS Benchmarking Database	Composite of two questions rating access to and unmet need for prescription medication (CAHPS question)	Member Survey	DID
Hypothesis 1.2: Wellness Plan members will have equal or greater access to preventive care services.			
Research Question 1.2.1: Are women aged 50-64 in the IWP more likely to have had a breast cancer screening than other adults in Medicaid?			
Study group: Female IWP members 50-64 yrs Comparison group: Female FMAP members 50-64 yrs	Percent of women 50-64 years of age who had a mammogram to screen for breast cancer (HEDIS BCS) during the measurement year	Medicaid claims	Means tests CY 2014-2022
Study group: Female IWP members 50-64 yrs Comparison group: Female FMAP members 50-64 yrs	Whether a woman 50-64 years of age had a mammogram to screen for breast cancer (HEDIS BCS) during the measurement period	Medicaid claims	DID CY 2014-2022
Research Question 1.2.2: Are women aged 21-64 in the IWP more likely to have had a cervical cancer screening than other adults in Medicaid?			
Study group: Female IWP members 21-64 yrs Comparison group: Female FMAP members 21-64 yrs	Percent of women 21-64 years of age who were screened for cervical cancer (HEDIS CCS) in the measurement year or the 2 years prior to the measurement year	Medicaid claims	Means tests CY 2017-2022
Adults in Medicaid	Whether a woman 21-64 years of age was screened for cervical cancer (HEDIS CCS) in the measurement year or the 2 years prior to the measurement year	Medicaid claims	DID CY 2017-2022
Research Question 1.2.3: Are adults in the IWP more likely to have had a flu shot in the past year than other adults in national estimates from National CAHPS Benchmarking Database?			
Adults in national estimates from National CAHPS Benchmarking Database	Percent of members 21-64 years of age who received an influenza vaccination (CAHPS question)	Member Survey	Means tests

Comparison Strategy	Outcome Measure(s)	Data Sources	Analytic Approach
Research Question 1.2.4: Are adults with diabetes in the IWP more likely to have had Hemoglobin A1c testing than other adults with diabetes in Medicaid?			
For those identified as having diabetes Study group: IWP members 3 comparison groups: FMAP adult members SSI adult members IowaCare members	Percent of members with type 1 or type 2 diabetes who had Hemoglobin A1c testing (HEDIS CDC) during the measurement year	Medicaid claims	Means tests CY 2012-2022
For those identified as having diabetes Study group: IWP members 3 comparison groups: FMAP adult members SSI adult members IowaCare members	Whether a member with type 1 or type 2 diabetes had Hemoglobin A1c testing (HEDIS CDC) during the measurement period	Medicaid claims	CITS Pre-IWP CY 2011-2013 Post-IWP CY 2014-2022
Research Question 1.2.5: Are adults in the IWP more likely to report greater access to preventive care than other adults in national estimates from National CAHPS Benchmarking Database?			
Adults in national estimates from National CAHPS Benchmarking Database	Access to and unmet need for preventive care (CAHPS question)	Member Survey	DID

Comparison Strategy	Outcome Measure(s)	Data Sources	Analytic Approach
Hypothesis 1.3: Wellness Plan members will have equal or greater access to mental and behavioral health services.			
Research Question 1.3.1: Are adults in IWP with major depressive disorder more likely to have higher anti-depressant medication management than other adults with major depressive disorder in Medicaid?			
For those identified as having major depressive disorder Study group: IWP members 2 comparison groups FMAP adult members SSI adult members	Percent of members with major depressive disorder who remained on antidepressant medication (HEDIS AMM)	Medicaid claims	Means tests CY 2015-2022
For those identified as having major depressive disorder Study group: IWP members 2 comparison groups FMAP adult members SSI adult members	Time to first lapse in anti-depressant medication Newly developed measure identifying continuous use of anti-depressant medication utilizing medication lists from HEDIS AMM	Medicaid claims	Survival analyses CY 2015-2022
Research Question 1.3.2: Are adults in the IWP more likely to utilize mental health services than other adults in Medicaid?			
Study group: IWP members 2 comparison groups: FMAP adult members SSI adult members	Percent of members receiving any mental health services Newly developed measure utilizing HEDIS FUH Mental Health Diagnosis Value Set	Medicaid claims	Means tests CY 2014-2022
For those identified as having mental health diagnosis Study group: IWP members Two comparison groups 1: FMAP adult members 2: SSI adult members	Whether member with mental health diagnosis received mental health services	Medicaid claims	DID CY 2016-2022

Comparison Strategy	Outcome Measure(s)	Data Sources	Analytic Approach
Members having an ED visit for a mental health illness Study group: IWP members 2 comparison groups FMAP adult members SSI adult members	Whether member had a follow-up visit after ED visit for mental illness (HEDIS FUM)	Medicaid claims	DID CY 2015-2022
Research Question 1.3.3: Are adults in the IWP more likely to have greater access to preventive care than other adults in national estimates from National CAHPS Benchmarking Database?			
Adults in national estimates from National CAHPS Benchmarking Database	Access to and unmet need for preventive care (CAHPS question)	Member Survey	DID
Hypothesis 1.4: Wellness Plan members will have equal or greater access to care, resulting in equal or lower use of emergency department services for non-emergent care.			
Research Question 1.4.1: Are adults in the IWP more likely to have fewer non-emergent ED visits than other adults in Medicaid?			
Study group: IWP members Comparison group: FMAP adult members	Number of non-emergent ED visits per 1,000 member months (HEDIS AMB) in the measurement year	Medicaid claims	Means tests CY 2014-2022
Study group: IWP members Comparison group: FMAP adult members	Whether member had a non-emergent ED visit (HEDIS AMB) in the measurement period	Medicaid claims	DID CY 2014-2022
Research Question 1.4.2: Are adults in the IWP more likely to have fewer follow-up ED visits than other adults in Medicaid?			
Study group: IWP members Comparison group: FMAP adult members	Percent of members with ED visit within the first 30 days after index ED visit in the measurement year Newly developed measure using the structure of hospital readmission from HEDIS and ED value set to define the visits	Medicaid claims	Means tests CY 2014-2022
Research Question 1.4.3: Are adults in the IWP more likely to utilize ambulatory care than other adults in Medicaid?			
Study group: IWP members Comparison group: FMAP adult members	Rate of outpatient and emergency department visits per 1,000 member months (HEDIS AMB)	Medicaid claims	Means tests CY 2014-2022

Comparison Strategy	Outcome Measure(s)	Data Sources	Analytic Approach
Research Question 1.4.4: What other circumstances are associated with overutilization of ED?			
Members utilizing the ED ED providers	Identification of facilitators and barriers to other types of care and factors related to non-emergent ED use (e.g. knowledge of alternatives, access, ease of use, up-front cost, work or childcare coverage, financial stress)	Qualitative member interviews, ED provider interviews	Qualitative thematic coding

Evaluation Methods Summary: Coverage continuity

Comparison Strategy	Outcome Measure(s)	Data Sources	Analytic Approach
Hypothesis 2.1: Wellness Plan members will experience equal or less churning.			
Research Question 2.1.1: Are adults in the IWP less likely to have gaps in health insurance coverage over the past 12 months than other adults in Medicaid?			
Study group: IWP members Comparison group: FMAP adult members	Number of months in the previous year when the respondent did not have health insurance coverage (Developed for IWP evaluation)	Member Survey	DID
Research Question 2.1.2: Are adults in the IWP more likely to have higher rates of consecutive coverage than other adults in Medicaid?			
Study group: IWP members Comparison group: FMAP adult members IowaCare members	Percent of members with 6 months continuous eligibility and 12 months continuous eligibility (Developed for IWP evaluation)	Enrollment files	CITS Pre – CY 2010-2013 Post – CY 2014-2021
Research Question 2.1.3: Are adults in the IWP less likely to change plans or lose eligibility during the year than other adults in Medicaid?			
Study group: IWP members Comparison group: FMAP adult members IowaCare members	Whether member did not change plans or lose eligibility, changed plans or lost eligibility once, changed plans or lost eligibility 2-3 times or changed plans or lost eligibility 4 or more times (Developed for IWP evaluation)	Enrollment files	CITS Pre – CY 2010-2013 Post – CY 2014-2021
Hypothesis 2.2: Wellness Plan members will maintain continuous access to a regular source of care when their eligibility status changes.			
Research Question 2.2.1: Are adults in the IWP more likely to have a personal doctor than other adults in national estimates from National CAHPS Benchmarking Database?			
Adults in national estimates from National CAHPS Benchmarking Database	The percent who respond that they currently have a personal doctor (CAHPS question)	Member Survey	Means tests

Comparison Strategy	Outcome Measure(s)	Data Sources	Analytic Approach
Research Question 2.2.2: Are adults in the IWP more likely to have a positive experience with changing personal doctor/PCP than other adults in Medicaid/than in prior years?			
Study group: IWP members Comparison group: FMAP adult members	Member experiences with changing personal doctor/primary care provider (Developed for IWP evaluation)	Member Survey	DID

Evaluation Methods Summary: Quality of Care

Comparison Strategy	Outcome Measure(s)	Data Sources	Analytic Approach
Hypothesis 3.1: Wellness Plan members will have equal or better quality of care.			
Research Question 3.1.1: Are adults in the IWP less likely to receive antibiotic treatment for acute bronchitis than other adults in Medicaid?			
Study group: IWP members 2 Comparison groups: FMAP adult members SSI adult members	The percent of members 19–64 years of age who were enrolled for at least 11 months during the measurement year with a diagnosis of acute bronchitis who were not dispensed an antibiotic prescription (HEDIS AAB)	Medicaid claims	Means tests CY 2014-2022
Research Question 3.1.2: Are adults aged 40-64 with COPD in IWP more likely to have pharmacotherapeutic management of COPD exacerbation than other adults in Medicaid?			
Study group: IWP members 2 Comparison groups: FMAP adult members SSI adult members	The percent of COPD exacerbations for members age 40-64 years of age who had an acute inpatient discharge or emergency department visit during the first 11 months of the measurement year and who were enrolled for at least 30 days following the inpatient stay or emergency department visit and who were dispensed appropriate medications (PQI)	Medicaid claims	Means tests CY 2014-2022
Research Question 3.1.3: Are adults in the IWP more likely to self-report receipt of flu shot than other adults in Medicaid?			
Study group: IWP members 2 Comparison groups: FMAP adult members SSI adult members	Percent of respondents who reported having a flu shot (CAHPS question)	Member Survey	Means tests

Comparison Strategy	Outcome Measure(s)	Data Sources	Analytic Approach
Research Question 3.1.4: Are adults in the IWP less likely to report visiting the ED for non-emergent care than other adults in Medicaid?			
Study group: IWP members 2 Comparison groups: FMAP adult members SSI adult members	Percent of respondents who reported that the care they received at their most recent visit to the emergency room could have been provided in a doctor's office if one was available at the time (Developed for IWP evaluation)	Member Survey	Means tests
Hypothesis 3.2: Wellness Plan members will have equal or lower rates of hospital admissions.			
Research Question 3.2.1: Are adults in the IWP less likely to have hospital admissions for COPD, diabetes short-term complications, CHF or asthma than other adults in Medicaid?			
Study group: IWP members 2 Comparison groups: FMAP adult members SSI adult members	The number of discharges for COPD, CHF, short-term complications from diabetes or asthma per 100,000 Medicaid members (PQI)	Medicaid claims	Means tests CY 2014-2022
Research Question 3.2.2: Are adults in the IWP less likely to utilize general hospital/acute care than other adults in Medicaid?			
Study group: IWP members 2 Comparison groups: FMAP adult members SSI adult members	This measure summarizes utilization of acute inpatient care and services in the following categories: total inpatient, surgery and medicine using number of discharges per 1000 member months, number of days stay per 1000 member months and average length of stay for all members who were enrolled for at least 1 month during the measurement year (HEDIS IHU)	Medicaid claims	Means tests CY 2014-2022
Research Question 3.2.3: Are adults in the IWP less likely to have an acute readmission within 30 days of being discharged for acute inpatient stay than other adults in Medicaid?			
Study group: IWP members 2 Comparison groups: FMAP adult members SSI adult members	For members age 19-64 years who were enrolled for at least on month during the measurement year, the number of acute inpatient stays during the measurement year that were followed by an acute readmission for any diagnosis within 30 days and the predicted probability of an acute readmission (Developed for IWP evaluation)	Medicaid claims	Means tests CY 2014-2022
Research Question 3.2.4: Are adults in the IWP less likely to have a self-reported hospitalization in the previous 6 months than other adults in Medicaid?			
Study group: IWP members 2 Comparison groups: FMAP adult members SSI adult members	Hospitalization reported in the previous 6 months (Developed for IWP evaluation)	Member Survey	DID

Comparison Strategy	Outcome Measure(s)	Data Sources	Analytic Approach
Research Question 3.2.5: Are adults in the IWP less likely to have a self-reported 30-day hospital readmission in the previous 6 months than other adults in Medicaid?			
Study group: IWP members 2 Comparison groups: FMAP adult members SSI adult members	30-day readmissions reported in last 6 months (Developed for IWP evaluation)	Member Survey	DID
Hypothesis 3.3: Wellness Plan members will report equal or greater satisfaction with the care provided.			
Research Question 3.3.1: Are adults in the IWP more likely to report that their personal doctor communicated well with them during office visits than other adults in national estimates from National CAHPS Benchmarking Database?			
Adults in national estimates from National CAHPS Benchmarking Database	This is a CAHPS composite measure designed to assess respondent perception of how well their personal doctor communicated with them during office visits.	Member Survey	Means tests
Research Question 3.3.2: Are adults in the IWP more likely to report that their provider supported them in taking care of their own health than other adults in national estimates from National CAHPS Benchmarking Database?			
Adults in national estimates from National CAHPS Benchmarking Database	This is a CAHPS Patient-Centered Medical Home (PCMH) composite measure designed to assess respondent perception of how well their provider supported them in taking care of their own health.	Member Survey	Means tests
Research Question 3.3.3: Are adults in the IWP more likely to report that their provider paid attention to their mental or emotional health than other adults in national estimates from National CAHPS Benchmarking Database?			
Adults in national estimates from National CAHPS Benchmarking Database	This is a CAHPS Patient-Centered Medical Home (PCMH) composite measure designed to assess respondent perception of how well their provider paid attention to their mental or emotional health which is the CAHPS way to assess the comprehensive care component of the PCMH.	Member Survey	DID
Adults in national estimates from National CAHPS Benchmarking Database	This is a CAHPS Patient-Centered Medical Home (PCMH) composite measure designed to assess respondent perception of how well their provider paid attention to their mental or emotional health which is the CAHPS way to assess the comprehensive care component of the PCMH.	Member Survey	DID
Research Question 3.3.4: Are adults in the IWP more likely to report that their provider talked with them about their prescription medications than other adults in national estimates from National CAHPS Benchmarking Database?			
Adults in national estimates from National CAHPS Benchmarking Database	This is a CAHPS Patient-Centered Medical Home (PCMH) composite measure designed to assess respondent perception of how well their provider talked with them about their prescription medications which is the CAHPS way to assess the shared decision-making component of the PCMH.	Member Survey	DID

Comparison Strategy	Outcome Measure(s)	Data Sources	Analytic Approach
Adults in national estimates from National CAHPS Benchmarking Database	This is a CAHPS Patient-Centered Medical Home (PCMH) composite measure designed to assess respondent perception of how well their provider talked with them about their prescription medications which is the CAHPS way to assess the shared decision-making component of the PCMH.	Member Survey	DID
Research Question 3.3.5: Are adults in the IWP more likely to report that their provider paid attention to the care they received from other providers than other adults in national estimates from National CAHPS Benchmarking Database?			
Adults in national estimates from National CAHPS Benchmarking Database	There are three individual items from the CAHPS Patient-Centered Medical Home (PCMH) items designed to assess respondent perception of their provider's attention to the care they received from other providers. This is the CAHPS way to assess the care coordination component of the PCMH.	Member Survey	DID
Adults in national estimates from National CAHPS Benchmarking Database	There are three individual items from the CAHPS Patient-Centered Medical Home (PCMH) items designed to assess respondent perception of their provider's attention to the care they received from other providers. This is the CAHPS way to assess the care coordination component of the PCMH.	Member Survey	DID
Research Question 3.3.6: Are adults in the IWP more likely to report higher ratings of their personal doctor than other adults in national estimates from National CAHPS Benchmarking Database?			
Adults in national estimates from National CAHPS Benchmarking Database	Rating of personal doctor on 0-10 scale (CAHPS question)	Member Survey	Means tests
Research Question 3.3.7: Are adults in the IWP more likely to report higher ratings of their overall care than other adults in national estimates from National CAHPS Benchmarking Database?			
Adults in national estimates from National CAHPS Benchmarking Database	Rating of all care received on 0-10 scale (CAHPS question)	Member Survey	Means tests
Research Question 3.3.8: Are adults in the IWP more likely to report higher ratings of their health plan than other adults in national estimates from National CAHPS Benchmarking Database?			
Adults in national estimates from National CAHPS Benchmarking Database	Rating of health care plan on 0-10 scale (CAHPS question)	Member Survey	Means tests

Logic Model: Experiences of IWP Members

LOGIC MODEL FOR MEDICAID EVALUATION: ASSESSING ONGOING EXPERIENCES OF IWP MEMBERS

NEED(s): The Iowa Wellness Plan (IWP), Iowa's version of Medicaid expansion, provides comprehensive health coverage at low or no cost to low-income Iowans between the ages of 19 and 64. Iowa and CMS will continue to evaluate the effectiveness of various policies that are designed to improve the health of Medicaid beneficiaries.

THEORY OF CHANGE: The IWP seeks to increase access for low-income Iowans to quality, affordable health care services and coverage. Through the expansion of eligibility to populations not previously eligible for Medicaid coverage, their will be both a decrease in the number of uninsured Iowans as well as in increase in the access to care, quality of care and other positive implications of having health care coverage.

YOUR PLANNED WORK			YOUR INTENDED RESULTS		
Inputs	Activities	Participation	Short-Term Outcomes	Medium-Term Outcomes	Long-Term Outcomes

Eligible IWP Members:
• Adults ages 19-64
• Income up to 138% FPL
 	
Stakeholder Collaboration
• CMS – federal government
• Iowa Department of Human Services
• Iowa Medicaid Enterprise (IME)
• Managed Care Organizations (MCOs)
  • Amerigroup
  • Iowa Total Care
• State Provider Associations
• Advocacy groups
 	
IWP Components
• Funding
• Program staff
• Program infrastructure
 	
Outside Data Sources:
• National CAHPS Benchmarking Database
	Activities of IWP Members
	• Yearly wellness exam (WE)
	  • Preventive exam from a plan-enrolled physician
	  • Dental well exam from a plan-enrolled dental provider
	• Health risk assessment (HRA) survey tool
	
	Additional Activities:
	• IWP education and promotion by MCOs, DHS, & providers
	• Financial hardship waiver
	
	Medicaid Evaluation Activities
	• IWP Member Surveys
	  • Fielded every 18 months
	  • Survey foundation will be based on the CAHPS survey
	  • Mailed to stratified random sample of 1500 members to each of the following groups:
	  • Amerigroup
	  • Iowa Total Care
	  • Traditional state Medicaid plan
	  • Survey eligibility: Members must have been enrolled in IWP for at least the previous 6 months
	  • Follow-up survey to be mailed + telephone follow up
		•Completion of WE
		•Completion of HRA
		•Completion of both: wellness exam and HRA
		
		•Demographics of members that are more likely to complete both required activities
		•Demographics of members who are less likely to complete required activities
			IWP members will have equal or greater access to primary care and specialty services
			• Increased likelihood of having an ambulatory or preventive care visit
			• Greater access to urgent care
			• Greater access to routine care
			• Increased likelihood to get timely appointments, answers to questions, and have less time in waiting room
			• Increased likelihood to know what to do to obtain care after regular office hours
			• Increased likelihood to report greater access to specialist care
			• Increased likelihood to report greater access to prescription medication
			
			IWP members will have equal or greater access to preventive care services
			• Increased likelihood for women aged 50-64 to have had a breast cancer screening
			• Increased likelihood for women aged 21-64 to have had a cervical cancer screening
			• Increased likelihood for adults to have had a flu shot in the past year
			• Increased likelihood for adults with diabetes to have had Hemoglobin A1c testing
			• Increased likelihood to report greater access to preventive care
			
			IWP members will have equal or greater access to mental and behavioral health services
			• Increased likelihood for adults with major depressive disorder to have higher anti-depressant medication management
			• Increased likelihood to to utilize mental health services
			• Increased likelihood to report greater access to preventive care
				IWP members will have equal or greater access to care, resulting in equal or lower use of emergency department services for non-emergent care
				• Increased likelihood to have fewer non-emergent ED visits
				• Increased likelihood to have fewer follow-up ED visits
				• Increased likelihood to utilize ambulatory care
				
				IWP members will experience equal or less churning
				• Decreased likelihood to have gaps in health insurance coverage over the past 12 months
				• Increased likelihood of having higher rates of consecutive coverage
				• Decreased likelihood change plans or lose eligibility during the year
					IWP members will maintain continuous access to a regular source of care when their eligibility status changes
					• Increased likelihood to have a personal doctor than other adults
					• Increased likelihood to have a positive experience with changing personal doctor/PCP
					
					IWP members will have equal or better quality of care
					• Decreased likelihood to receive antibiotic treatment for acute bronchitis
					• Increased likelihood for adults aged 40-64 with COPD to have pharmacotherapeutic management of COPD exacerbation
					• Increased likelihood for adults to self-report receipt of flu shot
					• Decreased likelihood to report visiting the ED
					
					IWP members will have equal or lower rates of hospital admissions
					• Decreased likelihood to have hospital admissions for COPD, diabetes short-term complications, CHF, or asthma
					• Decreased likelihood to utilize general hospital/acute care
					• Decreased likelihood to have an acute readmission within 30 days of being discharged for acute inpatient stay
					• Decreased likelihood to to have a self-reported hospitalization in the previous 6 months
					• Decreased likelihood to have a self-reported 30-day hospital readmission in the previous 6 months
					
					IWP members will report equal or greater satisfaction with the care provided
					• Increased likelihood to report that their personal doctor communicated well with them during office visits
					• Increased likelihood to report that their provider supported them in taking care of their own health
					• Increased likelihood to report that their provider paid attention to their mental or emotional health
					• Increased likelihood to report that their provider talked with them about their prescription medications
					• Increased likelihood to report that their provider paid attention to their care they received from other providers
					• Increased likelihood to report higher ratings of their personal doctor
					• Increased likelihood to report higher ratings of their overall care
					• Increased likelihood to report higher ratings of their health plan

ASSUMPTIONS	EXTERNAL FACTORS
• IWP members are aware of IWP program requirements • IWP members value preventive health services • IWP members value health insurance coverage	• MCO changes within the state • Underlying health status of IWP members impacting health needs • Barriers to transportation and other factors related to seeking out care and preventive services (knowledge, access, ease of use, infrastructure, up-front cost, work or childcare coverage, reliability of service)

F. Attachments

F-1. Independent Evaluator

The State will work within policies and procedures established under the Iowa Code to contract with an independent entity to complete the evaluation activities. In the past, The University of Iowa Public Policy Center (UI PPC) has conducted many independent evaluations of Medicaid changes (please see: http://ppc.uiowa.edu/health). We fully anticipate that the PPC will meet the requirements of an independent entity under these policies and procedures. In addition, The University of Iowa brings the ability to meet the prevailing standards of scientific and academic rigor as appropriate and feasible for each aspect of the evaluation, including standards for the evaluation design, conduct, and interpretation and the reporting of findings. The PPC has in the past, and will continue, to use the best available data; use controls and adjustments for and reporting of limitations of data and their effects on results; and discuss the generalizability of results.

F-2.Budget

	Y1 (Q1 - Q4)	Y2 (Q1 - Q4)	Y3 (Q1 - Q4)	Y4 (Q1 - Q4)	Y5 (Q1 - Q3)	Total
Compensation						
Total Salary	$ 810,364	$ 773,122	$ 751,842	$1,057,857	$ 781,385	$4,174,570
Total Fringe	$ 259,303	$ 258,105	$ 257,502	$ 343,400	$ 256,700	$1,375,012
F&A Cost: 8%	$ 112,984	$ 120,929	$ 127,591	$ 130,822	$ 101,508	$ 593,834
Total Compensation and F&A	**$ 1,182,651**	**$ 1,152,156**	**$ 1,136,936**	**$ 1,532,079**	**$ 1,139,593**	**$ 6,143,415**
Reimbursables						
Supplies	$ 420	$ 420	$ 420	$ 420	$ 315	$ 1,995
Travel	$ 12,000	$ 12,000	$ 12,000	$ 12,000	$ 9,000	$ 57,000
Contractual	$135,431	$138,664	$141,994	$145,424	$115,996	$ 677,510
Other	$104,031	$ 69,227	$ 71,650	$115,326	$116,159	$ 476,393
Survey and Primary Data Collection	$265,467	$427,533	$537,000	$189,750	$190,000	$1,609,750
Total Reimbursables	**$ 517,349**	**$ 647,844**	**$ 763,064**	**$ 462,921**	**$ 431,470**	**$ 2,822,648**
Total for Contract	**$ 1,700,000**	**$ 1,800,000**	**$ 1,900,000**	**$ 1,995,000**	**$ 1,571,063**	**$ 8,966,063**

F-3.Timeline and Major Milestones

Timeline

Quarter one is based on the time when the IWP evaluation plan is approved by CMS. These activities may extend past the current waiver period based on the start date.

QUARTER YEAR	Q 1 Yr 1	Q 2 Yr 1	Q 3 Yr 1	Q 4 Yr 1	Q 1 Yr 2	Q 2 Yr 2	Q 3 Yr 2	Q 4 Yr 2	Q 1 Yr 3	Q 2 Yr 3	Q 3 Yr 3	Q 4 Yr 3	Q 1 Yr 4	Q 2 Yr 4	Q 3 Yr 4	Q 4 Yr 4	Q 1 Yr 5	Q 2 Yr 5	Q 3 Yr 5	Q 4 Yr 5	Q 1 Yr 6	Q 2 Yr 6
Reports																						
Interim Report																						
Summative Report																						
Survey-based outcomes																						
Survey development																						
Survey data collection																						
Analyses																						
Report																						
Process Evaluation																						
Document Review																						
Script development																						
Tiered interviews																						
Qualitative interview and content analysis																						
Report production																						
Healthy Behaviors																						

QUARTER YEAR	Q 1 Yr 1	Q 2 Yr 1	Q 3 Yr 1	Q 4 Yr 1	Q 1 Yr 2	Q 2 Yr 2	Q 3 Yr 2	Q 4 Yr 2	Q 1 Yr 3	Q 2 Yr 3	Q 3 Yr 3	Q 4 Yr 3	Q 1 Yr 4	Q 2 Yr 4	Q 3 Yr 4	Q 4 Yr 4	Q 1 Yr 5	Q 2 Yr 5	Q 3 Yr 5	Q 4 Yr 5	Q 1 Yr 6	Q 2 Yr 6
Claims-based analyses																						
Member survey panel																						
Member survey cross-sectional																						
Disenrollment survey																						
Disenrollment interviews																						
MCO interviews																						
Yearly Report																						
Dental Wellness Plan																						
Consumer survey																						
Dentist survey																						
Admin. claims outcomes																						
Member interviews																						
Report																						
Retroactive Eligibility																						
Stakeholder interviews																						
Enrollment surveys																						
Claims analyses																						
Interim Report																						
Enrollment data analyses																						
State comparison																						

QUARTER YEAR	Q 1 Yr 1	Q 2 Yr 1	Q 3 Yr 1	Q 4 Yr 1	Q 1 Yr 2	Q 2 Yr 2	Q 3 Yr 2	Q 4 Yr 2	Q 1 Yr 3	Q 2 Yr 3	Q 3 Yr 3	Q 4 Yr 3	Q 1 Yr 4	Q 2 Yr 4	Q 3 Yr 4	Q 4 Yr 4	Q 1 Yr 5	Q 2 Yr 5	Q 3 Yr 5	Q 4 Yr 5	Q 1 Yr 6	Q 2 Yr 6
Provider interviews																						
Final Report																						
Cost Sharing																						
Consumer surveys																						
Claims analyses																						
Interim Report																						
HCUP ER analyses																						
Final Report																						
Cost and sustainability																						
Stakeholder interviews																						
Administrative documents																						
Claims analyses																						
Interim Report																						
IHA data analyses																						
State Comparisons																						
Final Report																						
NEMT																						
Stakeholder interviews																						
Survey development																						
Survey data collection																						

QUARTER YEAR	Q 1 Yr 1	Q 2 Yr 1	Q 3 Yr 1	Q 4 Yr 1	Q 1 Yr 2	Q 2 Yr 2	Q 3 Yr 2	Q 4 Yr 2	Q 1 Yr 3	Q 2 Yr 3	Q 3 Yr 3	Q 4 Yr 3	Q 1 Yr 4	Q 2 Yr 4	Q 3 Yr 4	Q 4 Yr 4	Q 1 Yr 5	Q 2 Yr 5	Q 3 Yr 5	Q 4 Yr 5	Q 1 Yr 6	Q 2 Yr 6
Analyses																						
Report																						

Major Milestones

Deliverable Reports	Delivery Date to IME	Delivery Date to CMS
Interim Report	September 30, 2023	December 31, 2023
Summative Evaluation Report	March 31, 2026	June 30, 2026

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

Iowa Wellness Plan Summative Evaluation Report

For the Period Ending 12/31/19

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.

Contents

Tables

Figures

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.

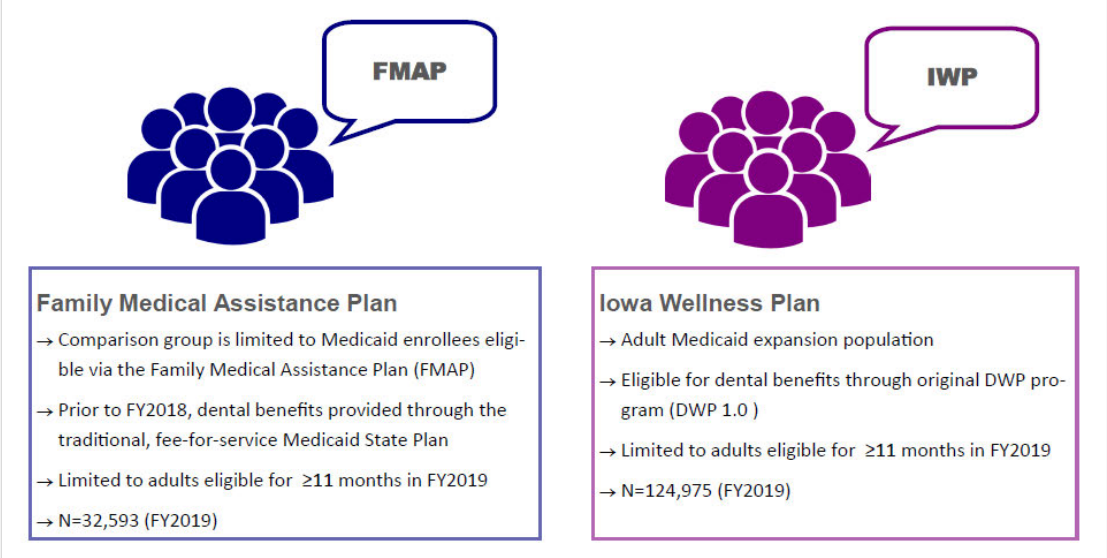
Comparison Strategy among DWP Members

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

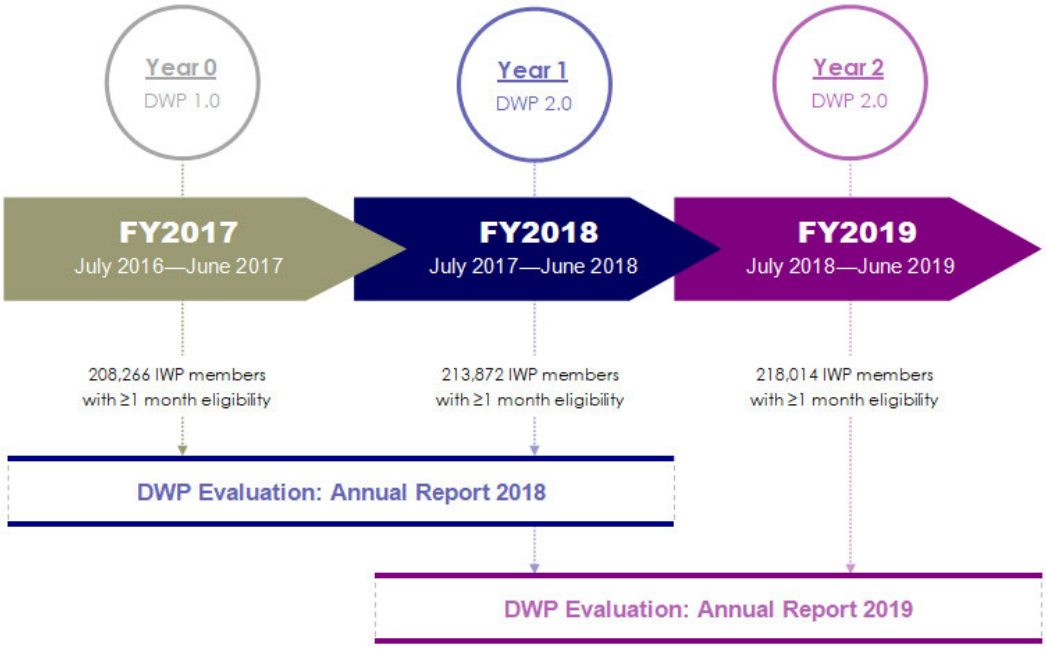


Evaluation Period

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%

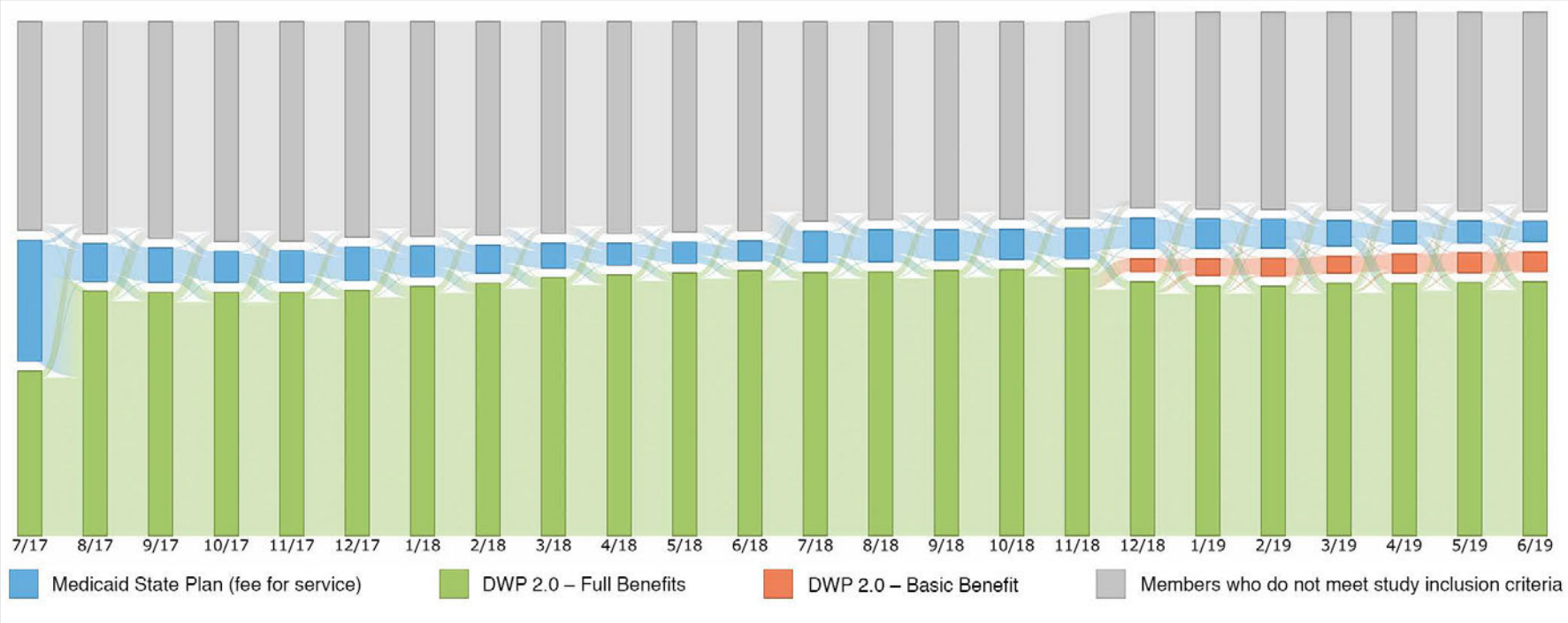
Percentages may not sum to 100 due to rounding.
‡Populations are not mutually exclusive.

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

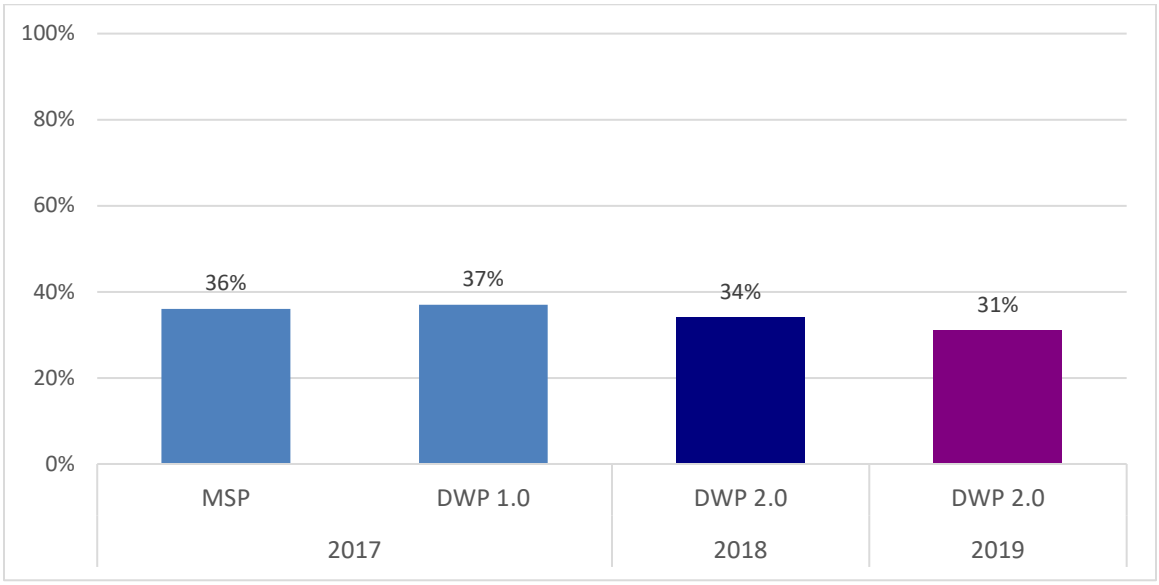
Question 1 - What are the effects of DWP 2.0 on member access to care?

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)

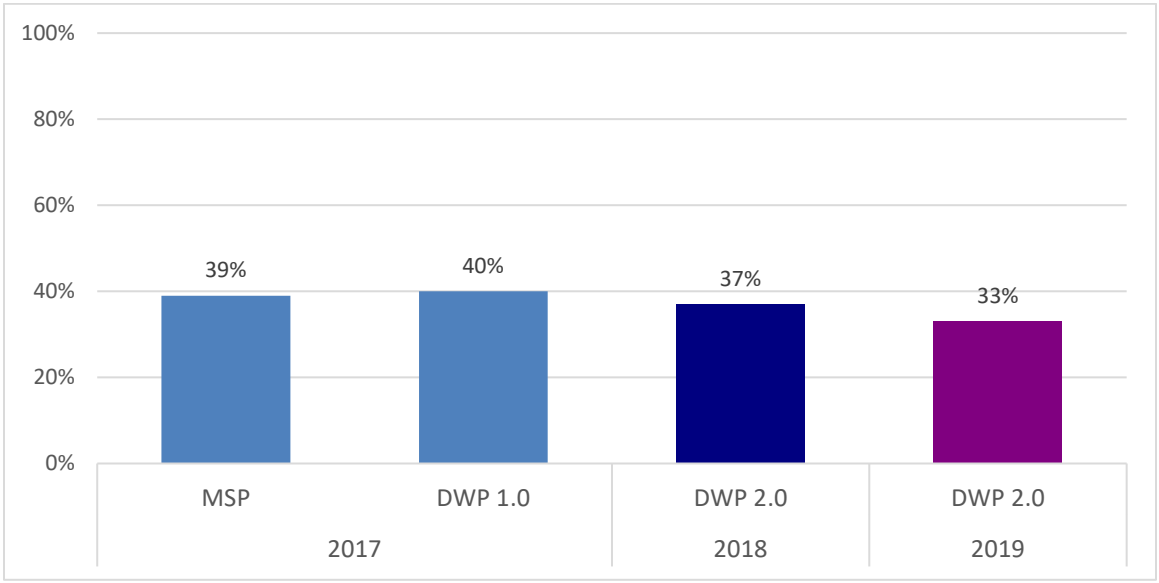


Proportions reported for DWP 2.0 refer to a program overall rate, i.e., includes former DWP 1.0 and FMAP populations.

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.

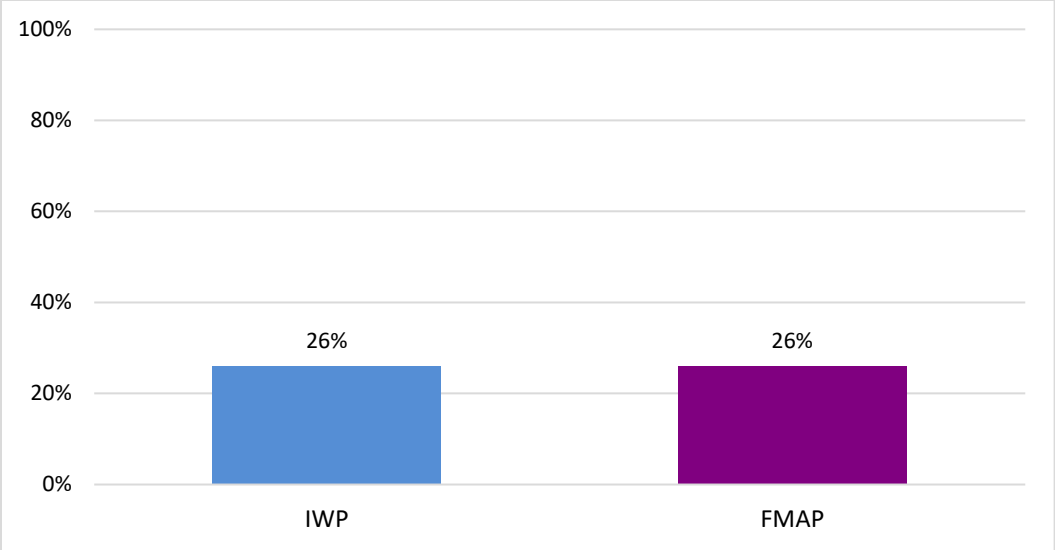
This hypothesis is tested using administrative data to examine utilization of preventive dental exams for new members. This hypothesis examines utilization of the preventive dental exam to qualify for DWP 2.0 healthy behavior requirements.

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.

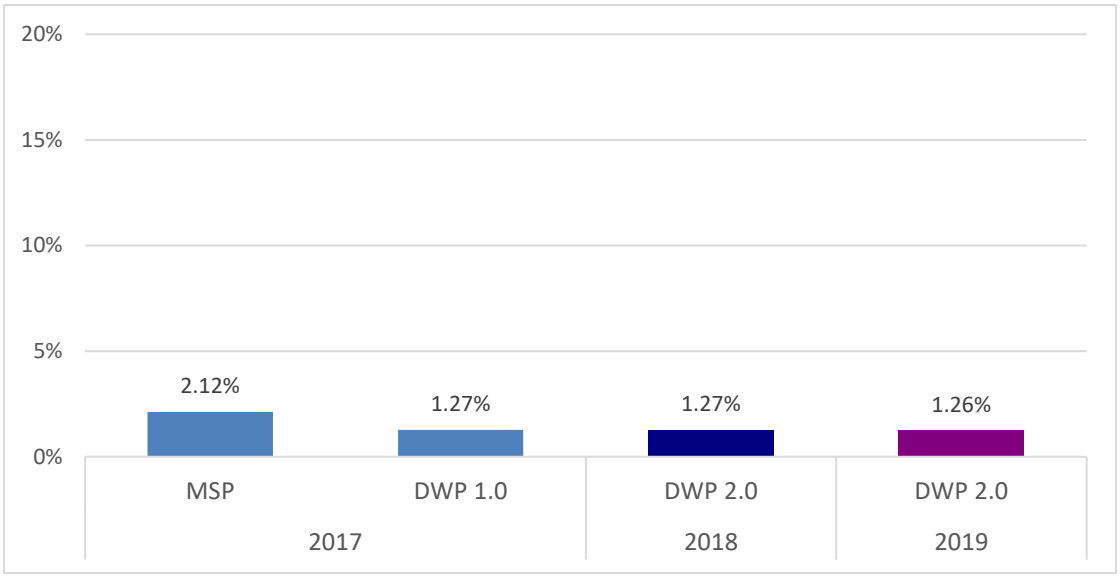
Hypothesis 1.3: DWP 2.0 members will have equal or lower use of emergency department (ED) services for non-traumatic dental conditions than either DWP 1.0 or FMAP members had prior to July 1, 2017.

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

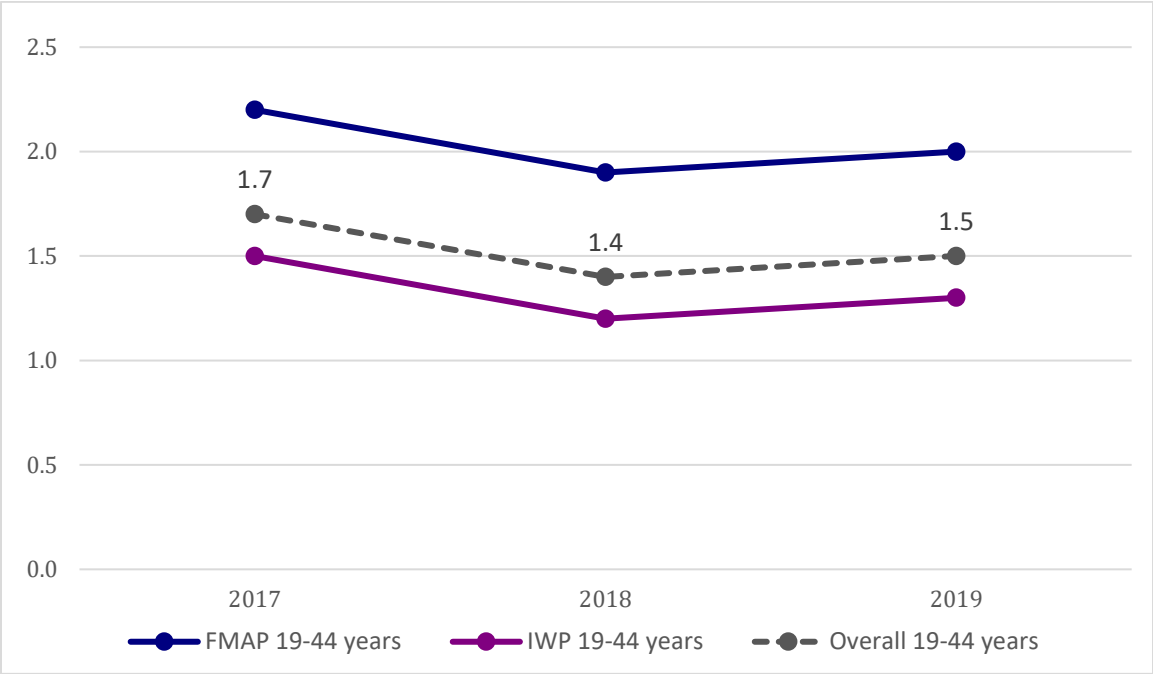


Figure 10. Rates of dental emergency department visits for non-traumatic dental conditions per 1,000 member months for members aged 45-64 years by group and year

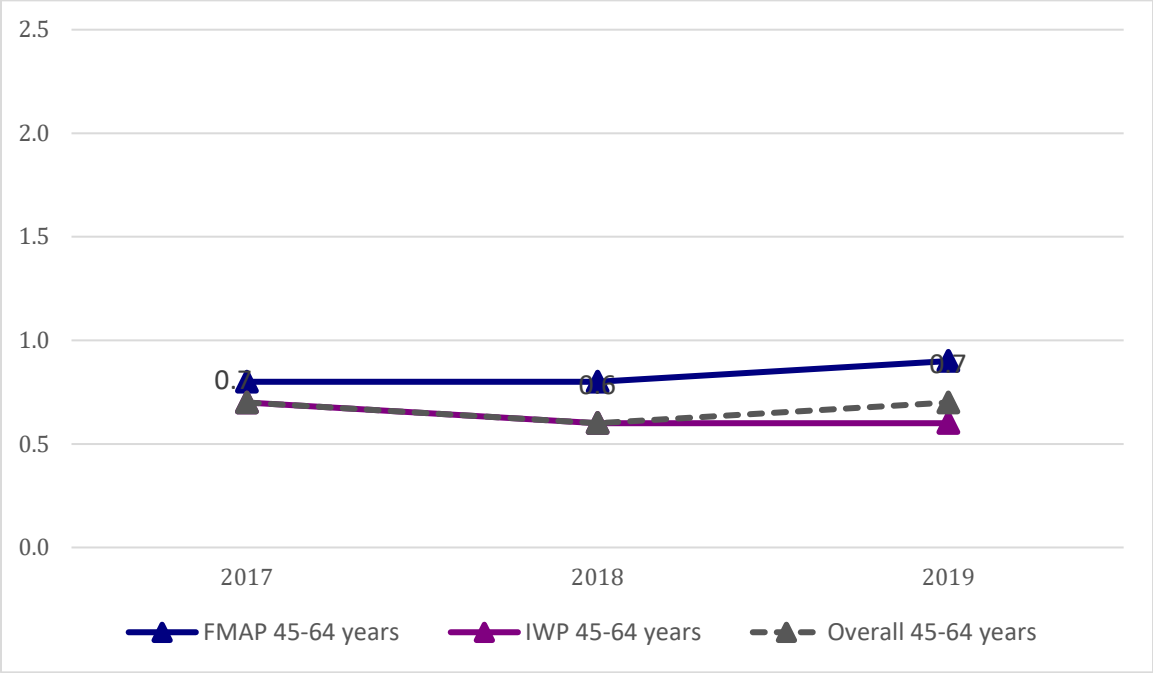
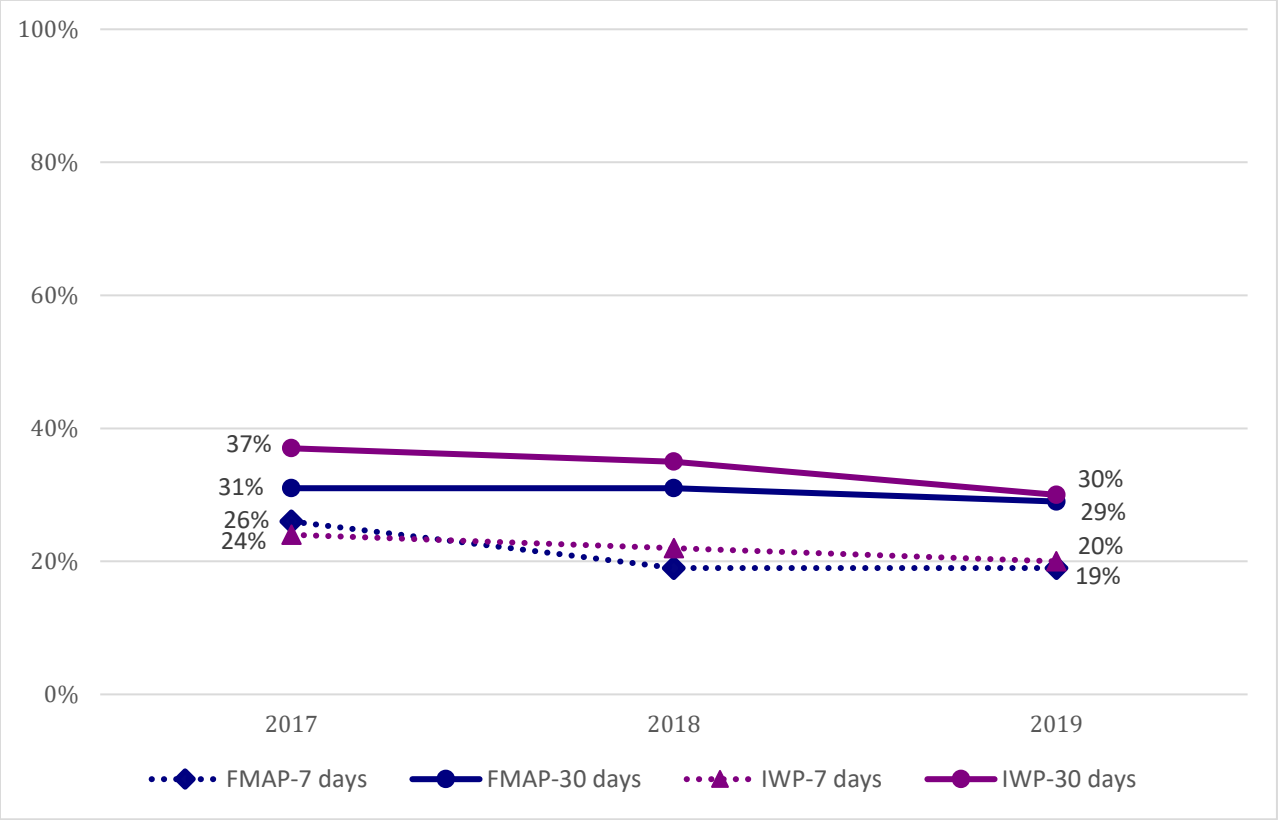


Figure 11. Percentage of individuals who followed up with a dentist 7 and 30 days after emergency department visits for non-traumatic dental conditions



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

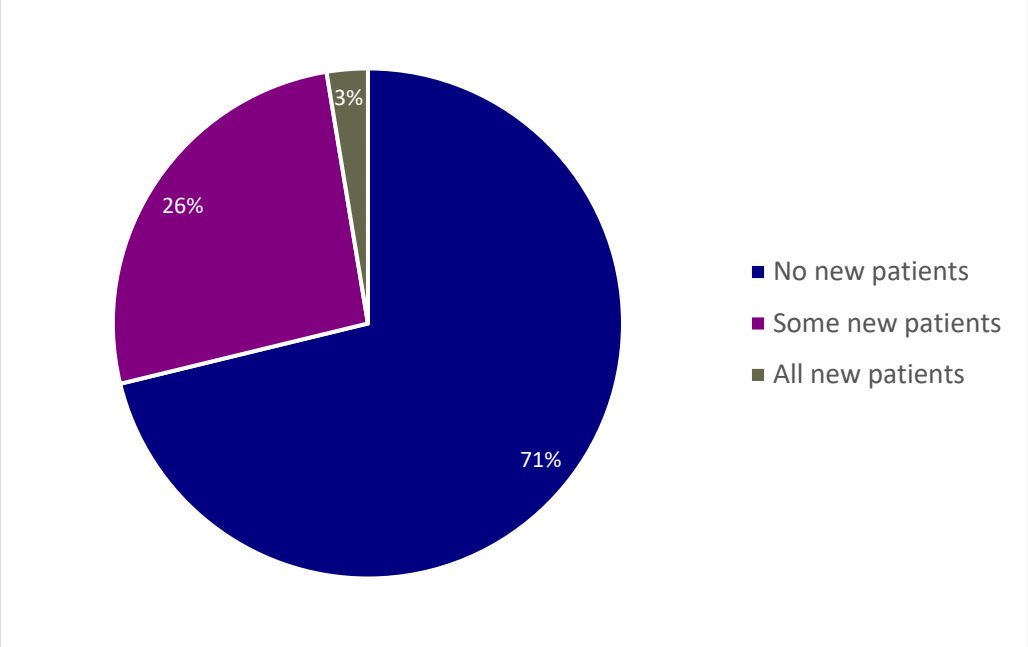
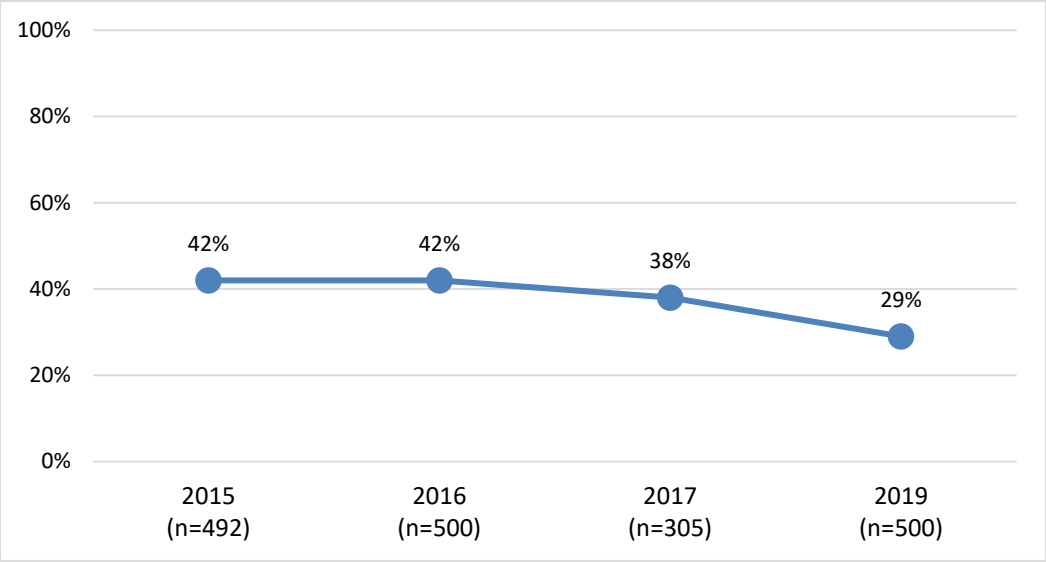


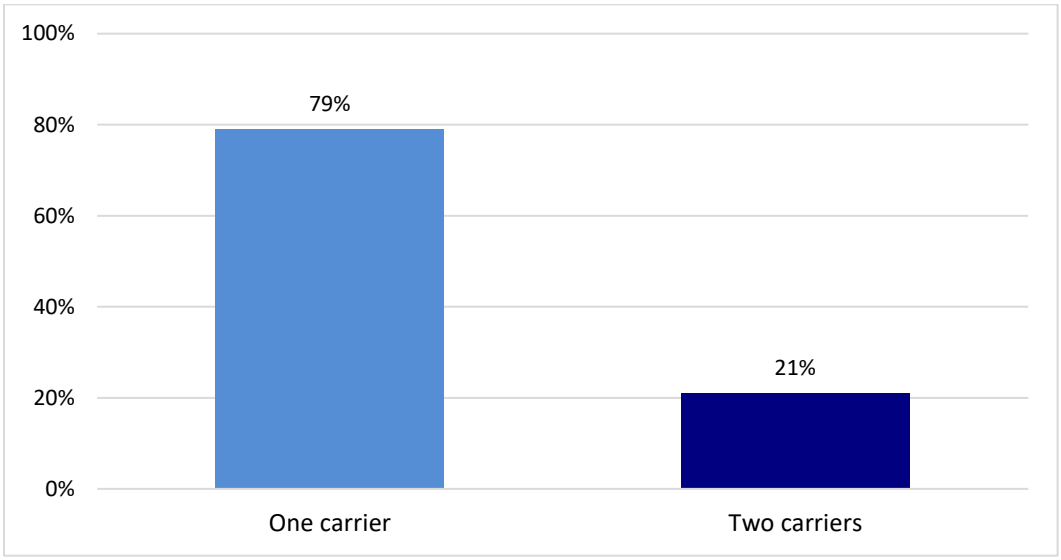
Figure 13. Self-reported acceptance of any new DWP patients over time, general dentists in private practice



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).

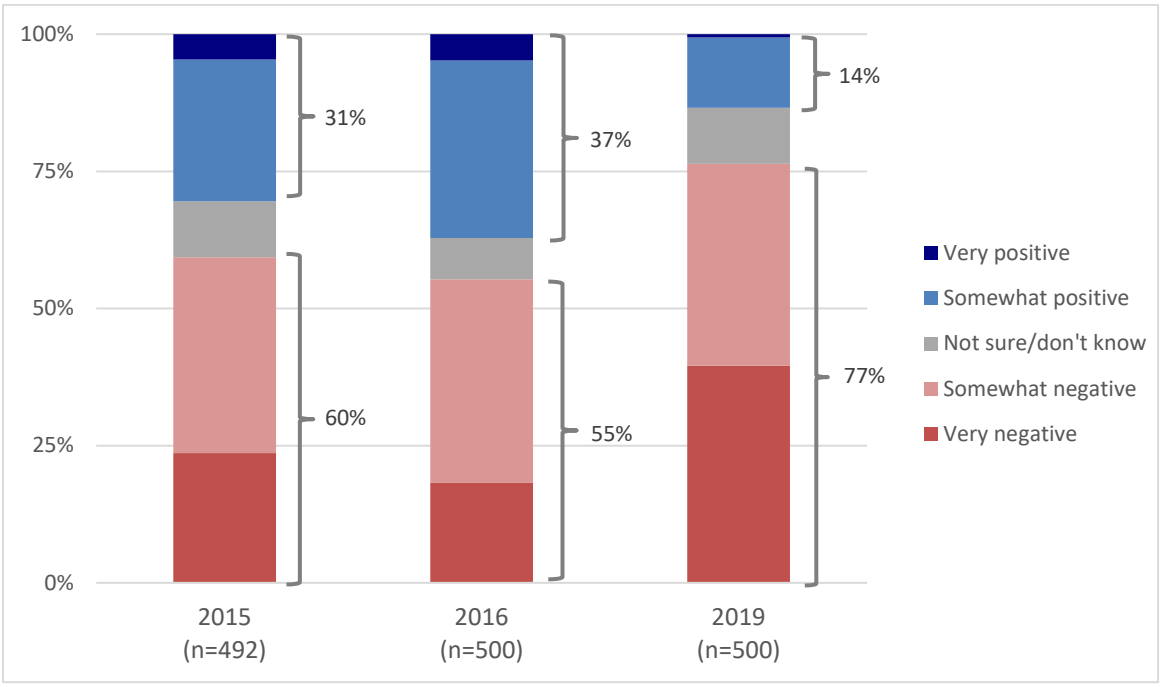
Figure 14. DWP patient acceptance by total number of carriers, general dentists accepting new DWP patients, 2019 Iowa Dentist Survey



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.

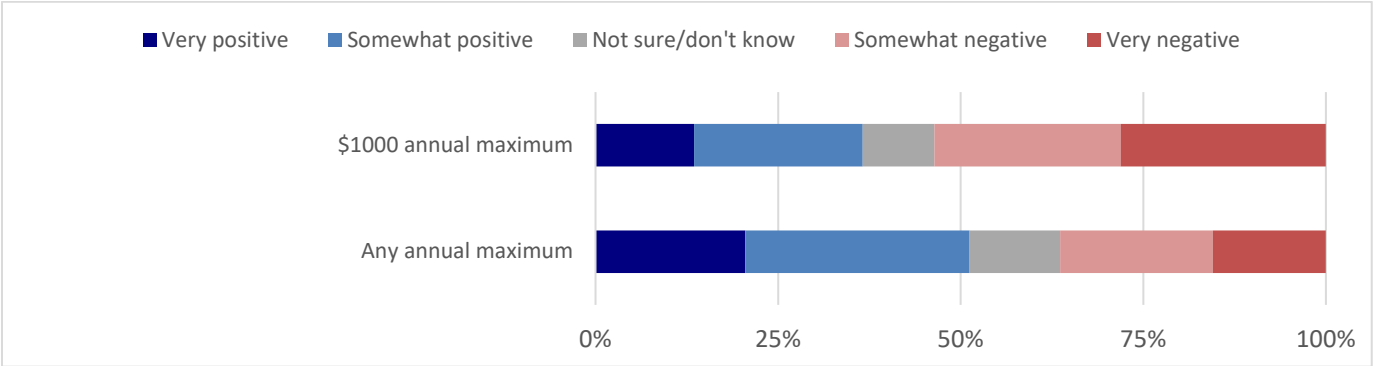
Figure 15. Dentists' overall attitude toward DWP 2.0, general dentists in private practice over time



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

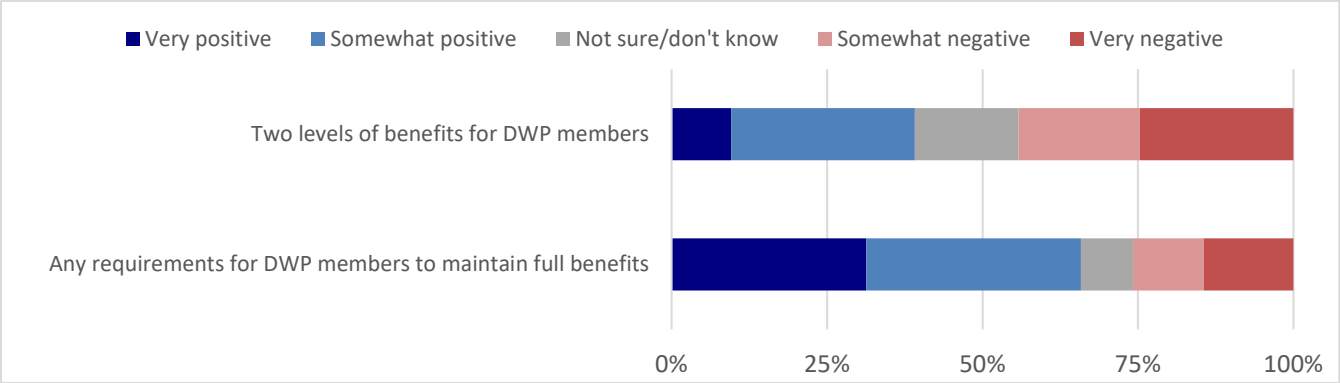
Regarding some of the specific components of the program, a majority of dentists (52%) had positive attitudes toward having *any* annual maximum; however, only 37% had favorable attitudes toward $1000 as the annual limit (Figure 16).

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



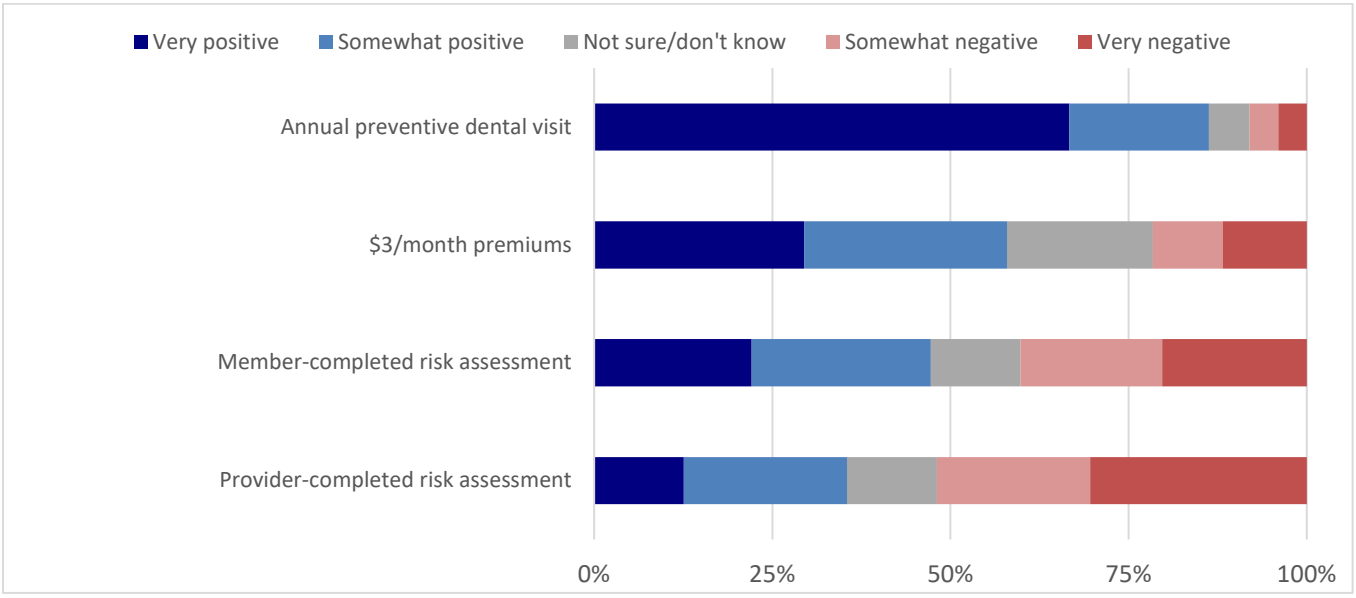
Dentists were generally favorable about having *any* requirements to maintain full benefits in general, however, were mixed about having the existing two benefit levels (Figure 17).

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



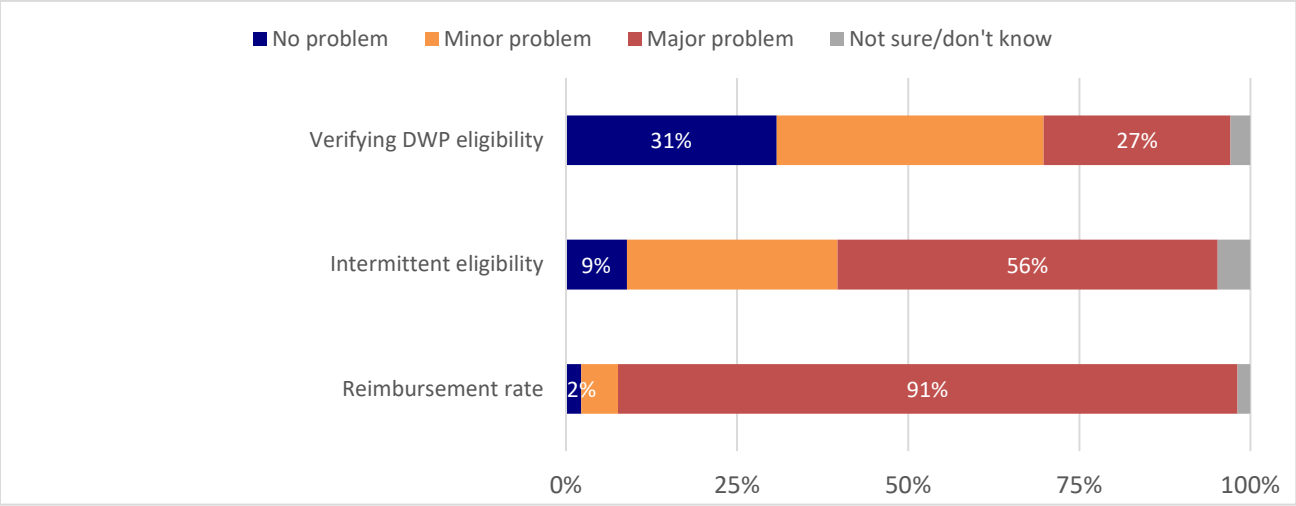
The type of program requirement dentists viewed most favorably was the annual preventive dental visit, whereas the provider-completed risk assessment was viewed least favorably (Figure 18Figure 18).

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.

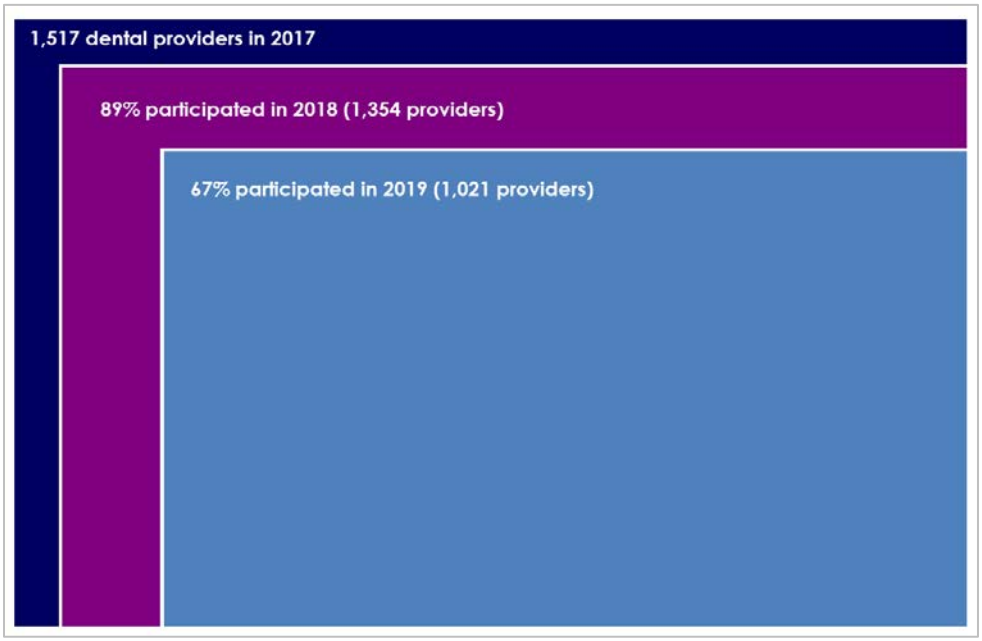
Table 5. Participating providers‡ and number of DWP patient visits* per provider

	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.

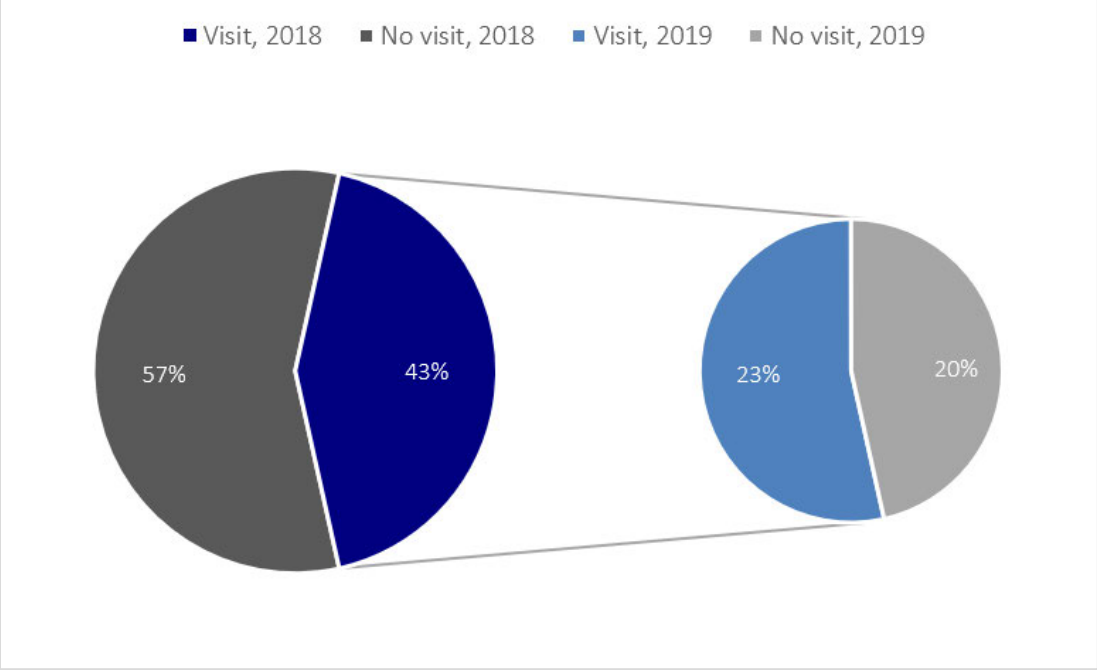
Measure 25: Routine dental examination [See Measure 4]

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.

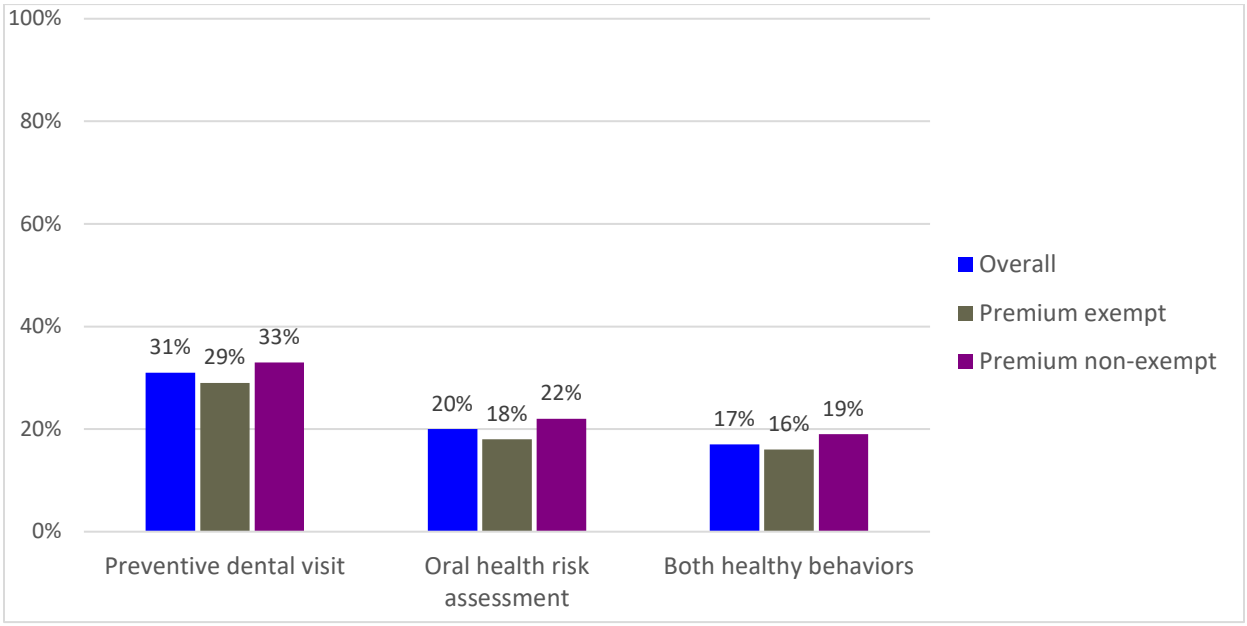
See Measure 4

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?

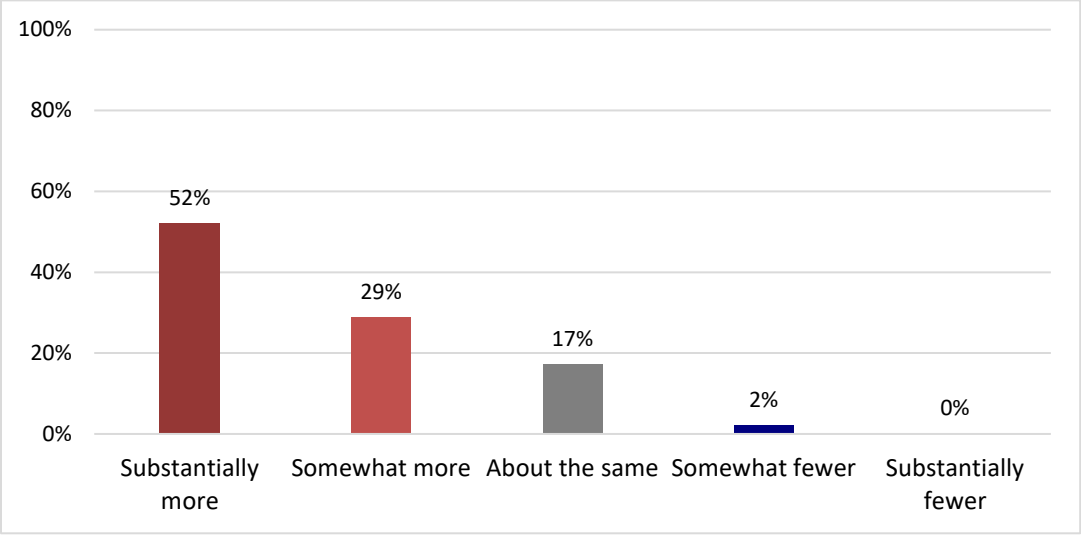
Hypothesis 4.1 DWP 2.0 member outreach services will address dentists' concerns about missed appointments.

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.

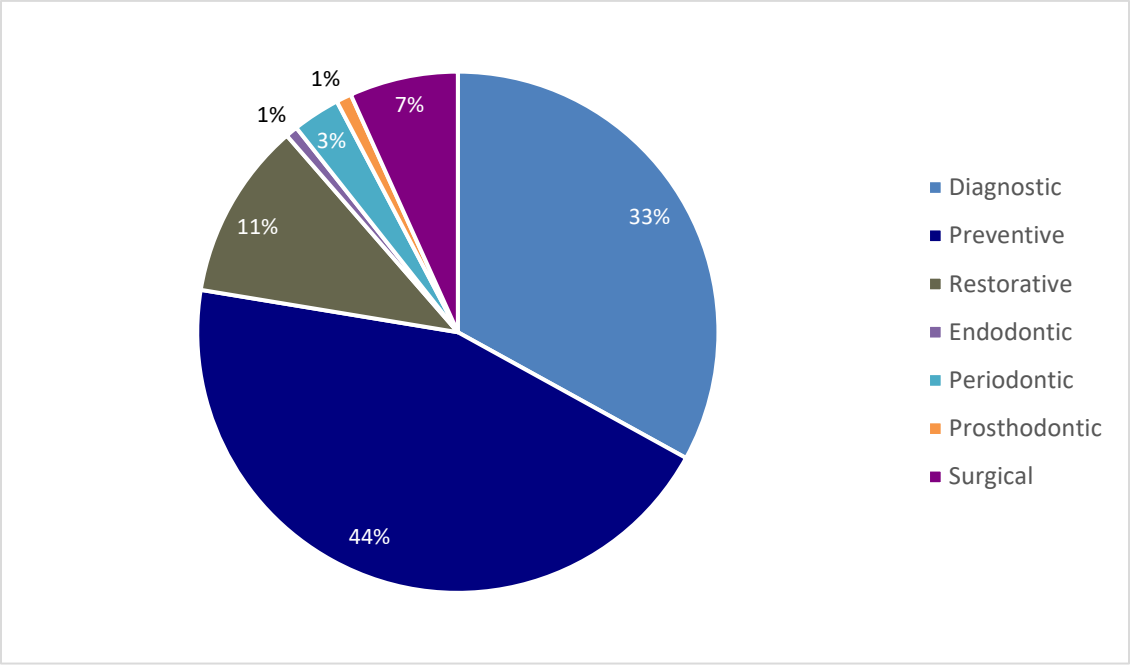
Measure 32: Utilization of specialty dental services

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

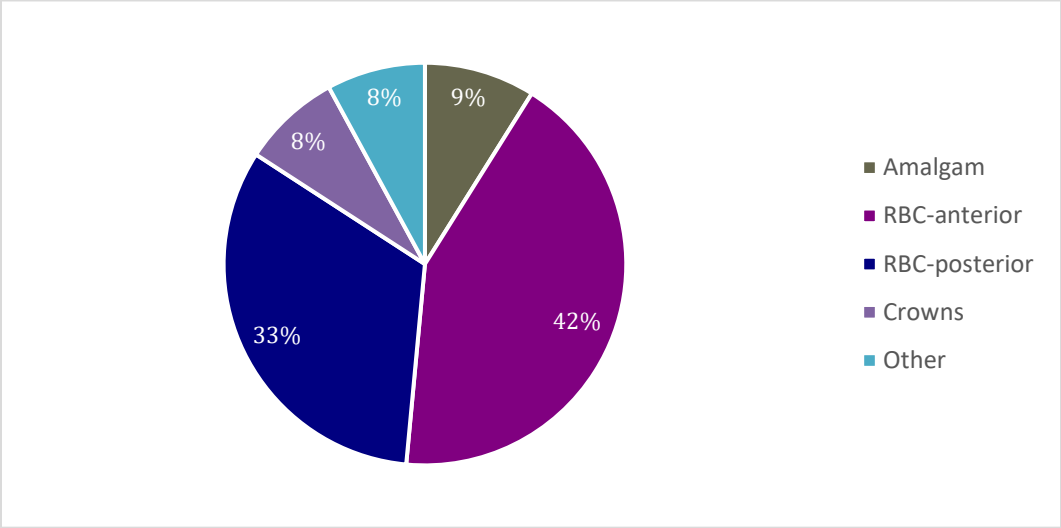
Diagnostic and Preventive Services

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.

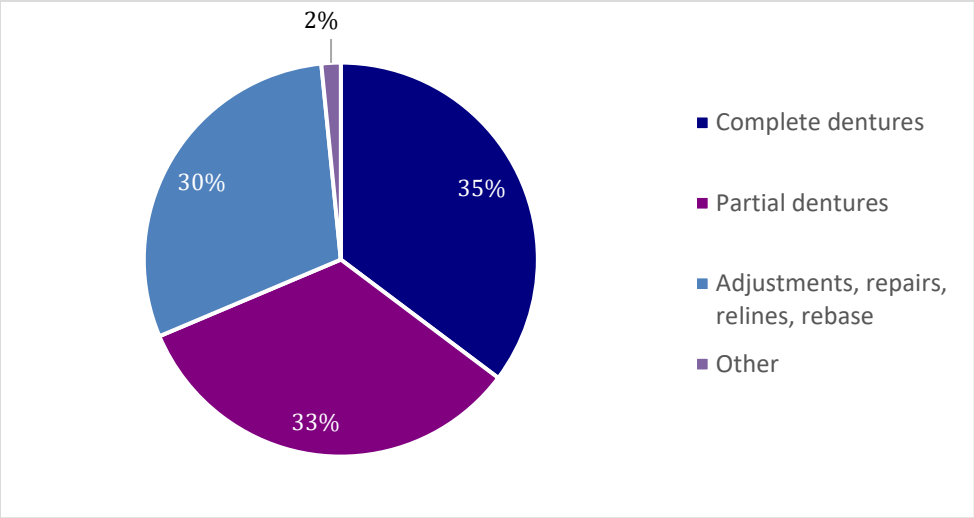
Periodontal Services

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.

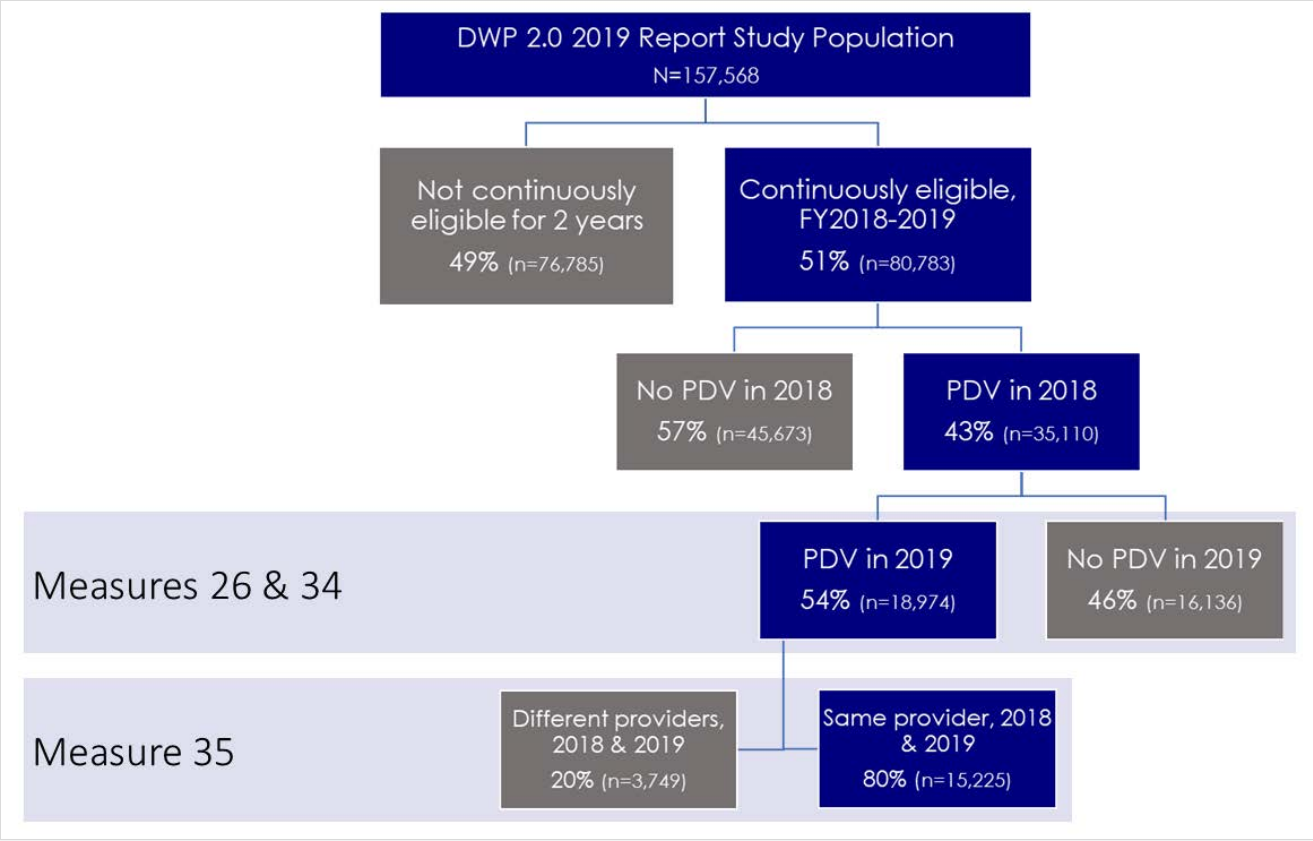
Measure 34: Care continuity – see Measure 26

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

Contents

Measures

Figures

Tables

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

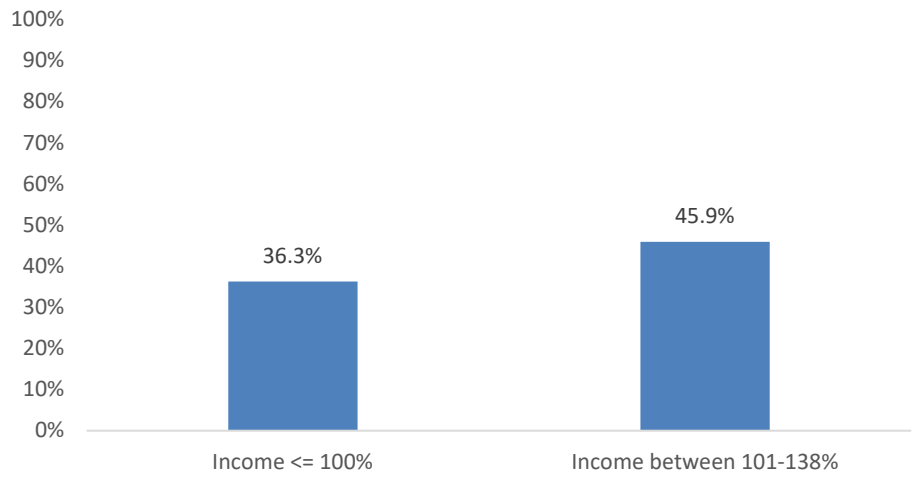
*Note: Values for average age, number of moves, number of ER visits, number of Rx drugs, and number of chronic conditions are means within the lower-income and higher-income groups by completion of both healthy behavior requirements, respectively. Values for all other variables are proportions of the 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

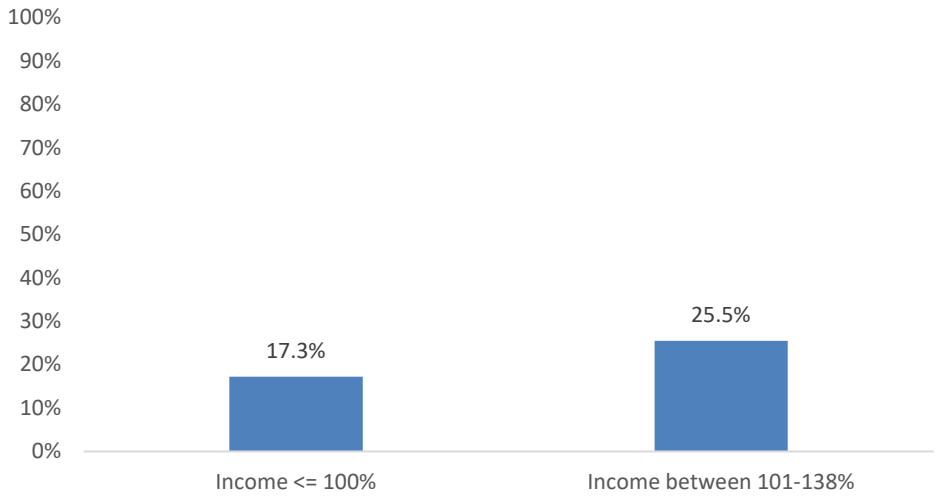


Note: Significantly different at p<0.001.

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

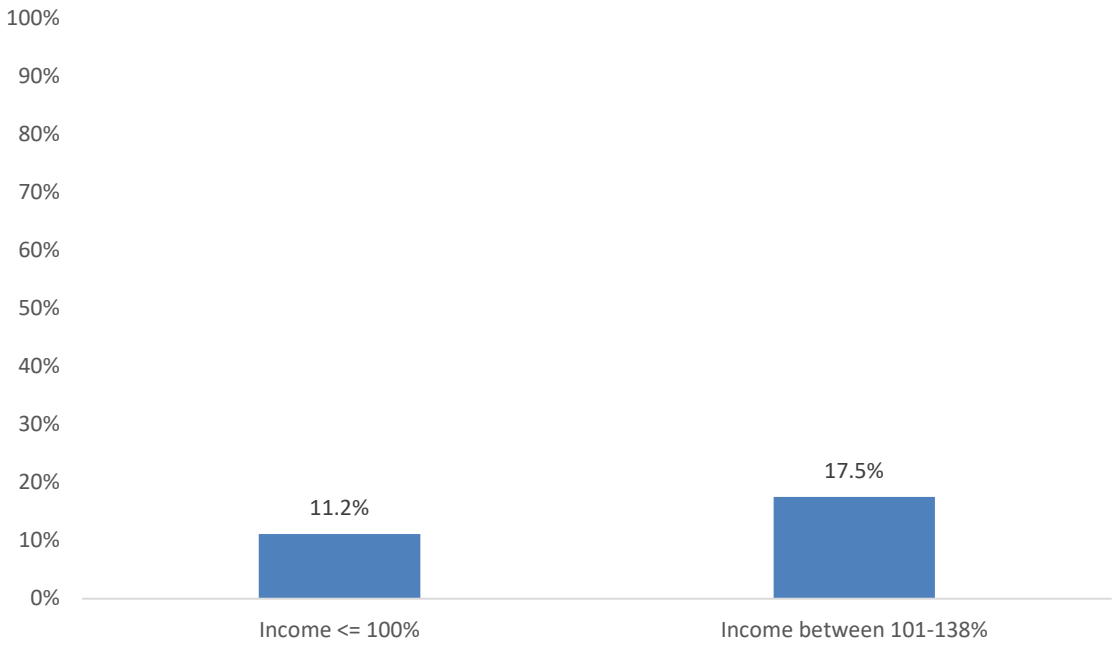


Note: Significantly different at p<0.001.

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.

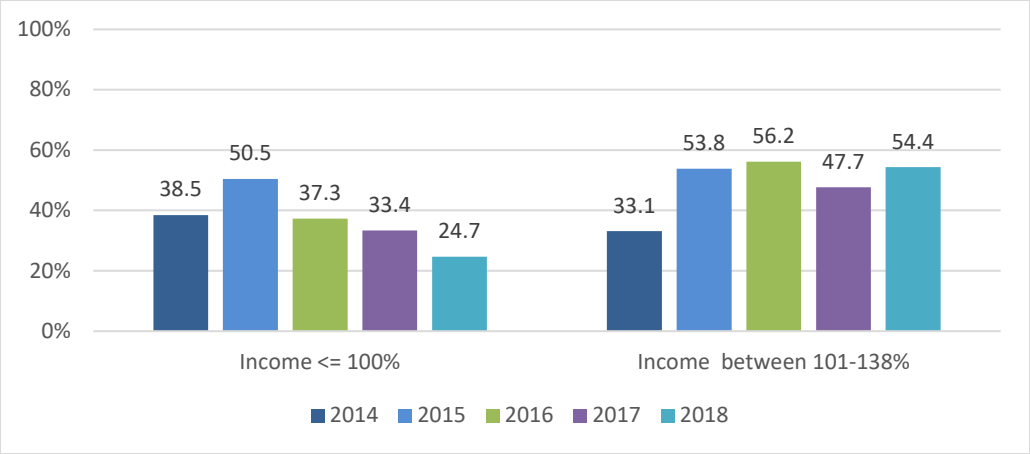
Comparing Annual Rates of Healthy Behavior Completion, 2014 to 2018

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

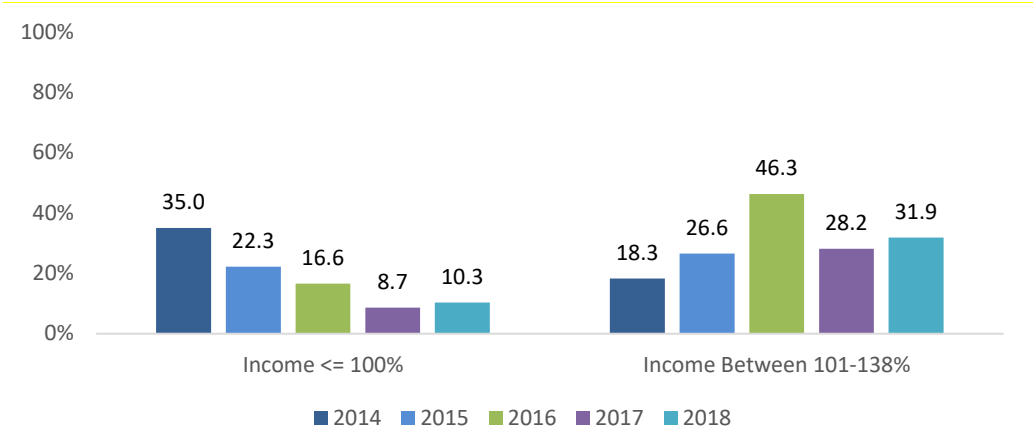


Note: Both the differences between programs within years and the differences between years within programs are statistically significant ($p<0.05$), except for years 2014 vs. 2016 of the lower income group ($p=0.127$) and years 2015 vs. 2016 ($p=0.764$), 2015 vs. 2018 ($p=1.000$), and 2016 vs. 2018 ($p=0.957$)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

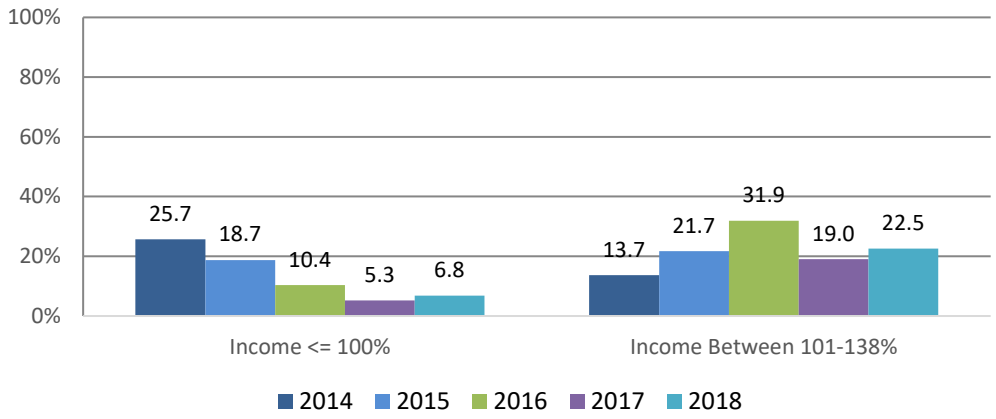


Note: Both the differences between programs within years and the differences between years within programs are statistically significant ($p<0.05$), except for years 2015 vs. 2017 of the higher income group ($p=0.955$).

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.

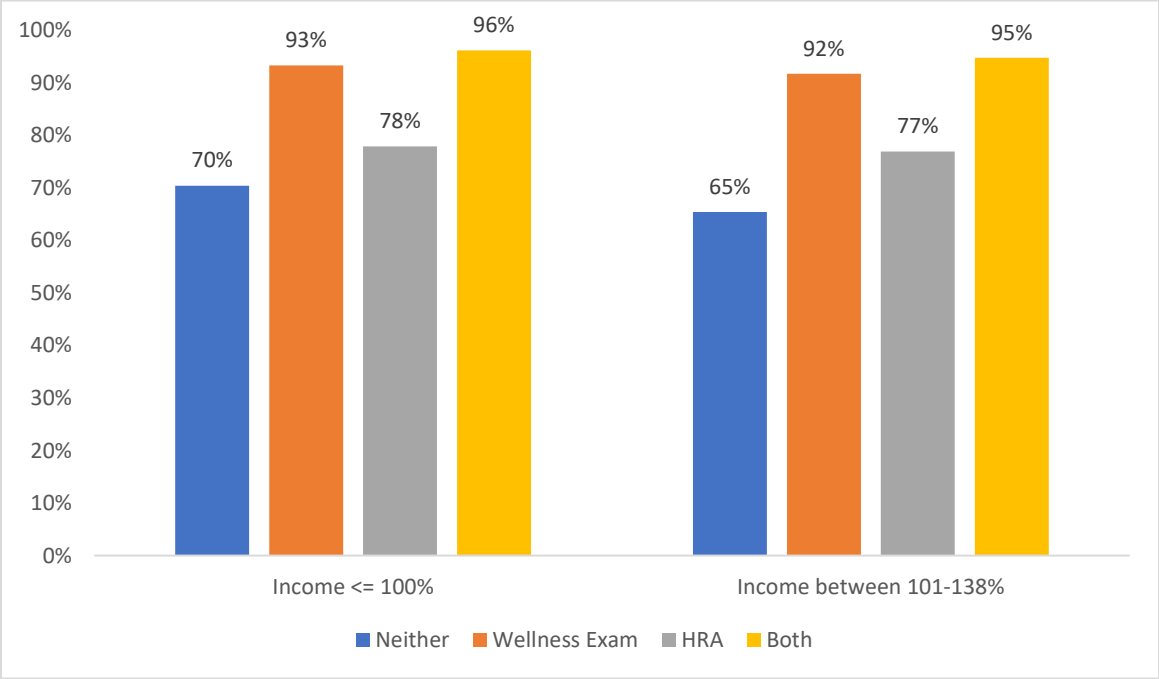
Results of Bivariate Analyses

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

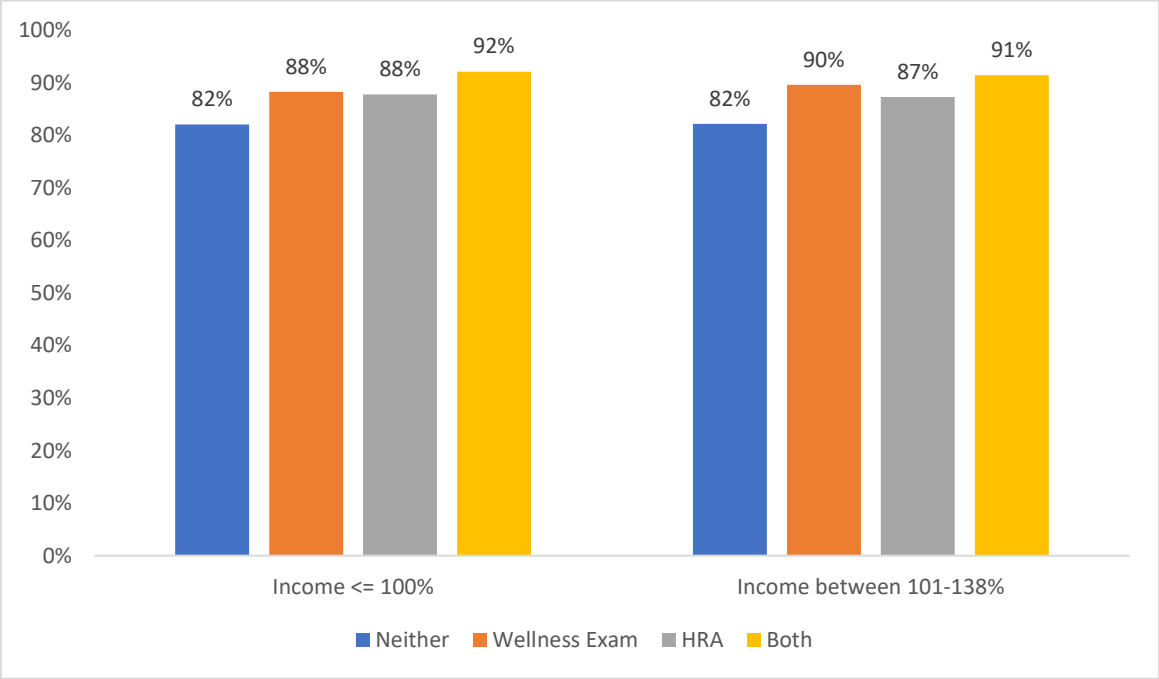
* Neither vs. heath risk assessment is significant at p<0.001

^ 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

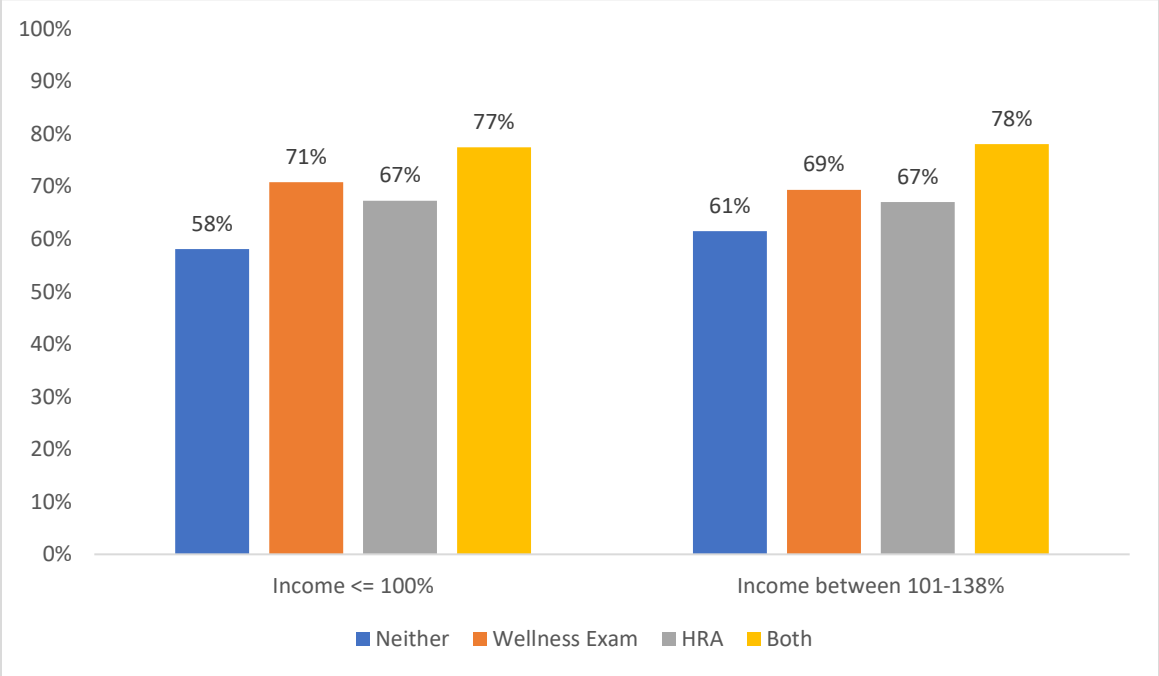
* Neither vs. heath risk assessment is significant at p<0.001 for low-income and p<0.01 for high-income

^ 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

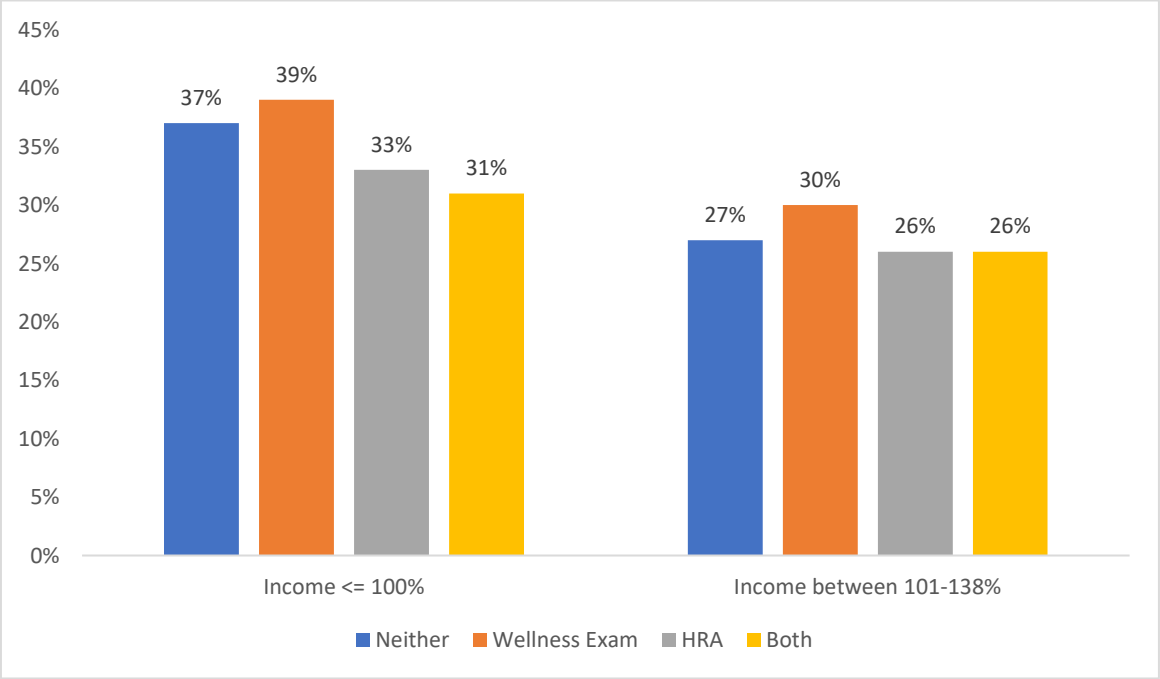
* Neither vs. heath risk assessment is significant at p<0.001 for low-income and p<0.05 for high-income

^ 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

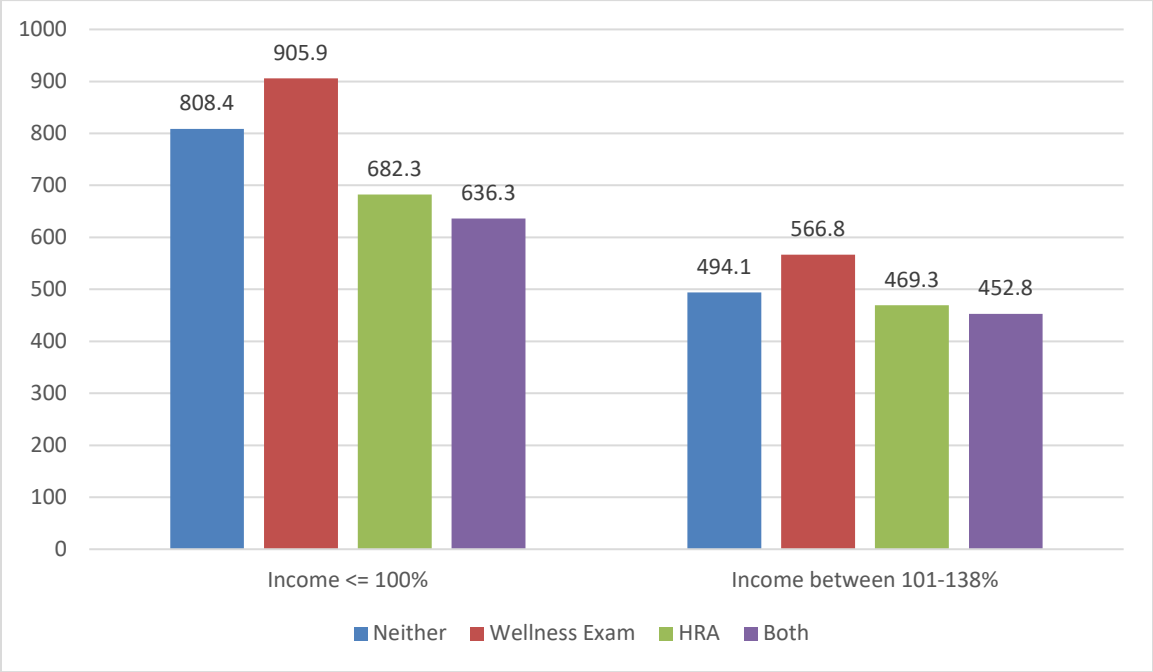


† Neither vs. wellness exam is significant at p<0.001

* 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

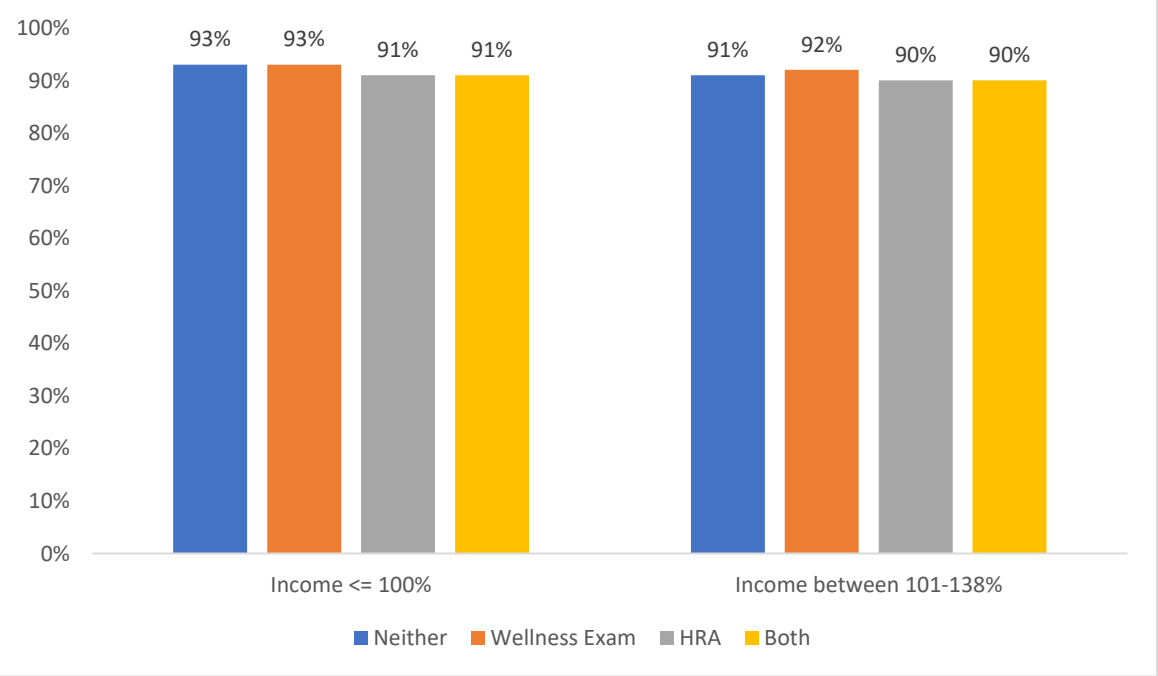
* Neither vs. heath risk assessment is significant at p<0.001 for low-income group only

^ 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

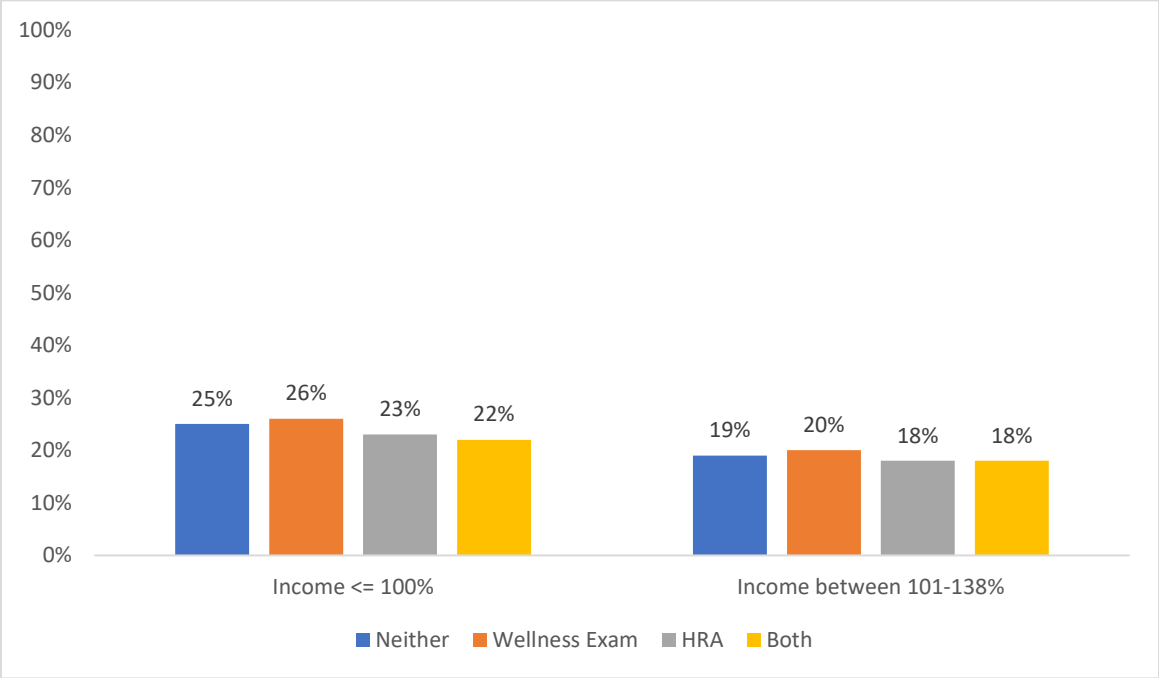
* Neither vs. heath risk assessment is significant at p<0.001 for low-income group only

^ 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

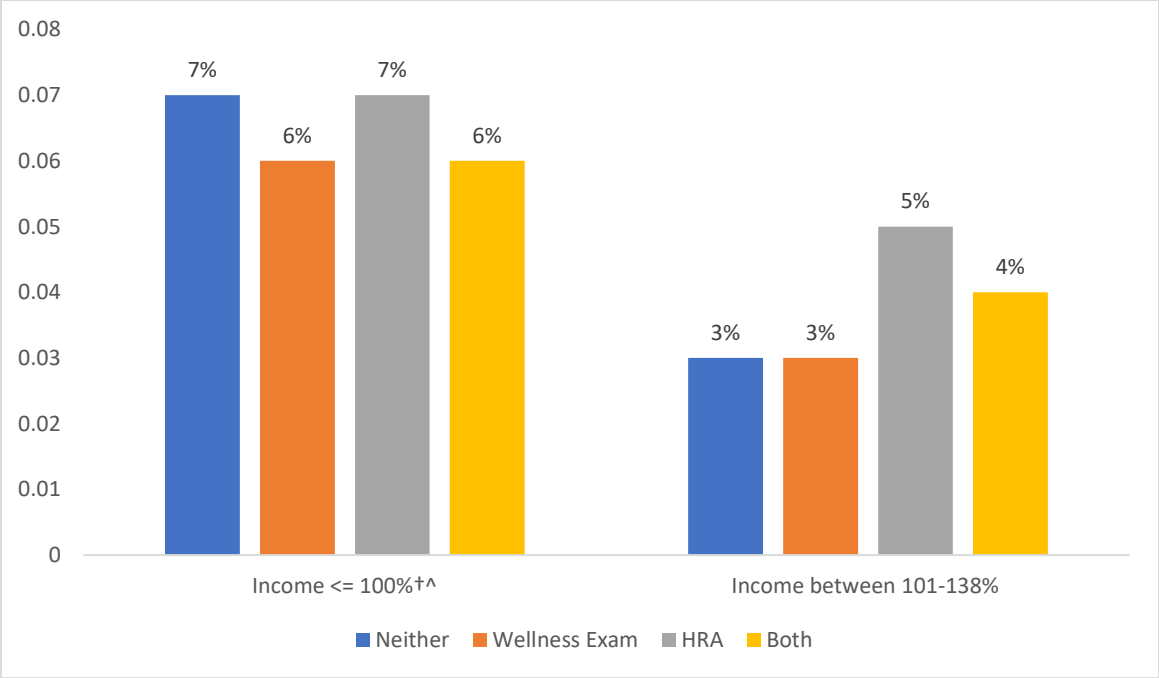
* Neither vs. heath risk assessment is significant at p<0.001 for low-income group only

^ 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

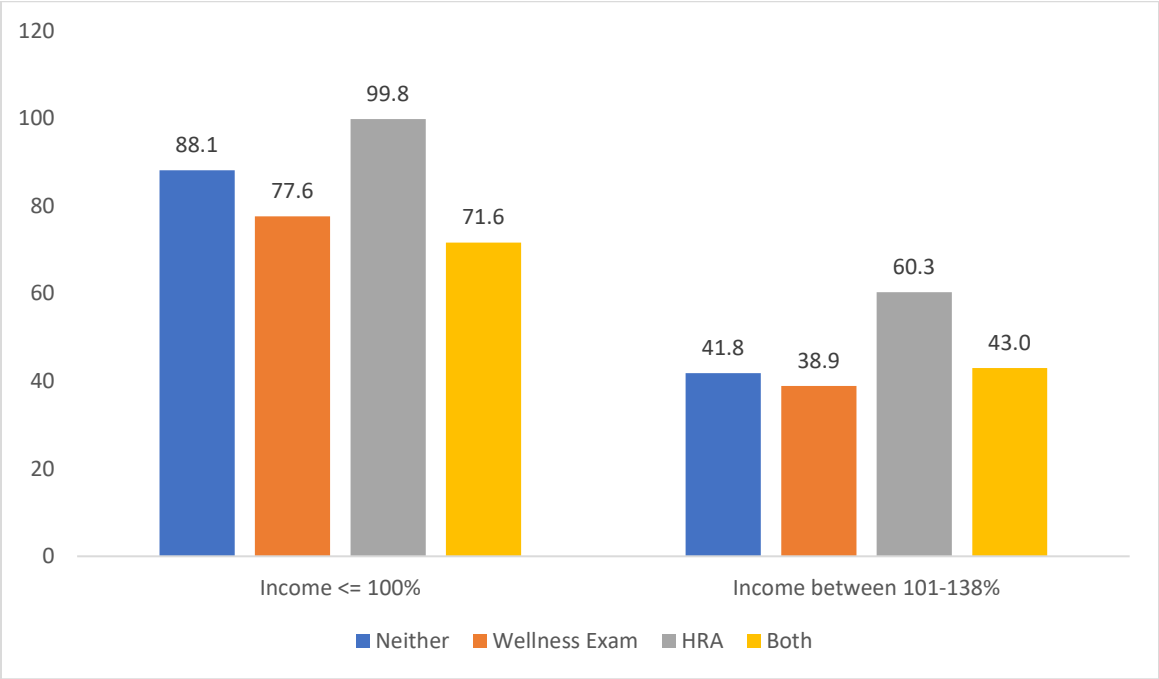


† Neither vs. wellness exam is significant at p<0.001 for low-income group only

* 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

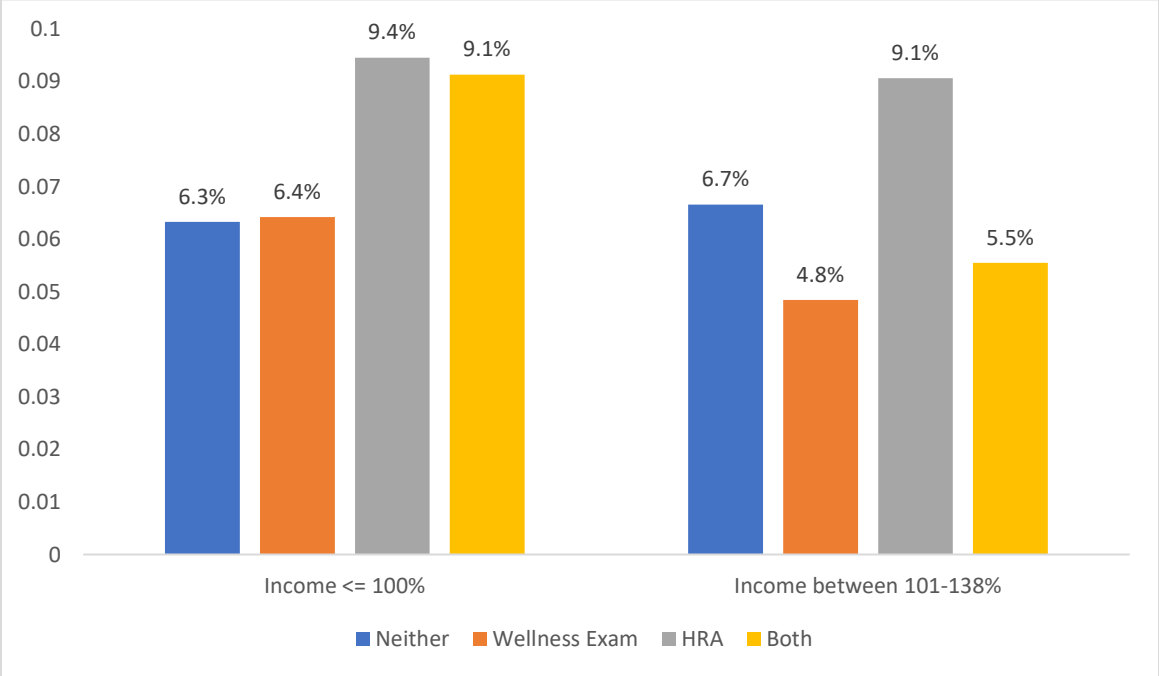
* Neither vs. heath risk assessment is significant at p<0.001

^ 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

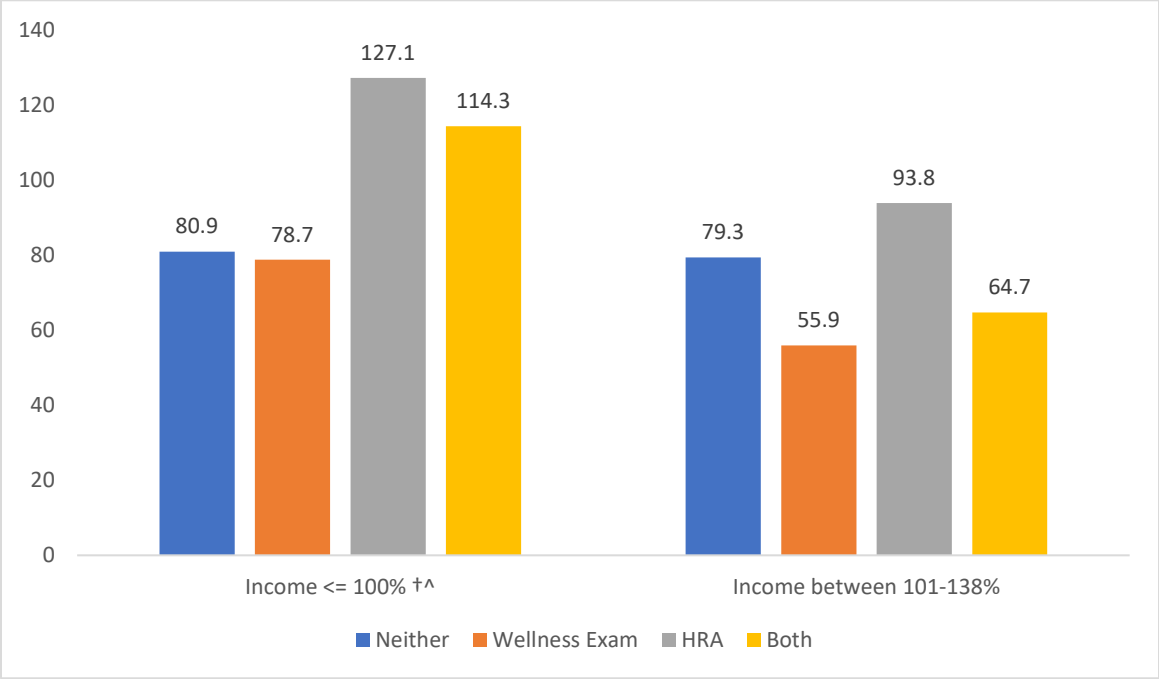


† Neither vs. wellness exam is not significant for either group

* 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

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