Iowa Medicaid Enterprise

Dental Plans
Report: State Fiscal Year 2019
Performance Data

Contents

Executive Summary	3
Plan Enrollment By Age	4
Plan Disenrollment by MCO	5
Plan Enrollment by MCO	5
Consumer Protections and Supports	6
Program Management	9
Dental Specific	19
Healthy Behaviors	20
Financials	21
Program Integrity	23
Appendix: Glossary	25

Executive Summary

Like all states, Iowa's Medicaid program must comply with all applicable federal program requirements. In addition to meeting requirements, states are granted considerable flexibility to tailor their Medicaid program to meet the specific priorities, demographics and constraints they face. Under the Medicaid program, dental services are an "optional" category of services for adults 21 years and older (dental benefits for individuals under the age of 21 are a mandatory benefit as part of the Early and Periodic Screening, Diagnostic and Treatment services as defined in section 1905(r) of the Social Security Act).

As an optional service, states choosing to provide adult dental benefits under their Medicaid program may determine the amount, duration, and scope of dental services they will furnish. Beginning in May, 2014, the Centers for Medicaid and Medicare Services (CMS) approved Iowa's request to offer adult dental benefits through a managed care model under a program called the Dental Wellness Plan (DWP) to members enrolled in the Iowa Health and Wellness Plan. In July, 2017 this model expanded to include all Medicaid enrollees 19 and over. Under managed care, DWP services are covered through dental plans contracted with the state and offered as a choice to members. Children enrolled in Medicaid or CHIP (but not in Hawki) are currently served under the traditional Fee for Services model administered directly by the Department of Human Services.

Performance monitoring and data analysis are critical components in assessing how well the dental plan administrators are maintaining and improving the quality of care delivered to members. The monthly data reports are a snapshot of information on major contract compliance areas and member enrollment. The department examines the data from a performance and compliance perspective and conducts further analysis if any issues are identified.

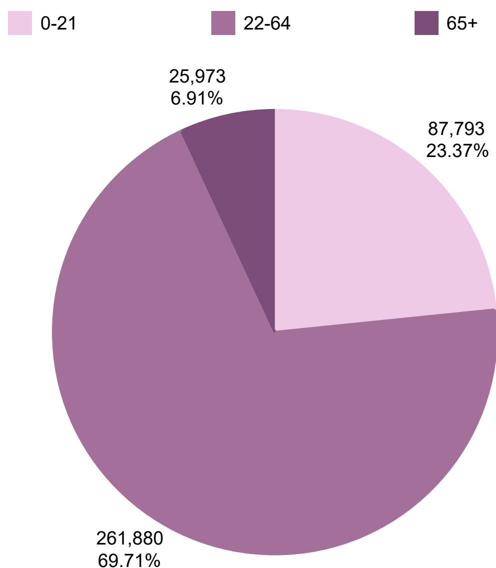
Over time, the data experience will grow and produce trend information that will allow us to examine if the dental plans are accomplishing health outcomes and promoting quality in the health care delivery system, in addition to meeting contract requirements. Quarterly reports will include additional data analysis and review of trends.

The dental plans include:

- Delta Dental of Iowa for Dental Wellness Plan (DWP) and Hawki
- Iowa Medicaid Enterprise (IME)
- MCNA Dental for Dental Wellness Plan (DWP)

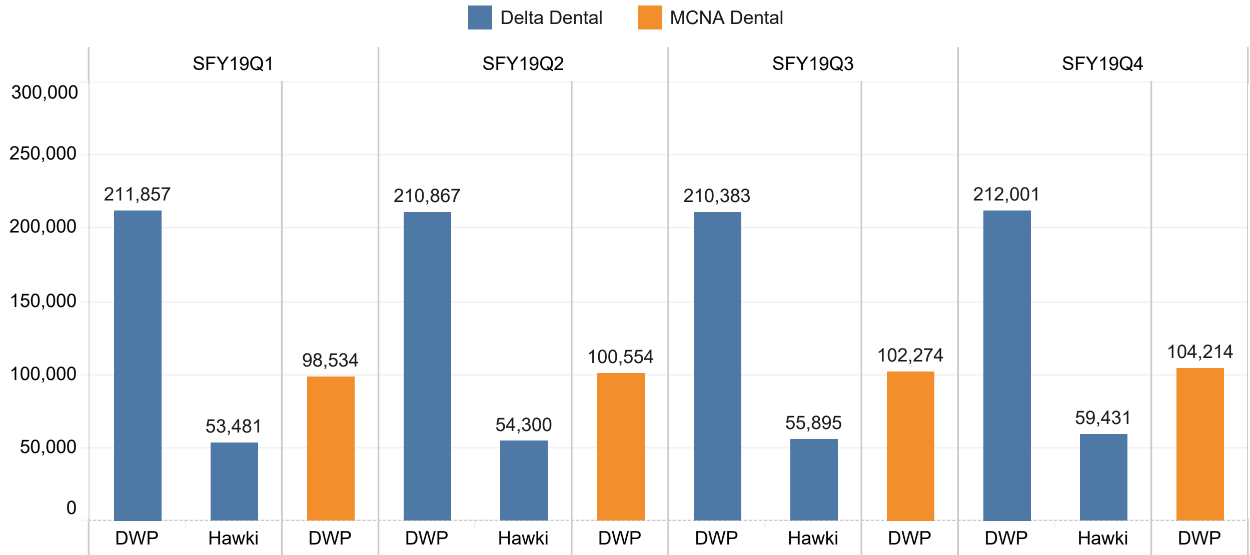
Not all Medicaid members have dental coverage. For example, members who solely qualify for the Family Planning Program or Three Day Emergency coverage do not received dental benefits. Those members covered through the Program of All Inclusive Care for the Elderly (PACE) includes dental but is paid under a single, comprehensive capitation.

Dental Plan Enrollment by Age



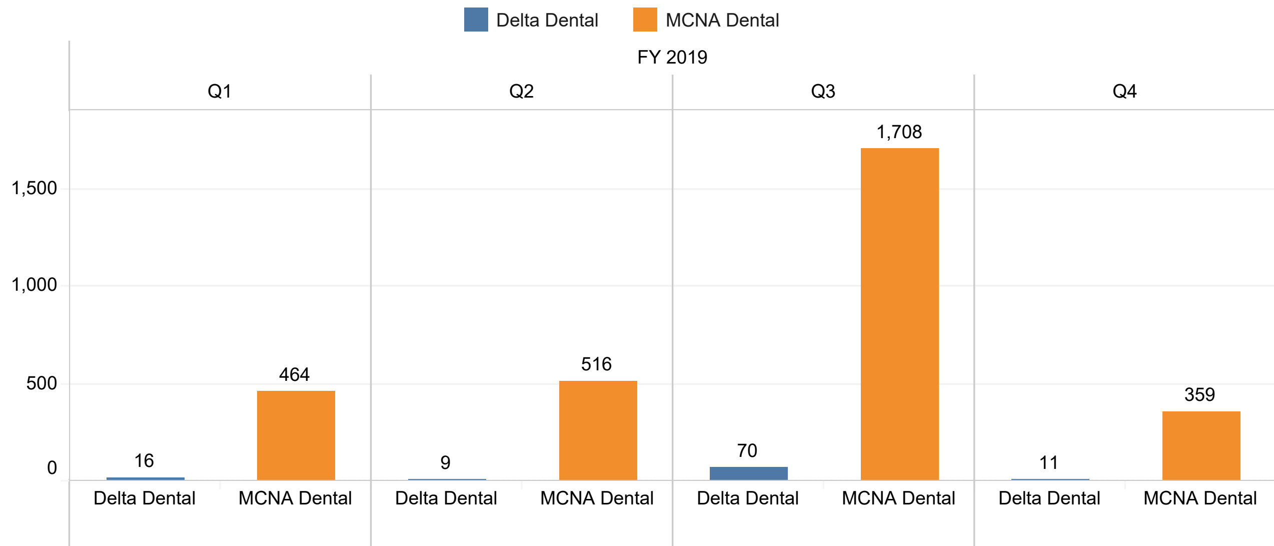
* June 2019 enrollment data as of July 10th, 2019 - data pulled on other dates will not reflect the same numbers due to reinstatements and eligibility changes. This includes hawk- enrollees. 296,046 members remain in Fee-for-Service.

Plan Enrollment by Dental Plan



* June 2019 enrollment data as of Julyl 10, 2019 – data pulled on other dates will not reflect the same numbers due to reinstatements and eligibility changes.

Plan Disenrollment By Dental Plan



* June 2019 enrollment data as of July 10, 2019 – data pulled on other dates will not reflect the same numbers due to reinstatements and eligibility changes. SFY19 Q3 spike attributed to March 2019 open enrollment period.

Consumer Protection and Support

Dental Plan Member Grievances and Appeals

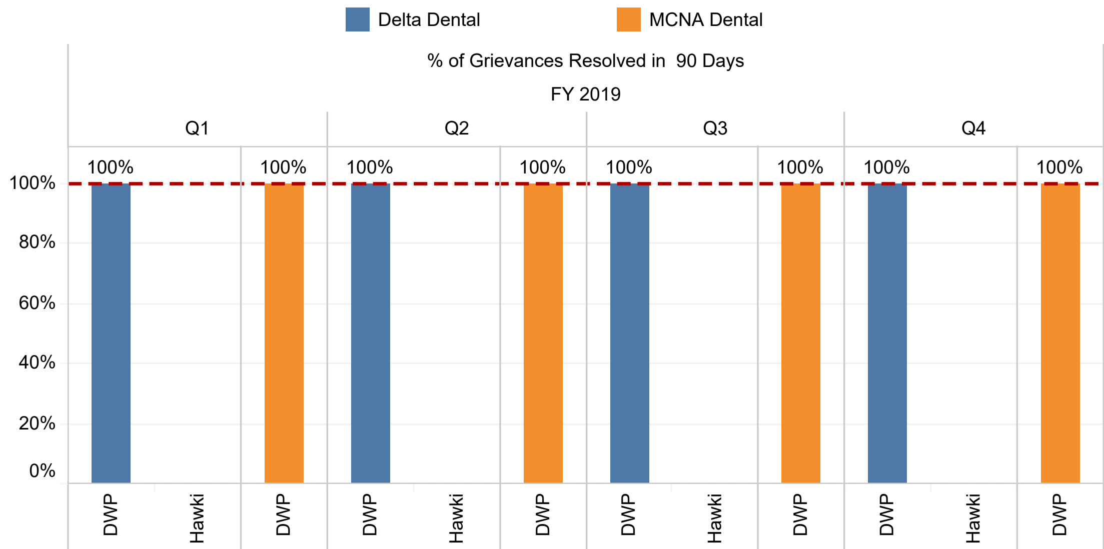
Grievance and appeal data demonstrates the level to which the member is receiving timely and adequate levels of service. If a member does not agree with the level in which services are authorized, they may pursue an appeal through the managed care organization.

Grievance: A written or verbal expression of dissatisfaction.

Appeal: A request for a review of a Dental Plan's denial, reduction, suspension, termination or delay of services.

Resolved: The appeal or grievance has been through the process and a disposition has been communicated to the member and member representative.

Percentage of Grievances Resolved within 90 Calendar Days of Receipts



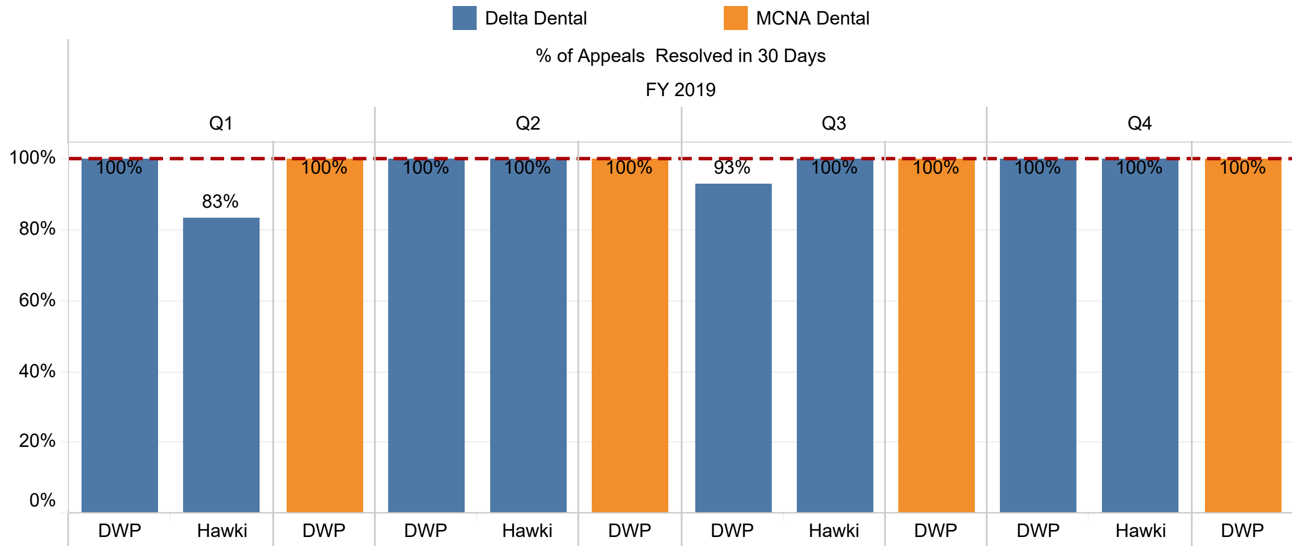
No Hawki grievances were reported in SFY19

Supporting Data

		Delta Dental				MCNA Dental	
		DWP		Hawki		DWP	
		Grievances Received	%Pop	Grievances Received	%Pop	Grievances Received	%Pop
FY 2019	Q1	15	0.01%	0	0.00%	453	0.46%
	Q2	8	0.00%	0	0.00%	271	0.27%
	Q3	8	0.00%	0	0.00%	203	0.20%
	Q4	6	0.00%	0	0.00%	337	0.32%

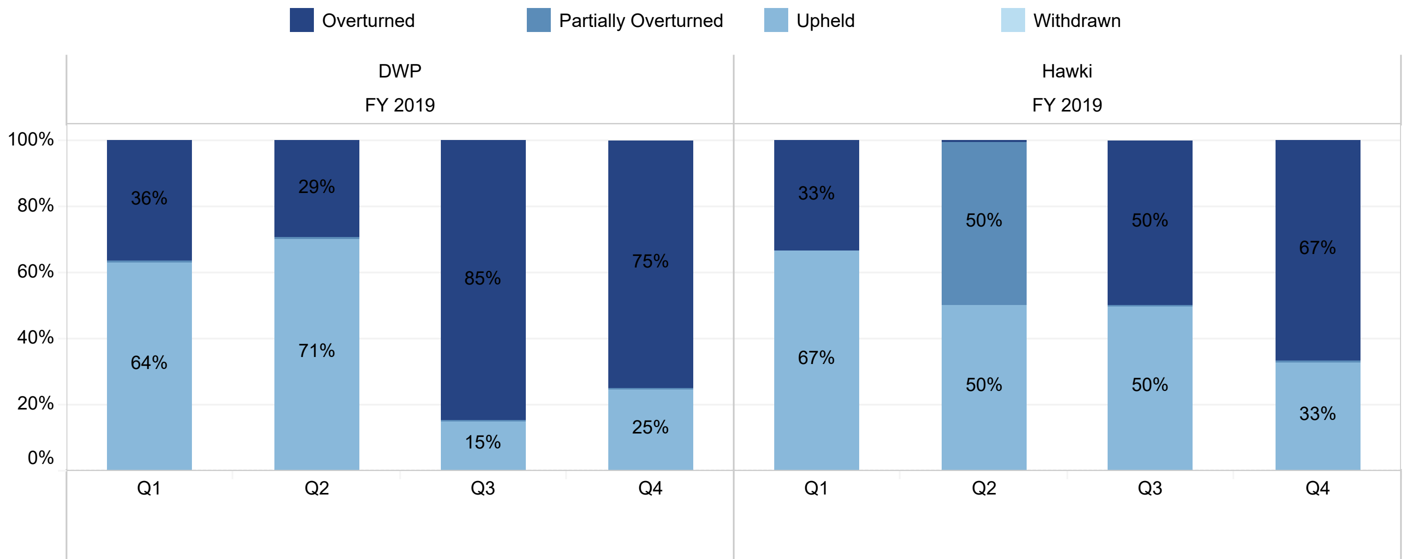
The grievance process is inclusive of the disenrollments

Percentage of Appeals Resolved within 30 Calendar Days of Receipt



Supporting Data

		Delta Dental				MCNA Dental	
		DWP		Hawki		DWP	
		Appeals Received	% Claims	Appeals Received	% Claims	Appeals Received	% Claims
FY 2019	Q1	11	0.02%	6	0.03%	5	0.01%
	Q2	17	0.03%	2	0.01%	3	0.01%
	Q3	14	0.02%	6	0.03%	3	0.00%
	Q4	9	0.01%	9	0.04%	1	0.00%


Delta Dental of Iowa Appeals Outcome
Overturned
Partially Overturned
Upheld
Withdrawn
DWP
FY 2019
Hawki
FY 2019
100%
80%
60%
40%
20%
0%
36%
64%
29%
71%
85%
15%
75%
25%
33%
67%
50%
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50%
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Q1
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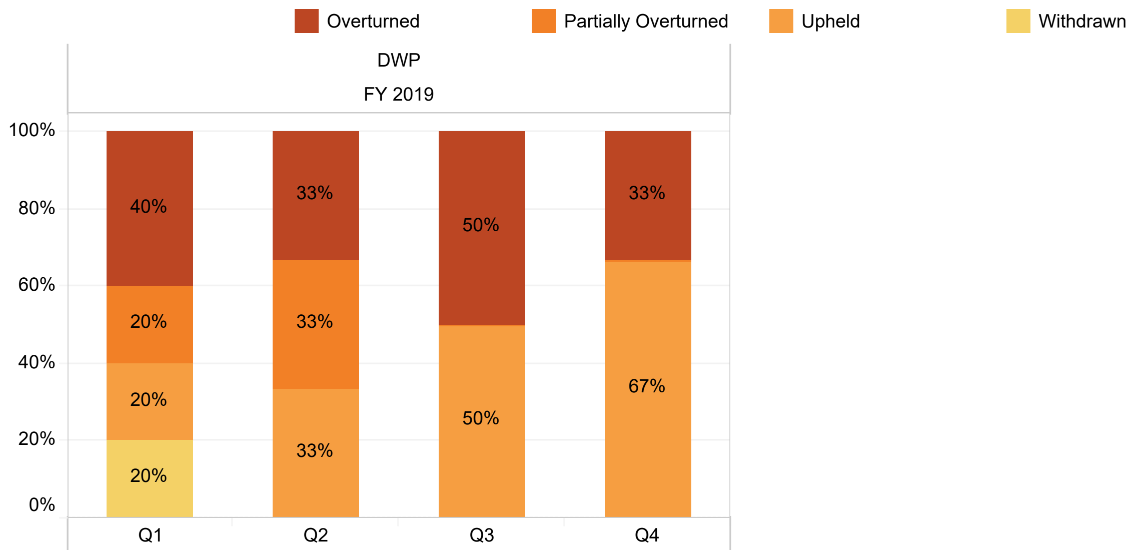
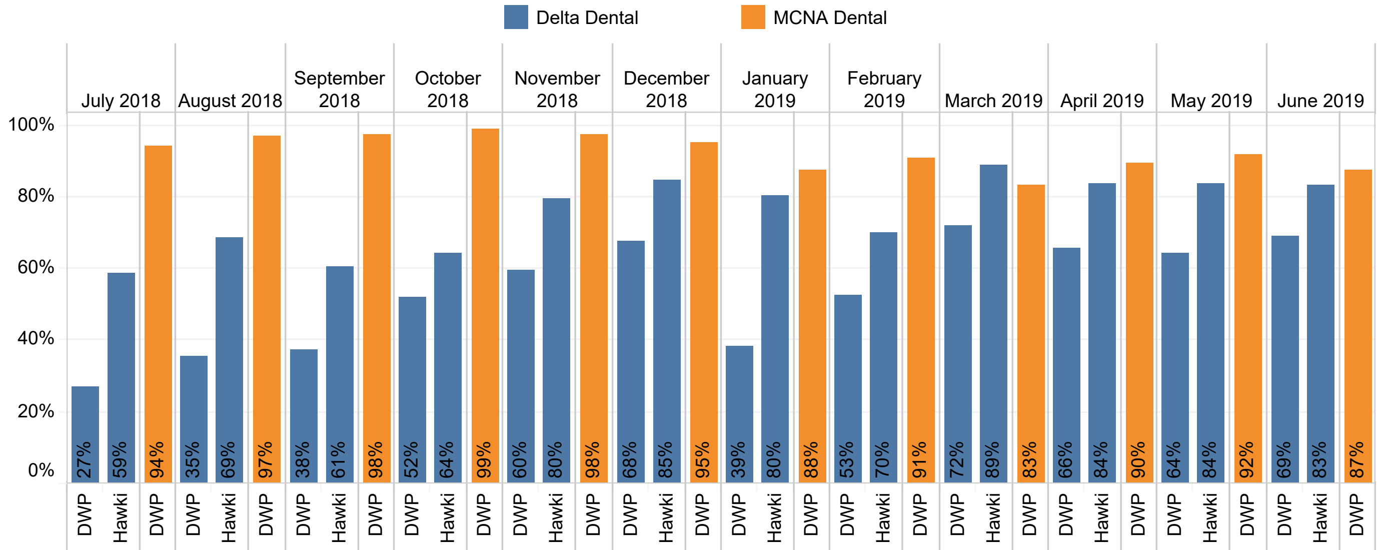
Q3
Q4
Q1
Q2
Q3
Q4


MCNA Dental Appeals Outcome
Overturned
Partially Overturned
Upheld
Withdrawn
DWP
FY 2019
100%
80%
60%
40%
20%
0%
40%
20%
20%
20%
33%
33%
33%
50%
50%
33%
67%
Q1
Q2
Q3
Q4

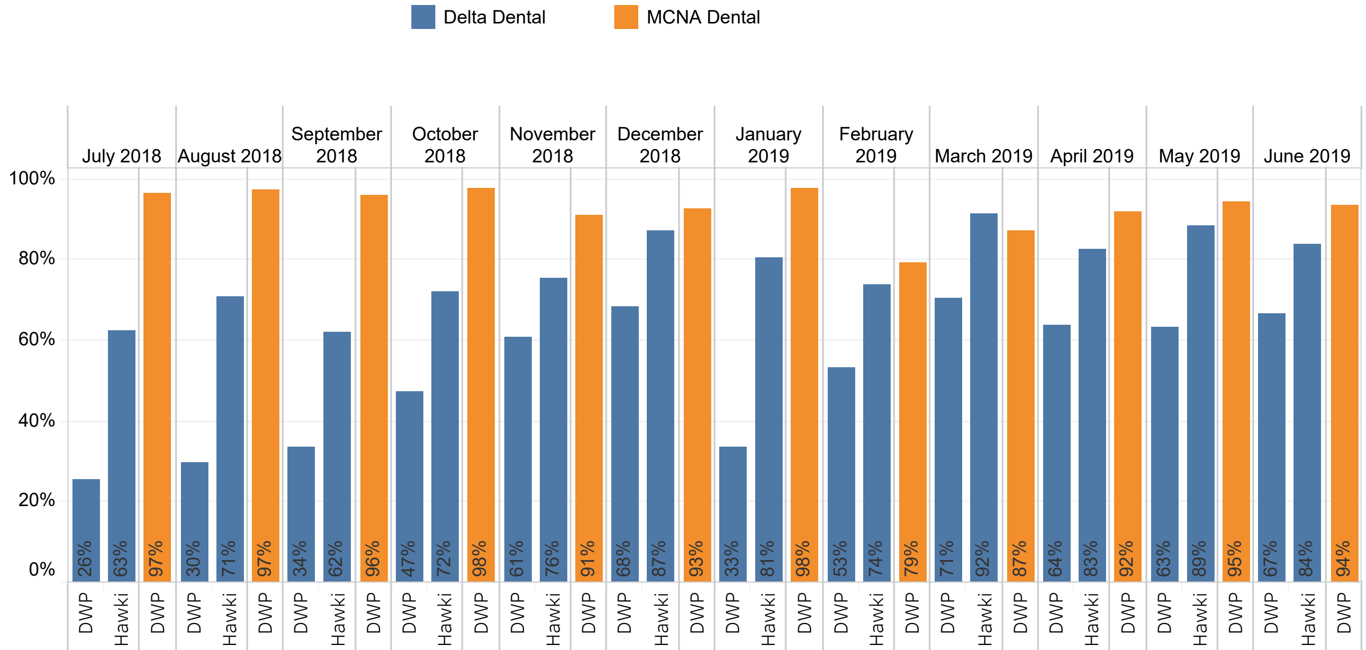
Program Management

Member Helpline

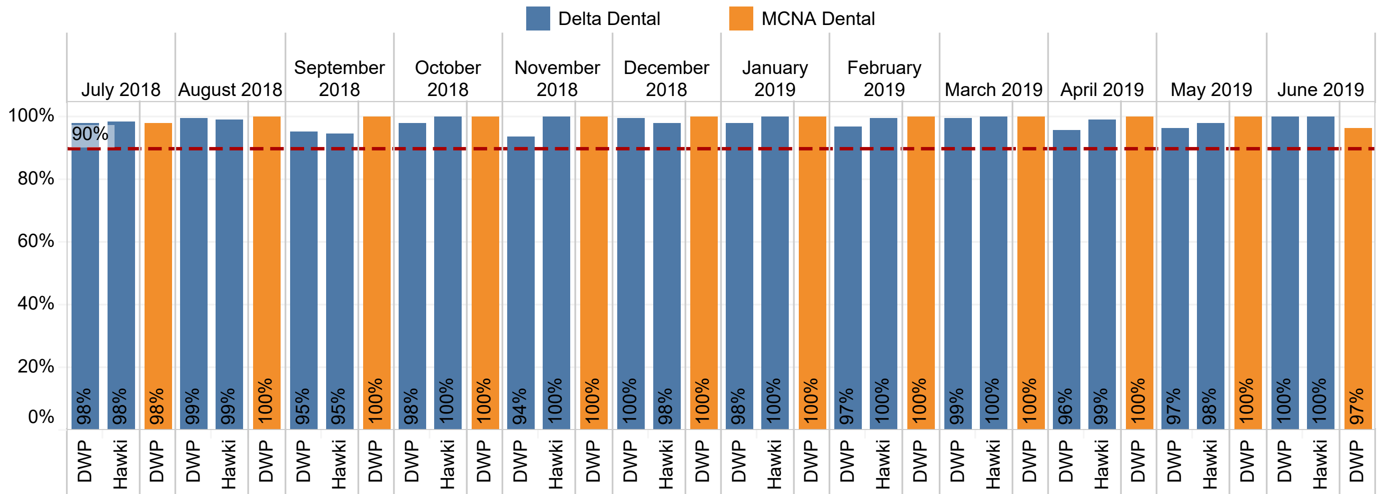
Member helpline data demonstrates the Dental Plan's ability to answer calls timely to ease member's access to information about their healthcare.

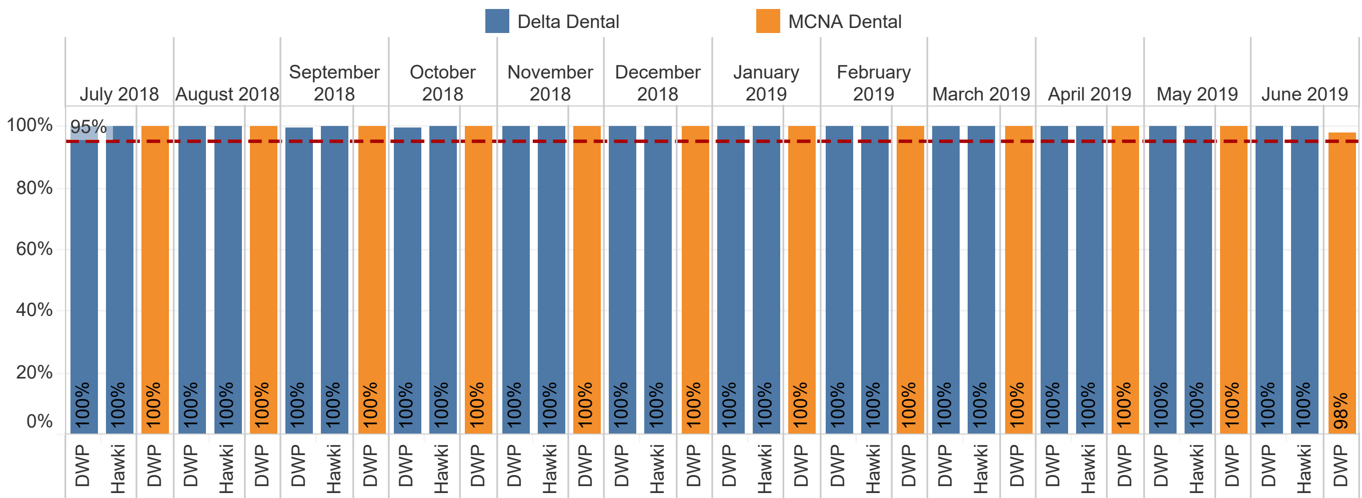


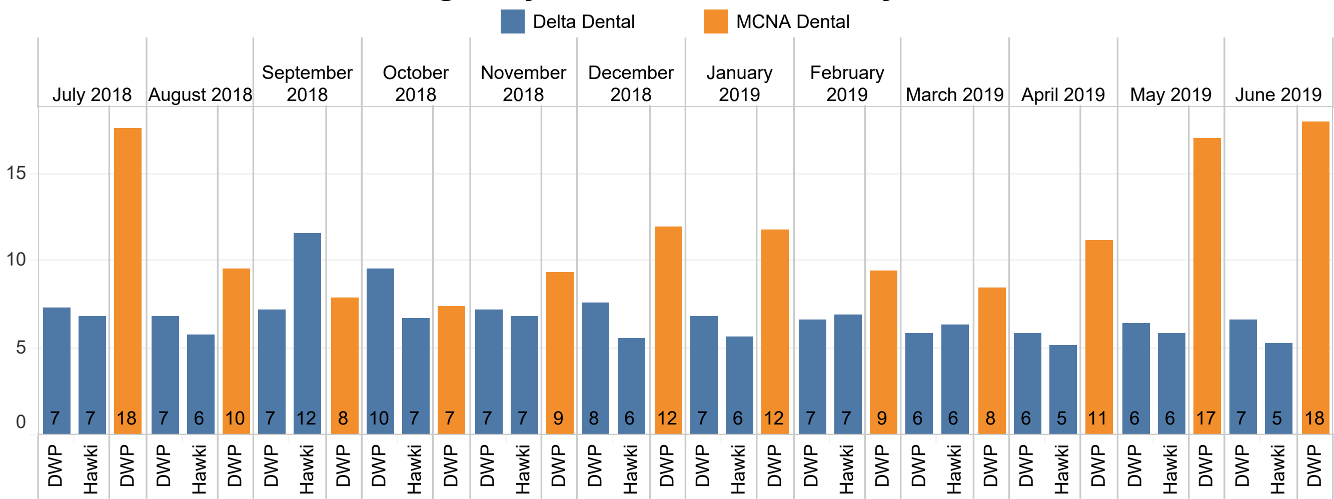
Provider Helpline
Provider helpline data demonstrates the Dental Plan's ability to answer calls timely to assure providers' access to information about their Medicaid members.



Dental Claims Payments



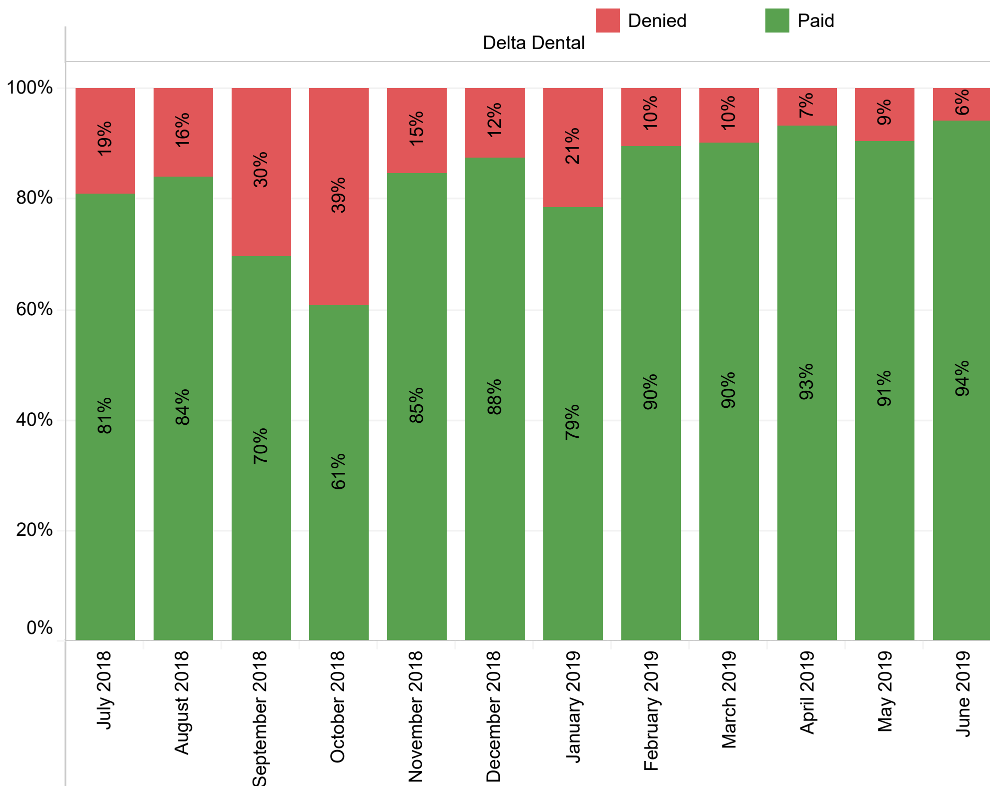




Dental Claims Status

Dental Wellness Plan Claims Status

Hawki Claims Status



Top 10 Reasons for Dental Claims Denials

Claim Adjustment Reason Codes (CARC): A nationally-accepted, standardized set of denial and payment adjustment reasons used by all Dental Plans.
http://www.wpc-edi.com/reference/codelists/healthcare/claim-adjustment-reason-codes/
Remittance Advice Remark Codes (RARCs): A more detailed explanation for a payment adjustment used in conjunction with CARCs. http://www.wpc-edi.com/reference/codelists/healthcare/remittance-advice-remark-codes/

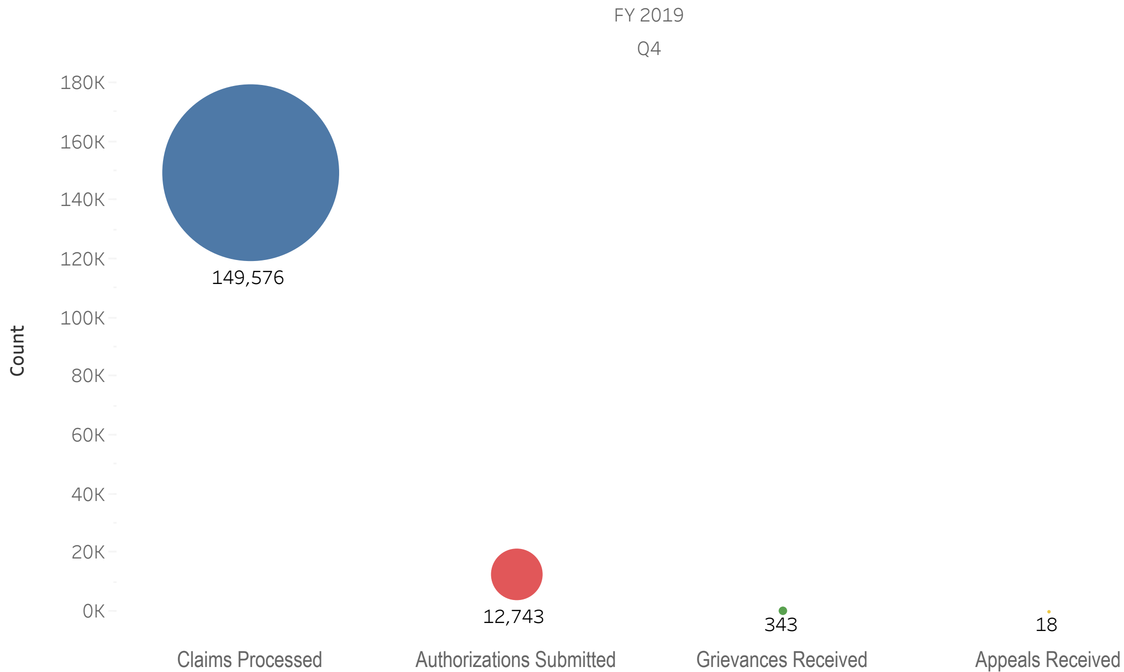
Counts reported for the metric by the plans include all month in the period.

			FY 2019	
			Q4	
			Count	Percent
Delta Dental	DWP	18- EXACT DUPLICATE CLAIM/SERVICE	6,023	64.34%
		272 - PROGRAM GUIDELINES WERE NOT MET	2,148	22.95%
		204 - THE SERVICE IS NOT COVERED UNDER THE PATIENT'S CURRENT BENEFIT PLAN	1,840	19.66%
		119 - BENEFIT MAXIMUM FOR THIS TIME PERIOD OR OCCURRENCE HAS BEEN REACHED	1,791	19.13%
		97 - THE BENEFIT FOR THIS SERVICE IS INCLUDED FOR ANOTHER SERVICE	1,575	16.83%
		242 - SERVICES NOT PERFORMED BY A CONTRACTED DENTIST	1,053	11.25%
		272 - PROGRAM GUIDELINES WERE NOT MET	857	9.16%
		27 - EXPENSES INCURRED AFTER COVERAGE TERMINATION	152	1.62%
	hawk-i	18- EXACT DUPLICATE CLAIM/SERVICE	2,223	144.26%
		27 - EXPENSES INCURRED AFTER COVERAGE TERMINATION	917	59.51%
		272 - PROGRAM GUIDELINES WERE NOT MET	224	14.54%
		242 -- SERVICES NOT PERFORMED BY A CONTRACTED DENTIST	80	5.19%
		97 - THE BENEFIT FOR THIS SERVICE IS INCLUDED FOR ANOTHER SERVICE	25	1.62%
MCNA Dental	DWP	2-THIS REQUEST HAS BEEN PREVIOUSLY REPORTED AND AN APPROVAL OR DENIAL WAS ISSUED.	1,585	19.72%
		24-CHARGES FOR RADIOGRAPHS HAVE BEEN COMBINED AND AN ALTERNATE BENEFIT OF A FULL MOUTH SERIES CONSIDERED.	1,545	19.23%
		67-SERVICE(S) DENIED AS FACILITY NOT SPECIFIED.	620	7.72%
		524-THE BENEFIT YEAR MAXIMUM HAS BEEN REACHED OR EXCEEDED. THE MEMBER MAY BE RESPONSIBLE FOR CHARGES THAT EXCEED THEIR YEARLY BENEFIT LIMIT.	320	3.98%
		36-PROCEDURE IS LIMITED TO ONCE IN A FIVE YEAR PERIOD PER THE COVERED BENEFITS OUTLINED IN YOUR PROVIDER MANUAL.	306	3.81%
		53-PLEASE SUBMIT THE PRIMARY CARRIER'S BENEFIT STATEMENT AND ANY PREVIOUS EXPLANATION OF BENEFITS.	292	3.63%
		755-THIS SERVICE IS BEING DENIED DUE TO NO PRIOR AUTHORIZATION ON FILE AND THE CLAIM WAS NOT SUBMITTED WITH THE REQUIRED DOCUMENTATION TO CONDUCT A POST AUTHORIZATION REVIEW.	216	2.69%
		17-THIS PROCEDURE IS CONSIDERED NON-COVERED IN ACCORDANCE WITH EITHER THE PROGRAM BENEFITS OR THE FACILITY CONTRACT WITH MCNA	198	2.46%
		48-PLEASE SUBMIT X-RAY(S) AND NARRATIVE WITH THIS REQUEST.	178	2.22%
		65-SERVICES PERFORMED BY A NON-PARTICIPATING FACILITY ARE NOT COVERED.	168	2.09%

* Delta Dental is reporting on all CARCs and RARCs regardless denial reason order

Quarterly Volume of Claims, Reprocessing, PAs, and Appeals

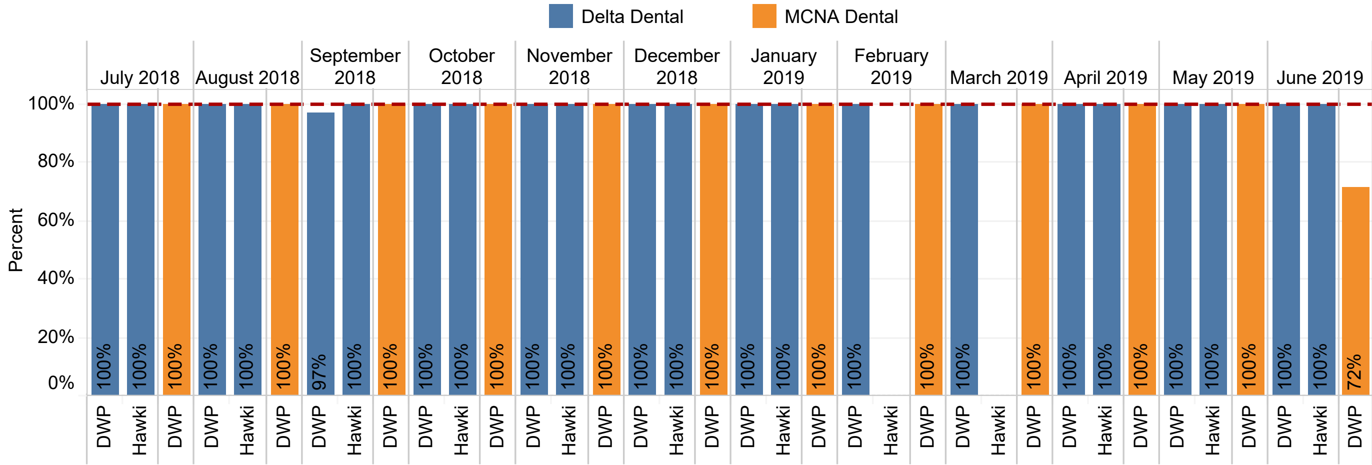
Quarterly Volume of Claims, Reprocessing, Prior Authorizations (PAs), and Appeals depict at scale the universe of actions that may be associated with paid or denied claims. Some claims require prior authorizations for services while other claims may be reprocessed due to provider requests or errors, and still others may be appealed by members. These numbers with the illustration provide context on the volume of these actions in the combined managed care universe of dental claims with MCNA and Delta Dental for both hawk-i as well as the Dental Wellness Plan. Each measure is accompanied with a total volume and a percentage value that shows the measure's relation to total claims.



Prior Authorization - Dental

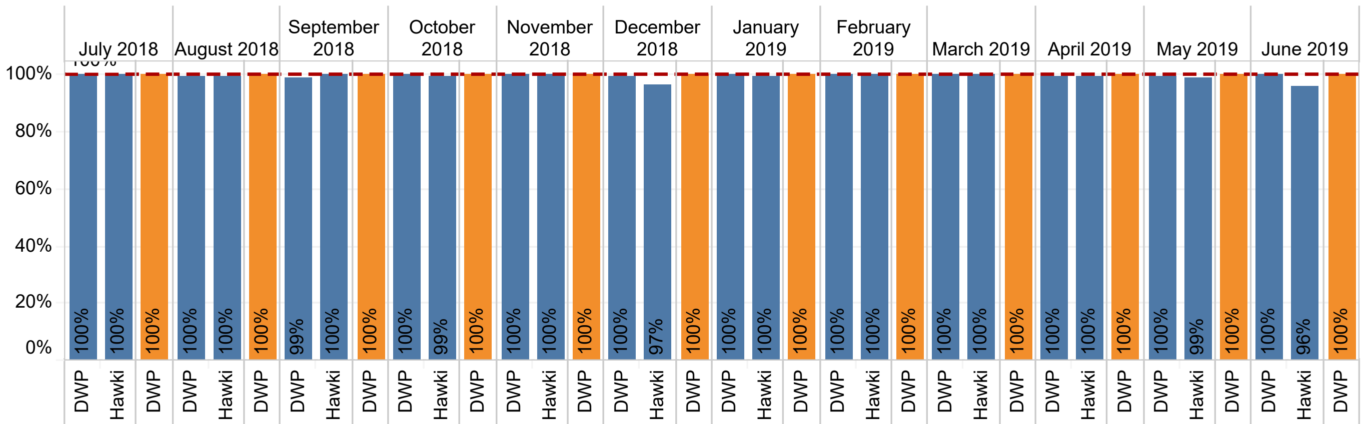
Prior Authorization (PA) data demonstrates the Dental Plan's capacity to receive and respond to requests for prior authorization of services in a timely manner.

100% of Dental PAs Requiring Physician Review Must Be Completed Within 20 Days

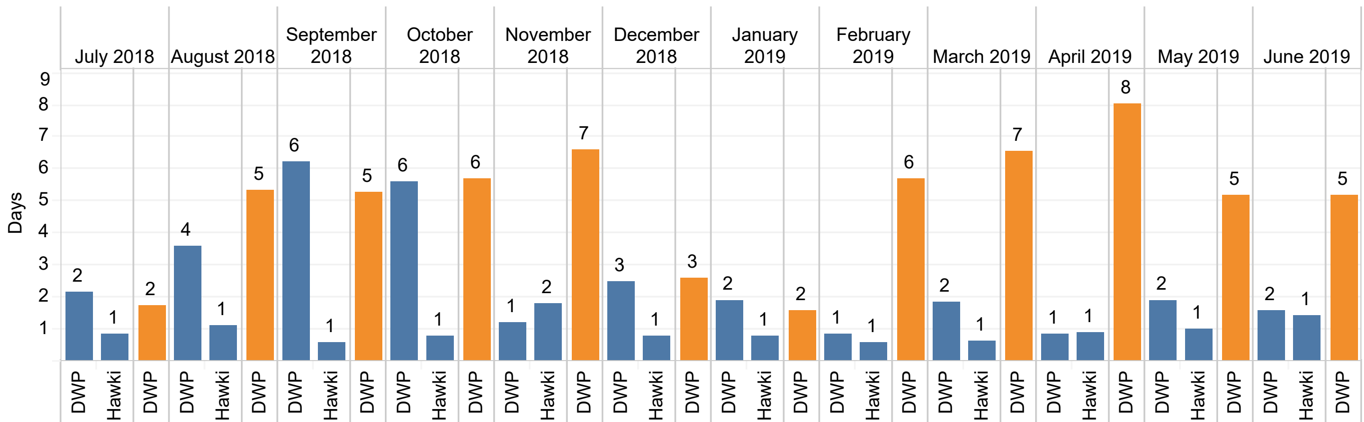


hawk-i prior authorizations have an optional physician review only.

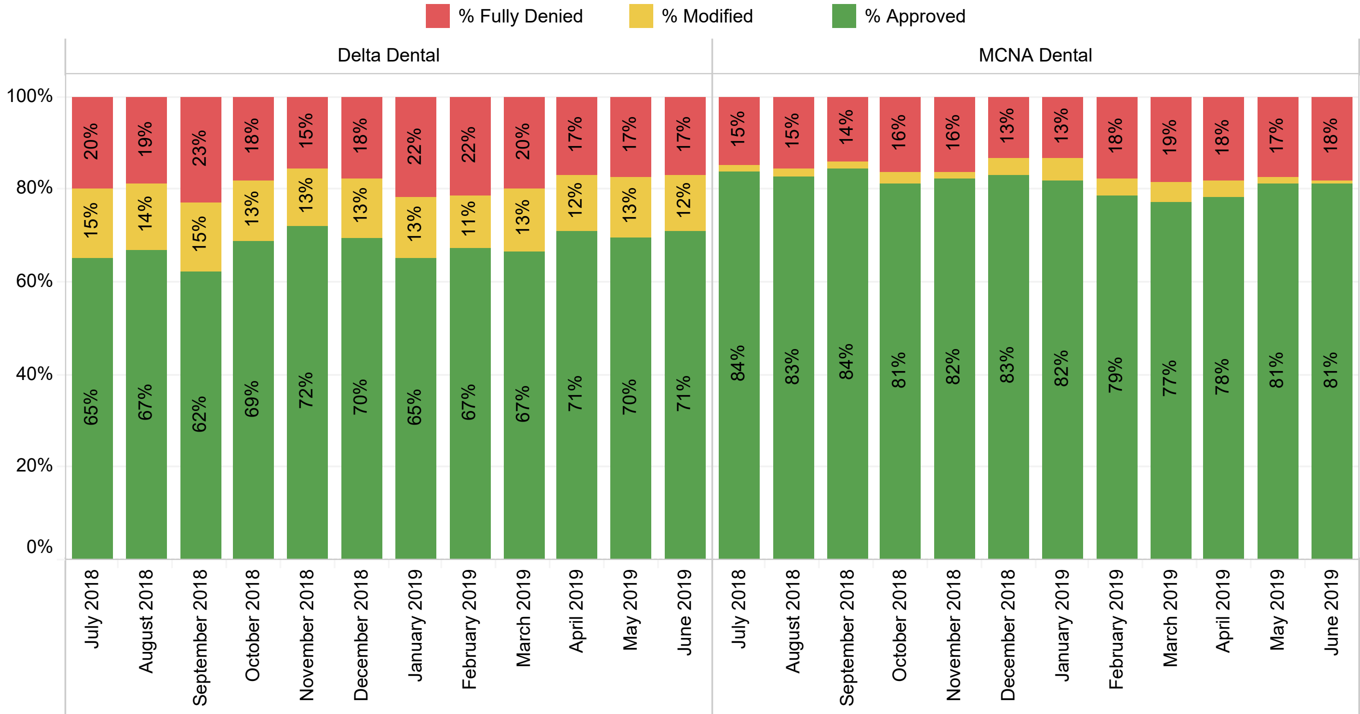
100% of Dental PAs Not Requiring Physician Review Must Be Completed Within 15 Days

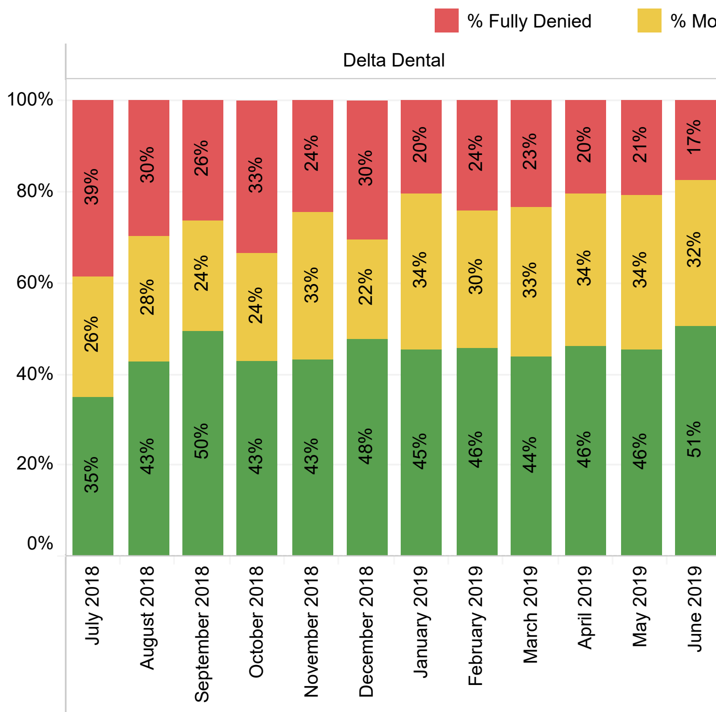


Average Number of Days to Process Dental Prior Authorizations



Prior Authorization Submission Status





Encounter Data Reported

Encounter Data are records of dental-related services rendered by a provider to a member. The department continues the process of validating all encounter data to ensure adequate development of capitation rates and overall program and data integrity.

		Delta Dental		MCNA Dental
		DWP	Hawki	DWP
Encounter Data Submitted Timely by 20th of the Next Month	July 2018	Y	Y	Y
	August 2018	N	Y	Y
	September 2018	N	Y	Y
	October 2018	Y	Y	Y
	November 2018	Y	Y	Y
	December 2018	Y	Y	Y
	January 2019	Y	Y	Y
	February 2019	Y	Y	Y
	March 2019	Y	Y	Y
	April 2019	Y	Y	Y
	May 2019	N	Y	Y
	June 2019	N	Y	Y

Utilization of Value Added Services Reported - Count of Members

Dental Plans may offer value added and health incentive services, at this time, only MCNA Dental offers value added services.

	MCNA Dental			
	FY 2019			
	Q1	Q2	Q3	Q4
Walmart Gift Card	2,285	2,203	1,959	1,924

Provider Network Access

There are two major methods used to determine adequacy of network in the contract between the department and the Dental Plans:

- Member and provider ratios by provider type and by region
- Geographic access by time and distance

As there are known coverage gaps within the state for both Medicaid and other health care markets; exceptions will be granted by the department when the Dental Plan clearly demonstrates that:

- Reasonable attempts have been made to contract with all available providers in that area; or
- There are no providers established in that area.

Links to time and distance reports can be found at:
https://dhs.iowa.gov/ime/about/performance-data-GeoAccess

Dental Specific

Distinct Members Receiving Services

Delta Dental | MCNA Dental

			FY 2019			
			Q1	Q2	Q3	Q4
Unique Members Receiving Services	DWP	Delta Dental	37,477	37,612	34,679	37,300
		MCNA Dental	10,498	10,538	10,303	10,919
	Hawki	Delta Dental	15,480	14,244	15,452	16,360

Emergency Dental Services

Emergent dental services are captured for members that receive services in emergency situations. These services are excluded from the member's annual benefit maximum. Certain dental benefits are also available to members in an emergency situation that would otherwise not be a part of the basic benefit tier.

Counts

	Delta Dental	MCNA Dental
SFYTD Unique Emergency Visits	8,748	34
SFYTD Unique Members Receiving Emergency Services	4,139	20

Paid Amounts

	Delta Dental	MCNA Dental
SFYTD Total Paid for Emergency Visits	$589,231.54	$26,622.66

* MCNA transitioned to excluded FQHC $0.00 pay line items that do not apply to the Annual Benefit Maximum

Healthy Behaviors

All Dental Wellness Plan members have full dental benefits during their first year of enrollment. In order to keep full benefits in subsequent years, members must complete healthy behaviors before their next enrollment period.

If Healthy Behaviors are not completed, members will receive an invoice for a monthly ($3) premium. If the invoice goes unpaid after 90 days, members will be receive basic dental benefits for the remainder of their enrollment year. If Healthy Behaviors are completed in the members current enrollment period, full benefits will be reinstated for the next enrollment period.

While completion of Healthy Behaviors is encouraged across all members enrolled in DWP, Iowa's 1115 Waiver states the following DWP enrollees will not be charged premiums and; therefore, will not have their benefits limited to basic services:

- Pregnant women.
- Individuals whose medical assistance for services furnished in an institution are reduced by amounts reflecting available income other than required for personal needs.
- 1915(c) Home and Community Based waiver enrollees.
- Individuals receiving hospice care.
- American Indian/Alaska Natives (AI/AN) who are eligible to receive or have received an item or service furnished by an Indian Health Services provider or through referral under contract health services.
- Breast and cervical cancer treatment program enrollees.
- Medically frail enrollees (also referred to as medically exempt

Dental Wellness Plan Members with Full and Basic Benefits

			FY 2019 Q1	FY 2019 Q2	FY 2019 Q3	FY 2019 Q4
DWP	Delta Dental	Members with Full Dental Benefits	100%	95%	89%	93%
		Members with Basic Dental Benefits	0%	5%	11%	7%
	MCNA Dental	Members with Full Dental Benefits	100%	90%	90%	95%
		Members with Basic Dental Benefits	0%	10%	10%	5%

The first period in which members may transition to the basic benefit structure is SFY19 Q2

Dental Wellness Plan Healthy Behaviors

		FY 2019 Q1	FY 2019 Q2	FY 2019 Q3	FY 2019 Q4
Delta Dental	Healthy Behaviors: Preventative Service	30,127	30,160	28,265	30,390
	Healthy Behaviors: Self Assessment	15,017	4,551	14,991	7,914
MCNA Dental	Healthy Behaviors: Preventative Service	7,101	7,143	7,219	7,638
	Healthy Behaviors: Self Assessment	2,564	1,370	1,515	3,102

Fiscal YTD Members with Completed Prevenatitive Service and Self Assessment

While there is a difference in benefit period and state fiscal year, this metric looks at members who have completed both components of Healthy Behavior regardless of being required to do so.

		FY 2019
Delta Dental	Healthy Behaviors: Self Assessment & Preventative Service	39,756
MCNA Dental	Healthy Behaviors: Self Assessment & Preventative Service	5,762

Appendix

Glossary

Administrative Loss Ratio (ALR): The percent of capitated rate payment or premium spent on administrative costs.

Appeal: A request for a review of a Dental Plan's denial, reduction, suspension, termination or delay of services.

Calls Abandoned: Member terminates the call before a representative is connected.

Capitation Payment: Medicaid payments the Department makes on a monthly basis to Dental Plans for member health coverage. Dental Plans are paid a set amount for each enrolled person assigned to them. Capitated rate payments vary depending on the member's eligibility.

Claim Adjustment Reason Code (CARC) & Readjustment Advice Remark Code (RARC): CARC is an explanation for why a claim or service line was paid differently than it was billed. The RARC provides further information.

Clean Claims: The claim is one that can be processed without obtaining addition information from the provider of the service or from a third party. It includes a claim with errors originating in a State's claim's system. It does not include a claim from a provider who is under investigation for fraud or abuse, or a claim under review for medical necessity.

Delta Dental of Iowa (DDIA): An Iowa licensed dental insurance carrier utilized by the Iowa Department of Human Services to administer assigned hawk-i and Dental Wellness Plan Members.

Denied Claims: Claim is received and services are not covered benefits, are duplicate, or have other substantial issues that prevent payment.

Dental Plan: A dental health insurance company retained to manage care for a segment of the population and adjudicate claims funded through capitation payments made to the plan for eligible members.

Dental Wellness Plan (DWP): Dental coverage that is part of the Iowa Health and Wellness Plan that serves the adult Medicaid population.

Disenrollment: Refers to members who have chosen to change their enrollment with one Dental Plan Administrator to an alternate Administrator.

Encounter Data: Records of dental-related services rendered by a provider to a member.

Fee-for-Service (FFS): Some Iowa Medicaid members are served through the FFS system where their health care providers are paid separately for each service. Members who are not enrolled in the Dental Wellness Plan or hawk-i program currently remain in FFS.

Grievance: A written or verbal expression of dissatisfaction.

Healthy and Well Kids in Iowa (*Hawki*): A program that provides health and dental coverage to children under age 19 in families whose gross income is less than or equal to 302 percent of the Federal Poverty Level (FPL) based on Modified Adjusted Gross Income (MAGI) methodology.

Healthy Behaviors: Interventions to change health behavior to establish healthy lifestyle habits.

Iowa Department of Human Services (DHS): DHS administers the Medicaid program that provides quality services for the well-being of eligible members.

Iowa Health and Wellness Plan (IHAWP): IHAWP covers Iowans, ages 19-64, with incomes up to and including 133 percent of the Federal Poverty Level (FPL). The health plan provides a comprehensive benefit package and is part of Iowa's implementation of the Affordable Care Act.

Iowa Medicaid Enterprise (IME): IME is staffed with state staff and contractors for the administration of the Iowa Medicaid program. Medicaid is a state and federal funded program that is administered by DHS.

Managed Care of North America (MCNA): An Iowa licensed dental insurance carrier utilized by the Department of Health and Human Services to administer assigned Dental Wellness Plan Members.

Glossary

Medical Loss Ratio (MLR): The percent of capitated rate payment or premium spent on claims and expenses that improve health care quality.

Oral Health Self-Assessment: A questionnaire to gather oral health information about the member which is used to evaluate oral health risks and quality of life.

Overturned: Upon further (external) review of an appeal, the Dental Plan reverses the original processing decision.

Partially Overturned: Upon further (external) review of an appeal, the Dental Plan decides to reverse the processing decision on some services but upholds other services.

Prior Authorization (PA): A PA is a requirement that the provider obtains approval from the health plan to prescribe medication or service. PAs ensure that services and medication delivered through the program are medically necessary.

Program Integrity (PI): PI encompasses a number of activities to ensure appropriate billing and payment and avoidance of fraud, waste and abuse.

Resolved: A grievance or appeal has been through the process and a disposition has been communicated to the member and member representative.

State Fiscal Year (SFY)**:** SFY is from July 1 to June 30.

Third Party Liability (TPL): TPL is the legal obligation of third parties (e.g., certain individuals, entities, insurers, or programs) to pay part or all of the expenditures for medical assistance furnished under a Medicaid state plan.

Underwriting: The process that an insurance company uses to determine acceptable risk, and if so, how much to charge in premiums based on the applicant's health history.

Upheld: Upon further (external) review of an appeal, the Dental Plan maintains the original processing decision.

Withdrawn: A filed appeal is abandoned as if the appeal had never been filed.