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RESEARCH REPORT

EVALUATION OF THE DENTAL WELLNESS PLAN 2.0:
Early Experiences of Private Practice Dentists

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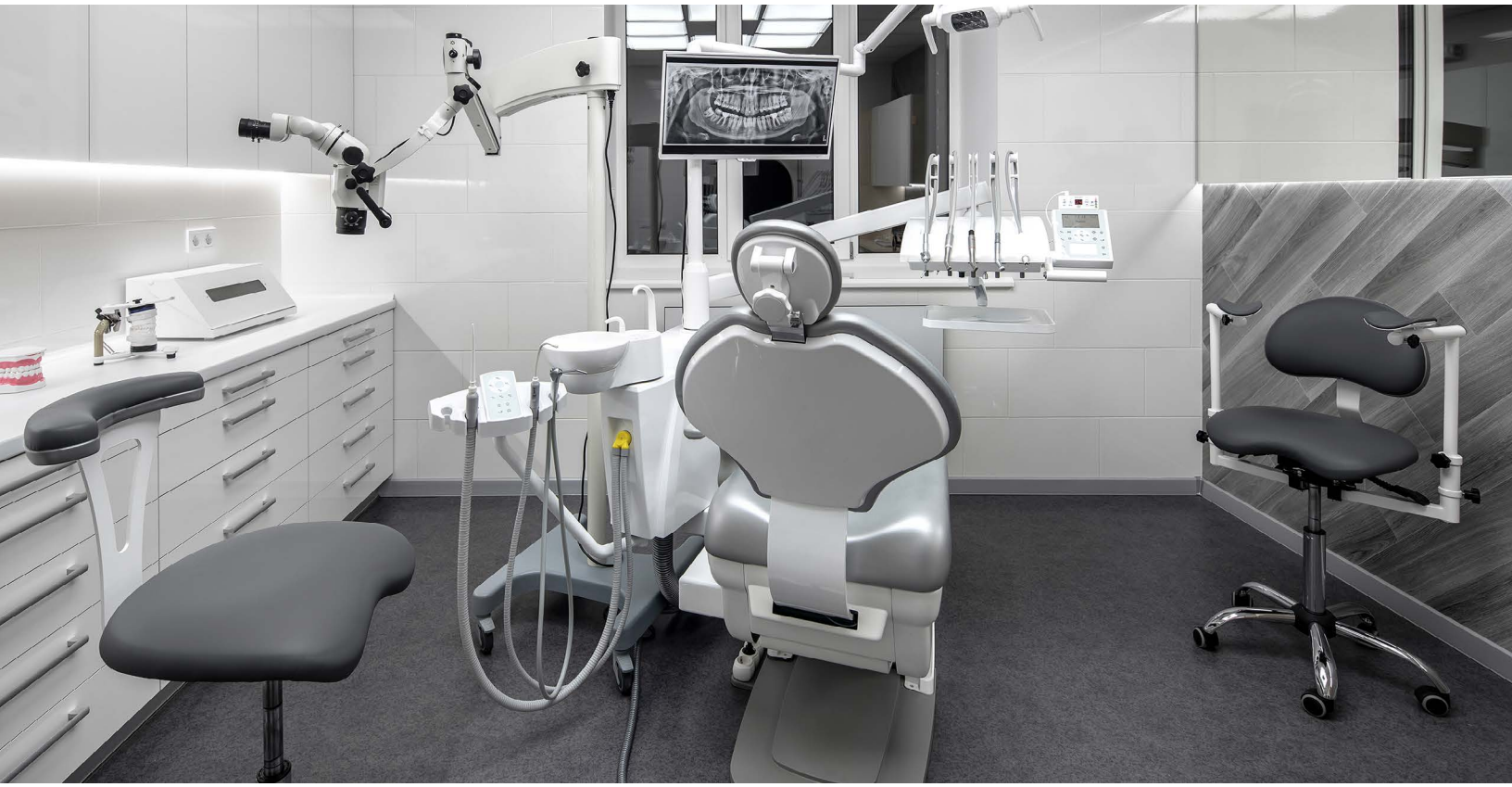

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EXECUTIVE SUMMARY

This report describes Iowa dentists' participation in, and early experiences with, the Dental Wellness Plan 2.0. The DWP 2.0 program began on July 1, 2017, when adult members from traditional Medicaid and the Medicaid expansion program (DWP 1.0) were merged into a single public dental benefit program.

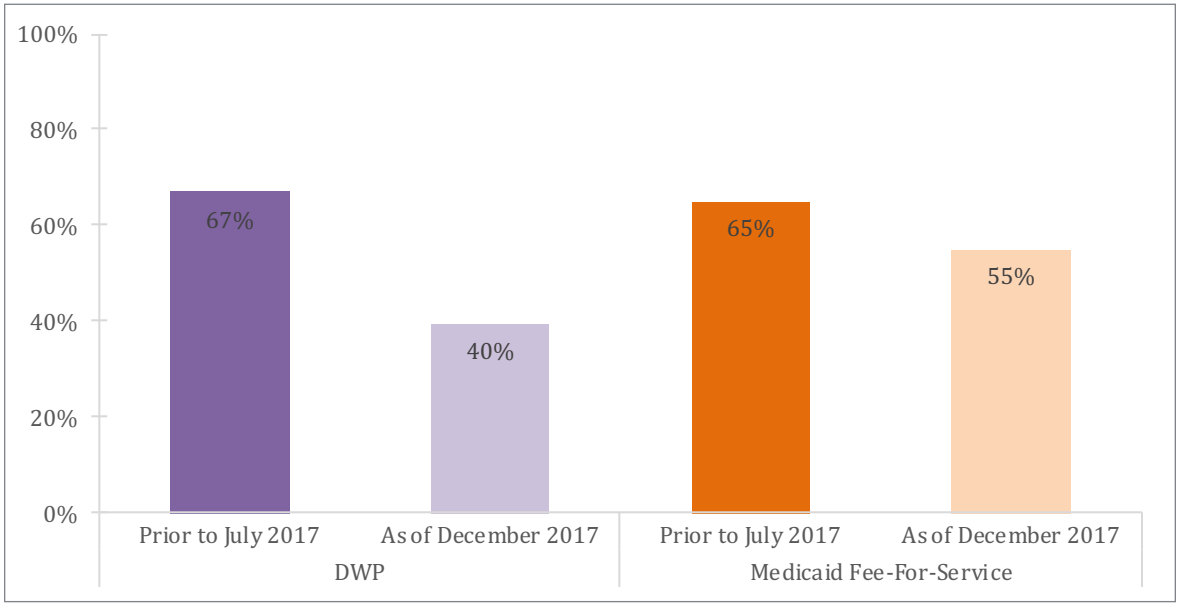
We solicited dentists' experiences through an online survey that was distributed to all private practice dentists in Iowa in December 2017, 6 months after these programmatic changes were implemented. 305 (21%) dentists responded to the survey.

KEY FINDINGS

One-third of responding dentists were not fully aware of the DWP 2.0 changes that occurred in July 2017. 65% of dentists were aware of the major changes with DWP 2.0; 9% were not aware of any of these (as listed above).

Self-reported provider participation in DWP and traditional Medicaid declined after DWP 2.0 was implemented (see figure below). Among dentists who are currently accepting new DWP patients, more than one-quarter plan to discontinue acceptance of those patients within the next 6 months.

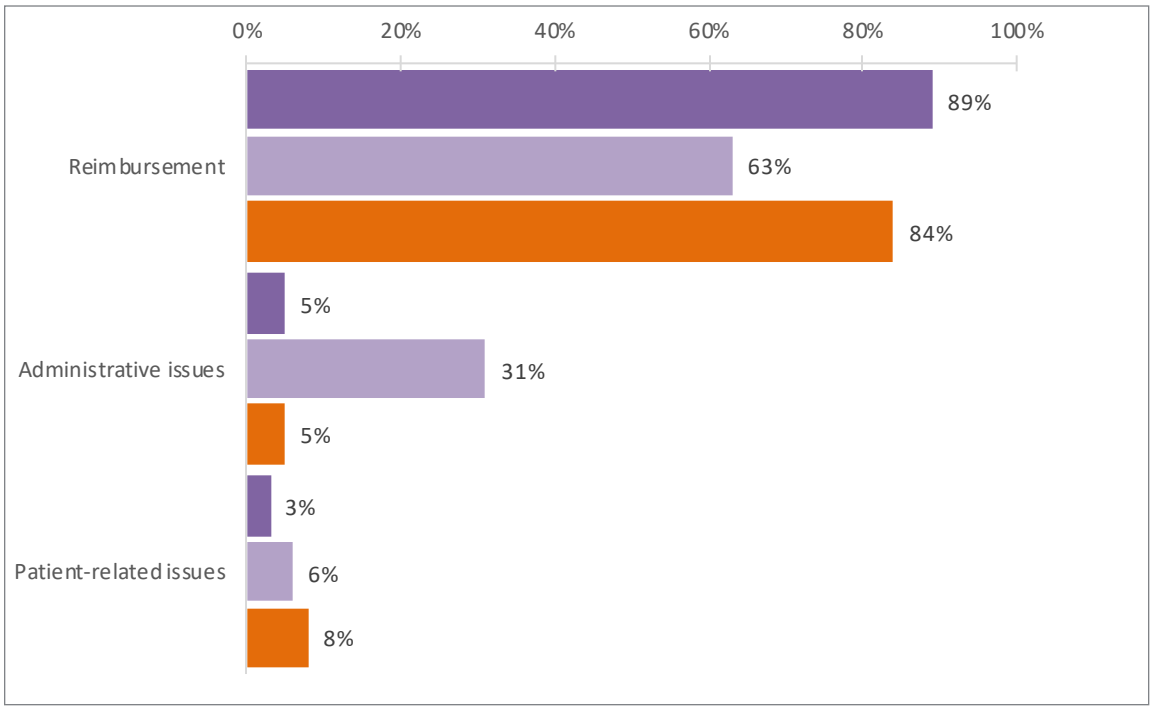
Proportion of dentists accepting new patients before and after July 2017 programmatic changes (n=305)



*Current Medicaid participation refers to acceptance of Medicaid-enrolled children only, since all adults were moved to DWP 2.0.

The most important reason dentists stopped accepting new patients of any type was reimbursement (see figure below).

Dentists' most important reasons for stopping acceptance of new patients covered by each plan
Carrier 1 [n=94], Carrier 2 [n=35], Medicaid FFS [n=37]



Overall, a majority of dentists (70%) reported a negative attitude toward DWP 2.0. However, differences were noted by carrier.

Dentists' open-ended comments most frequently cited frustrations with reimbursement rates and administrative issues. Administrative issues of concern included burdensome pre-authorizations and claims submission processes, and claims denial and delays.

BACKGROUND

This report describes Iowa dentists' participation in, and early experiences with, the Dental Wellness Plan 2.0. The DWP 2.0 program began on July 1, 2017, when adult members from traditional Medicaid and the Medicaid expansion program (DWP 1.0) were merged into a single public dental benefit program. In addition to merging the two adult Medicaid populations, changes to the DWP program included:

1. New members are randomly assigned to one of two DWP 2.0 carriers – Delta Dental of Iowa or MCNA Dental.
2. All members are eligible for comprehensive dental benefits during their first year.
3. Members must receive a preventive dental visit and complete a self-risk assessment every year in order to avoid monthly premiums.
4. Reimbursement rates changed to approximately the same level as previous traditional Medicaid rates.

METHODS

We solicited dentists' experiences through an online survey that was distributed to all private practice dentists in Iowa in December 2017, 6 months after these programmatic changes were implemented. 305 (21%) dentists responded to the survey.

FINDINGS

The aim of this study was to evaluate private practice dentists' experiences and perceptions about the Dental Wellness Plan (DWP) 2.0, and evaluate dentist participation 6 months after implementation of these changes.

In December 2017, an online survey was fielded to all Iowa private practice dentists (N=1395) about DWP 2.0 participation, attitudes, and experiences. In total, 305 (22%) dentists completed the survey. Additional detail about the DWP 2.0 program, as well as detailed research methods can be found in **Appendix 1**.

DEMOGRAPHIC AND PRACTICE CHARACTERISTICS

Table 1 presents demographic characteristics of survey respondent dentists as well as those of all Iowa private practice dentists. Most respondent dentists were White (91%), male (68%) and practiced general dentistry (89%). Survey respondents were slightly more likely to be younger, female, general dentists, and solo practitioners compared to the total population of private practice dentists in Iowa.

Table 1. Demographic and practice characteristics of survey respondents and all Iowa private practice dentists

Demographics	Survey respondents (n=305)	All Iowa private practice dentists[1] (=1395)
Age		
<30 years	11%	6%
30-39	26%	26%
40-49	21%	20%
0-59	23%	21%
≥60	19%	27%
Gender		
Female	32%	27%
Male	68%	73%
Race/Ethnicity[2]		
White	91%	85%
Black	<1%	<1%
Hispanic	2%	1%
Asian or Pacific Islander	3%	2%
Unknown	4%	10%
Specialty		
General dentistry	89%	81%
Orthodontics	2%	6%
Oral surgery	3%	4%
Pediatric dentistry	2%	4%
Endodontics	1%	3%
Periodontics	1%	1%
Prosthodontics	1%	1%
Solo or Group Practice		
Solo practice	48%	41%
Group practice	52%	59%
Years in current practice		
0-5	33%	-
6-10	17%	-

1 Source: Iowa Dentist Tracking System 2017 Final Report. Office of Statewide Clinical Education Programs. Oct 2017. https://medicine.uiowa.edu/oscep/sites/medicine.uiowa.edu.oscep/files/wysiwyg_uploads/2016%20Iowa%20Dentist%20Tracking%20System%20Committee%20Annual%20Meeting%20Book_0.pdf

2 IDTS only reported race/ethnicity data for all Iowa dentists (n=1530) rather than private practitioners only. Therefore, results may not be directly comparable to survey respondents.

Demographics	Survey respondents (n=305)	All Iowa private practice dentists[1] (=1395)
11-20	20%	-
>20	30%	-

AWARENESS ABOUT DWP 2.0 POLICY CHANGE

Survey respondents were shown a list of changes that were made to Medicaid and the Dental Wellness Plan starting July 1, 2017 (see box below). Dentists were asked if they were previously aware of *all* or *some* of these program changes. **65% were aware of *all* program changes, 26% were aware of *some* of the changes and 9% were *not aware of any of the changes***. Among those who were only aware of some changes, they reported the least awareness of change #4, related to the new healthy behavior requirements (see Appendix 3 for specific comments).

List of program changes provided to dentists:

1. All adults in Medicaid and Dental Wellness Plan were moved into the new DWP ("**DWP 2.0**").
2. Medicaid members are now randomly assigned to one of the two DWP 2.0 carriers: Delta Dental of Iowa and MCNA Dental. Members have 90 days to switch carriers if desired.
3. All DWP 2.0 members are now eligible for comprehensive dental coverage their first year in the program.
4. In order 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. If members to not pay the premium, dental coverage will be reduced to emergency services only.
5. Reimbursement rates for DWP 2.0 are approximately the same level as previous traditional Medicaid rates.

PARTICIPATION IN DWP AND MEDICAID

At the time of this survey, dentists' rates of participation in DWP and fee-for-service (FFS) Medicaid were lower than rates prior to July 2017 (Figures 1 and 2). Dentists were asked whether they accepted new DWP patients before DWP 2.0 was implemented, as well as their acceptance of new patients afterward. 67% of dentists reported that they had accepted new DWP patients prior to DWP 2.0, whereas 39% reported accepting new patients after. Acceptance of new Medicaid patients decreased from 65% of dentists to 55%; it should be noted that Medicaid acceptance prior to DWP 2.0 includes both children and adults, whereas Medicaid acceptance after DWP 2.0 includes children only, as all adults were moved into the DWP 2.0). For this report, dentist participation is defined as accepting NEW patients.

When asked who in the practice was primarily responsible for making the decision to accept DWP or Medicaid patients, 60% of respondents were solely responsible. Other respondents said the dentists in the practice made the decision as a group (20%), the owner dentist made the decision (11%), clinic management/administration (5%), or some other entity (3%).

Figure 1. Proportion of dentists accepting new DWP patients before and after July 2017 by number of dental carriers accepted (n=305)

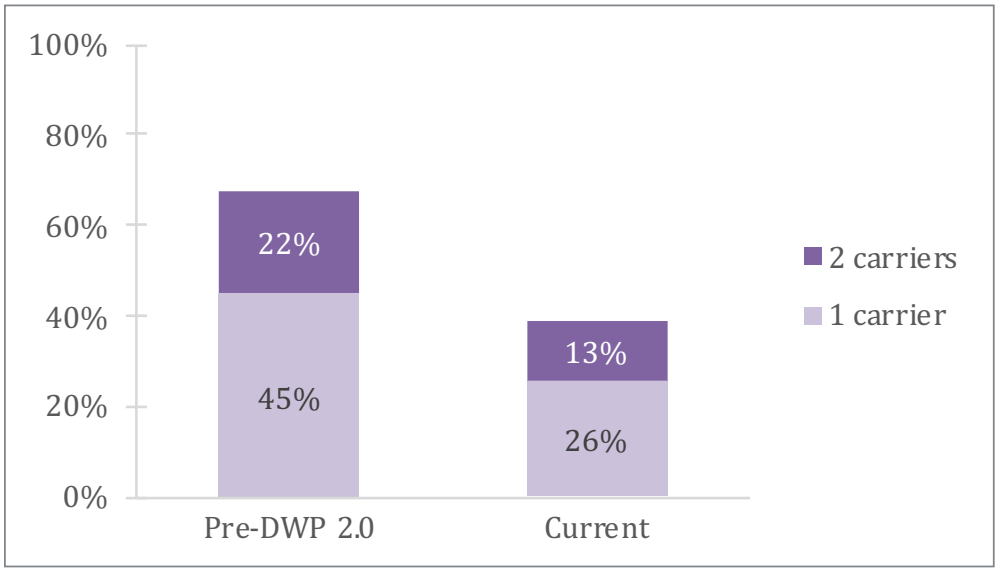
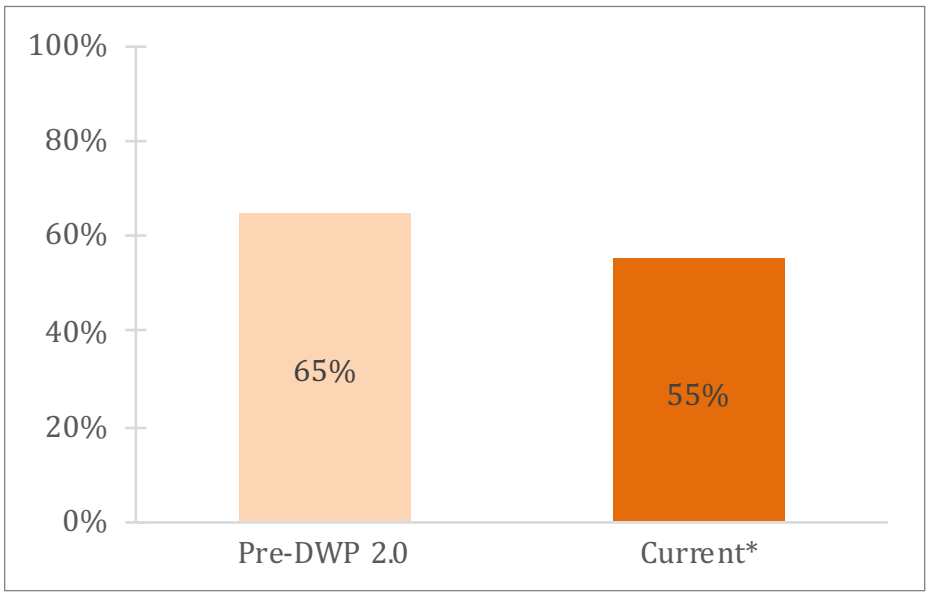


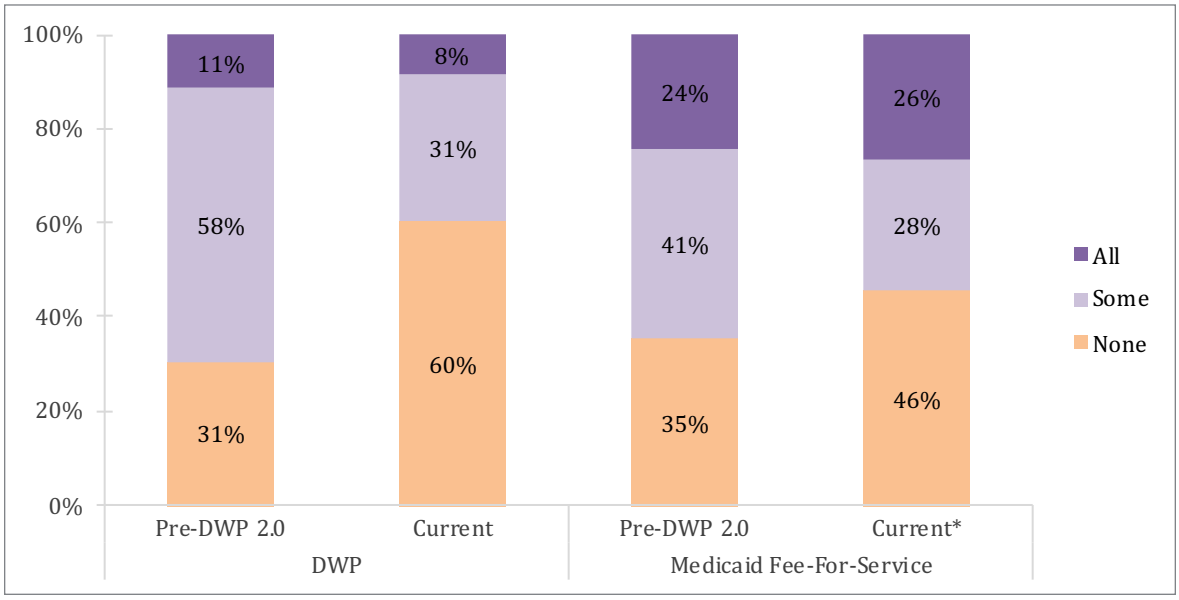
Figure 2. Proportion of dentists accepting new Medicaid patients before and after July 2017 (n=305)



*Current Medicaid participation refers to acceptance of Medicaid-enrolled children only, since all adults were moved to DWP 2.0.

Dentists who reported current or past participation were asked about their level of participation (i.e., if they accepted *all* or *some* new DWP patients). The proportions accepting *all* and *some* new DWP patients both decreased, whereas the proportion accepting *all* new Medicaid patients increased slightly (**Figure 3**). Among dentists who currently accept only *some* new patients, the most common limit is accepting only referrals from family members of existing patients (see Appendix 4 for detailed results).

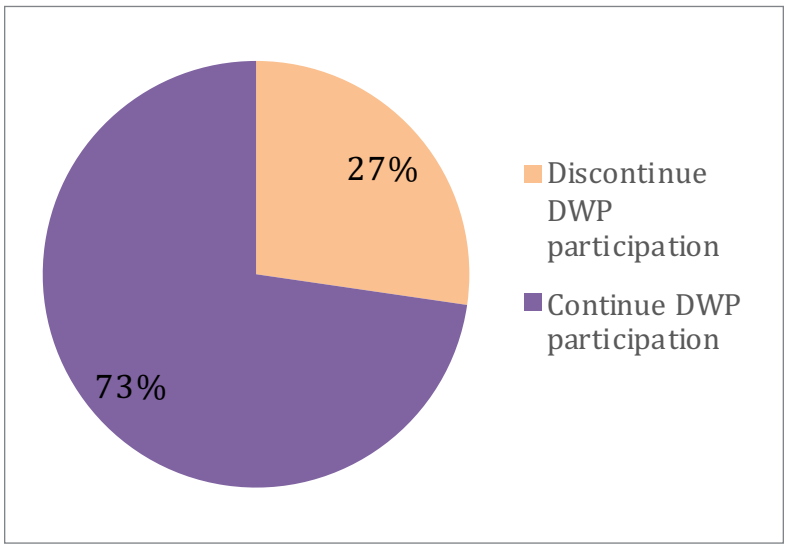
Figure 3. Level of acceptance of new DWP and Medicaid patients



We asked dentists who were currently accepting any new DWP patients (i.e., *all or some*) *if they plan to continue doing so for the next 6 months*. **Among those currently accepting new DWP patients, 27% plan to discontinue participation within the next 6 months (Figure 4).**

Among dentists who were not currently accepting new DWP patients, 43% (n=53) of these dentists were still enrolled as a Medicaid provider.

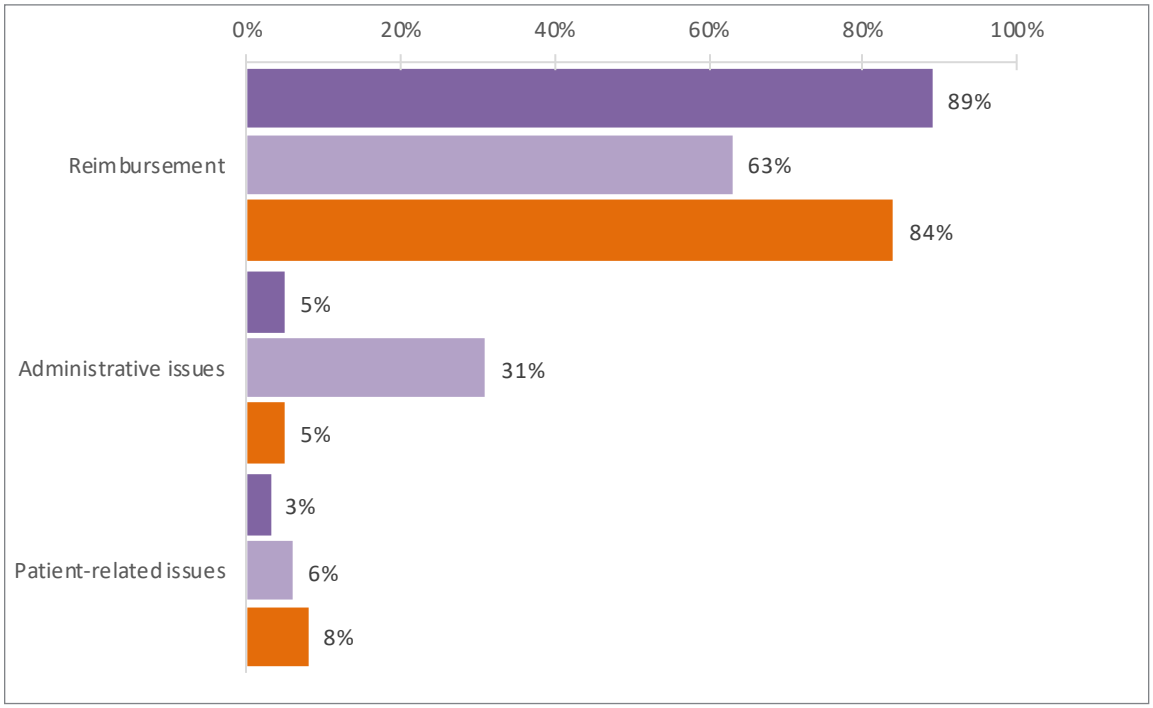
Figure 4. Plans for DWP participation within the next 6 months (n=96)



DENTIST ATTITUDES AND EXPERIENCES WITH DWP AND MEDICAID

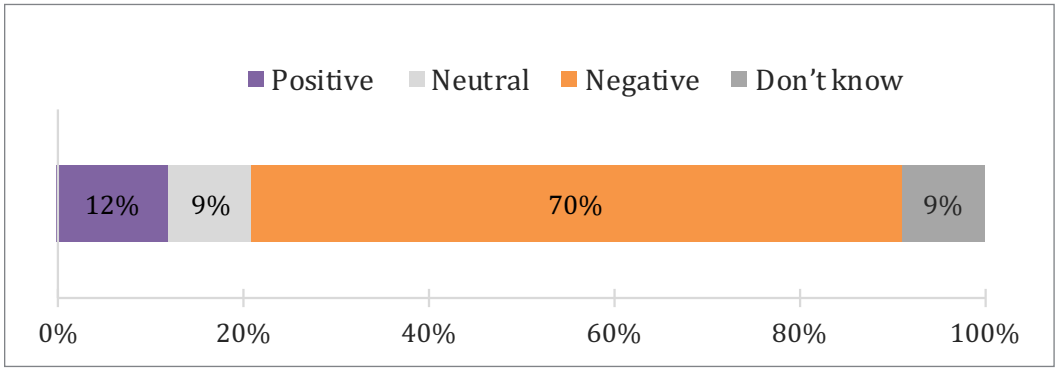
Reimbursement was the most important reason for dentists' discontinuation of accepting new DWP/Medicaid patients after implementation of DWP 2.0 (Figure 5). The proportion of dentists selecting reimbursement as a reason for discontinuation was the highest for Carrier 1 (89%), followed by Medicaid (84%) and Carrier 2 (63%). Among dentists who stopped accepting patients with Carrier 2, 31% identified administrative issues as the second most important reason for discontinuation.

Figure 5. `Dentists' most important reasons for stopping acceptance of new patients covered by each plan Carrier 1 [n=94], Carrier 2 [n=35], Medicaid FFS [n=37]



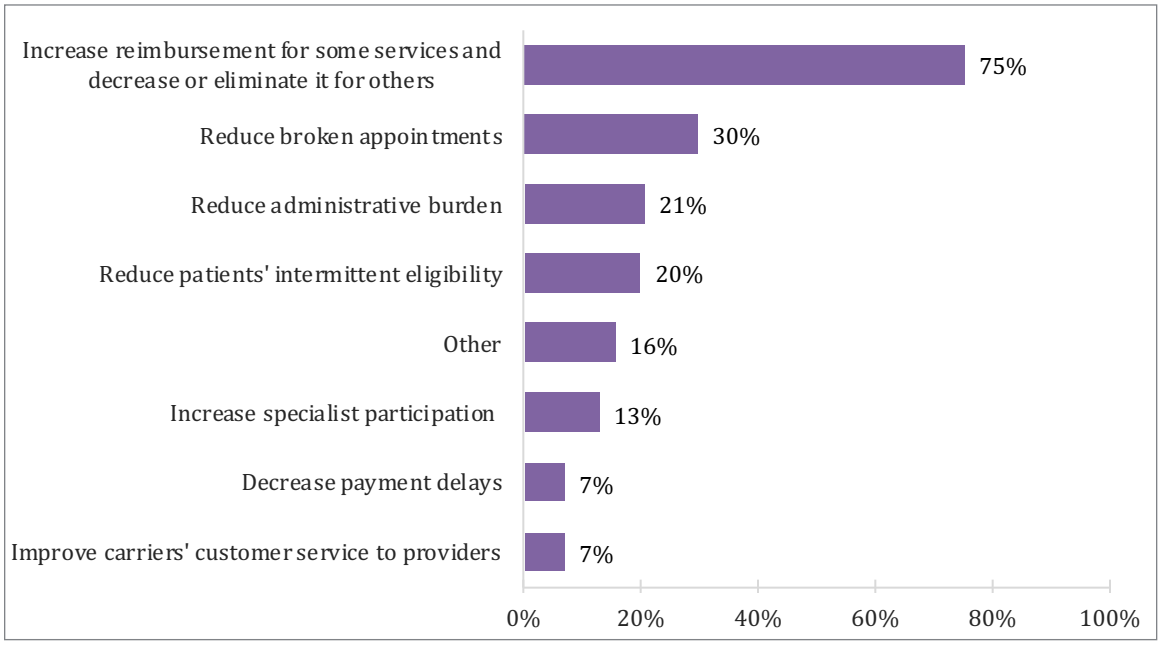
Overall, 7 in 10 dentists reported a negative attitude toward DWP 2.0 (Figure 6).

Figure 6. Dentists' overall attitude toward DWP 2.0 (n=305)



We asked dentists to identify the most important changes that could be made to increase dentists' participation in the DWP 2.0 program without increasing overall cost of the program. The 2 changes most frequently selected were: '*Increase reimbursement for some services and decrease or eliminate it for others*' (75%) and '*Reduce broken appointments*' (30%) (**Figure 7**). Among those who selected 'other', the most common themes in the open-ended responses were related to concerns with reimbursement and scope of services covered; comments emphasized the need to increase reimbursement rates and cover more procedures.

Figure 7. Dentists' most commonly identified changes that could be made to increase dentist participation in DWP 2.0 without increasing the overall cost of the program (n=297)



Note: Respondents were able to select more than one answer.

Among respondents who indicated that adjusting reimbursement rates would increase participation, we then asked them what types of services should be increased, decreased or eliminated from coverage. Most respondents only selected services for increased reimbursement. Most commonly, dentists would like to see increased reimbursement for: restorative services (97%), preventive services (90%), and oral surgery (89%). Detailed results can be found in Appendix 4.

OPEN-ENDED COMMENTS FROM DENTISTS

Respondents were asked to provide comments about changes to the Dental Wellness Plan. In total, 173 dentists provided comment. Comments were analyzed qualitatively and emergent themes are presented below, as well as illustrative quotations. Categories are presented based on the number of responses in each category from greatest to least. The complete list of comments can be found in Appendix 3. Some comments span multiple categories; therefore, many are listed in more than one table.

OVERALL COMMENTS ABOUT CHANGES TO DWP 2.0

Overall theme 1: Dentists are dissatisfied with reimbursement rates

Reimbursement was a recurrent issue that most respondents commented on. As previously mentioned, dentists were dissatisfied with reimbursement rates in DWP 2.0 and expressed concerns about operating at a loss.

- *"Again, the primary issue is with reimbursement. In speaking regularly with a majority of dentists in our area, we agree that a business cannot be operated at a loss. So to raise reimbursement 3-5% is a waste of time. It literally needs to double to get to a point to where there would be consideration of accepting DWP patients."*
- *"As a dentist who was taking new patients with Title XIX and the DWP, these changes are a step in the wrong direction. Until all dentists are required to accept XIX in Iowa, the reimbursement rates need to improve in order to have dentists accept new patients. With the expansion of the Medicaid population, more patients are flooding an already exhausted pool of dentists. I could no longer afford to keep seeing these patients as they were a majority of my new patient pool and I was the only dentist in town taking new patients with it. I think the reimbursement for disease control treatments should be increased such as restorative, periodontal treatments, and oral surgery. I guess what needs to be determined is do we provide comprehensive treatment for fewer patients or limited treatment for all patients? Limiting dentures, endodontic treatments, and crowns should be considered."*

Overall theme 2: Paperwork and pre-authorizations are burdensome

Respondents reiterated their concerns about administrative burden. Many commented that the amount of paperwork and pre-authorizations required for specific procedures were cumbersome to their practice.

- *"We accepted adult Medicaid patients, without limits, from our county, and we accepted many from surrounding counties as the schedule allowed. The DWP (both versions) administrative requirements are more than we can justify with the staff available. We continue to see children with Medicaid, and will continue to do so until the admin burden increases."*

Overall theme 3: Consider providing limits on benefits

A number of respondents commented on the range of services covered and made suggestions as to which services to cover and those to limit. Some dentists also recommended implementing a yearly maximum for dental benefits.

- *"Endodontic: limit to anterior teeth only or eliminate special procedures or limit yearly allowance. Fixed: limit to single units only. Preventive: increase $ on radiographs and don't lump into full mouth (this compromises motivation for proper diagnosis). Thank you for allowing fluoride. Periodontic: Thank you for allowing S&RP without pre authorizations. Eliminate specialty periodontic procedures. Removable: increase fees for permanent partials/completes but either increase or eliminate totally minor procedures like add tooth/add clasp (not profitable with lab fees). Oral Surgery: fees are acceptable for a GP. Eliminate or allow only oral surgeons to do procedures beyond 7210/7140. Some earned benefits would be welcomed. Not enough MCNA providers- consider allowing Delta Dental to administer all DWP; really disappointed in program that oral surgeons are pulling out."*
- *"Need to put restrictions on adult care, either a yearly maximum or decrease benefits such as endodontics, fixed prosthodontics and evaluate all aspects or this is will not be sustainable by the state. Administrators, Delta and MCNA, will likely see decreased funding and will leave the program, due to the need to follow sound business practices. Not sure DHS really pay much attention to dental, given the medical program problems."*

Overall theme 4: Dentists expressed a preference for DWP 1.0

Overall, many dentists said that they preferred DWP 1.0 over DWP 2.0. Reasons for this preference include: higher

reimbursement in DWP 1.0, the availability of bonus pool payments and the presence of the tiered benefits structure (some providers mentioned that the tiered structure improved their patients' responsibility towards recall and personal oral health).

- *"As a provider that believes in Public health initiatives I think DWP was a great program that seems to be moving in the wrong direction as far as helping the patient. I think the wait period for patients originally made sense to weed out the unwilling or non-committed patients. Dropping rates of reimbursement is now going to weed out doctors like myself that want to help these patients but due to my small practice may not be able to continue to handle the load of low reimbursement and staffing and lab fees. It saddens me to see the program move in this direction. I hope more positive changes happen in 2018."*
- *"Consider the bonus pool checks as an incentive. Very disappointed that the bonus pool program was eliminated."*

Overall theme 5: Dentists are frustrated by failed appointments

A common frustration among respondents was the issue of failed appointments.

- *"Make it difficult to get on it. I am serious. DWP for the fortunate ones. Right now patients take it as an entitlement. They think they should get paid for implants or crown to fix cosmetics, braces etc. And they don't value their appointments, too many no shows. If you made it difficult to get, like have to show up in person, take a quiz about the program so you know what you cover or not and you can't get it before you pass the quiz, and then and only then your eligible. And make a strike system. 2 no show appointment and you're not eligible for any coverage for 12 months."*

Overall theme 5: Dentists want more responsibility on the part of DWP/Medicaid patients

Respondents also expressed concerns about the DWP/Medicaid population with respect to their dental care-seeking behaviors and a lack of personal responsibility.

- *"Too many patients with too little responsibility to the program who feel entitled."*
- *"We cannot continue to give able bodied people free services. They must accept responsibility for their choices. In other words capable people must have "skin in the game". I give charitable dental work to those who have come upon hard times but are working hard to better themselves."*

Overall theme 6: There is a need to increase the DWP/Medicaid provider network

Some respondents discussed concerns about the lack of providers accepting DWP/Medicaid patients.

- *"If all dentists would take at least some DWP/Medicaid patients, then the patients would benefit substantially. My office is too busy to meet the demands of all of the DWP/Medicaid patients in the area in which I practice."*
- *"I hope this survey shows that Delta and MCNA don't have the required network of dentists actually taking DWP patients and changes the program back to the way it was. I was ok with taking a low reimbursement for adult Medicaid when I knew no one was profiting from it. Having my office lose money on DWP patients while Delta makes millions makes no sense."*

Overall theme 7: There are issues with eligibility determination and disruptions in coverage

Patients' intermittent eligibility was another issue discussed by some respondents. Comments referred to difficulty determining patients' eligibility and loss of continuity of care as a result of patients losing eligibility.

- *"We were disappointed that the reimbursement coverage was decreased dramatically when it "merged" with the adult Medicaid program. The intermittent coverage is also tough. I had a patient that was approved for a crown, we prepped the tooth in one month, and seated the crown the next month. Meanwhile, he let his coverage lapse so we were left without payment."*

Overall theme 9: Patients do not understand their plan or healthy behavior requirements

Patients' lack of understanding of their plan was another issue discussed by some respondents. Comments referred to patients' lack of awareness about which insurance they have and the healthy behavior requirements.

- *"Education for the patients about what dental program they have. Close to 80% of the patients*

that come to our office still think they have straight Medicaid, some people think they have dental coverage when they don't and they insurance cards they give us are usually Ameritas or United Healthcare. When asking them for their insurance card for dental they say that this is the only card they received. I feel these patients need to know that the providers are taking a considerable cut in their reimbursement rate. I am extremely happy that the different levels of the program are no longer. Although I feel the rule on approved prior authorizations before the service is completed should not be such an issue."

- *"When 7/1/18 rolls around and patients have not had an exam or done their self-assessment, it is going to be a nightmare. They will not know that their benefits are reduced. They will not pay a monthly premium. The dentist is going to bear the brunt of the fallout. The change on 7/1/17 was bad enough because most patients on DWP don't understand their benefits or even who their carrier was when the change happened. Because I am not participating with MCNA, I turned previous patients away who were randomly assigned MCNA and did not know enough to change to Delta IA who I do participate with. The general population on DWP does not have the knowledge base to understand all the ramifications/changes that continue to take place."*

Overall theme 10: Dentists have concerns about the oral health self-assessment

Respondents also expressed concerns about the feasibility and value in patients' completing the oral health self-assessment.

- *"I have two main issues with DWP 2.0. First, is the annual survey a patient has to complete to keep their full benefits. My question is why this even exists. I understand one could make the argument that it can promote an individual to take part in their evaluation of dental health. I understand how one could say that it is important to make one understand the benefit of self-reflection. However, by making this as a necessary component of keeping their full benefits, DWP is artificially creating more barriers and obstacles to overcome to obtain full dental benefits that they are eligible to receive. I believe the goal of Iowa Medicaid in regards to dental health was to create a level playing field in Iowa for patients to receive good dental care. How many private insurance member have to take a survey in order to have a restoration completed? Like I said, I understand the philosophical approach of the survey. However, let's take a different approach to self-assessment. Why don't we make it a requirement that the dentist at a recall, goes over oral hygiene assessment directly with the patient. That then will ensure that the patient is receiving adequate education and also a time for self-reflection. My 2nd main complaint about DWP is the transition."*

CONCLUSIONS

This study examined dentists' early experiences with DWP 2.0 and identified several important issues. First, dentist participation in DWP and Medicaid appeared to decline after the policy change in August 2017. Further, more than one-quarter of dentists who currently participate in DWP plan to discontinue participation within the next 6 months. These trends are likely to impact access to care for adults enrolled in DWP 2.0 and, due to the decrease in Medicaid FFS participation, potentially for children enrolled in the traditional fee-for-service Medicaid program as well. Reimbursement was the most common reason for discontinuing participation and was also mentioned in many open-ended comments as a key issue.

Dentists had vastly differing attitudes toward the 2 private dental carriers. Dentists were much more likely to have a positive opinion of Carrier 1; in their open-ended comments, many dentists cited administrative frustrations and lack of professionalism specific to Carrier 2.

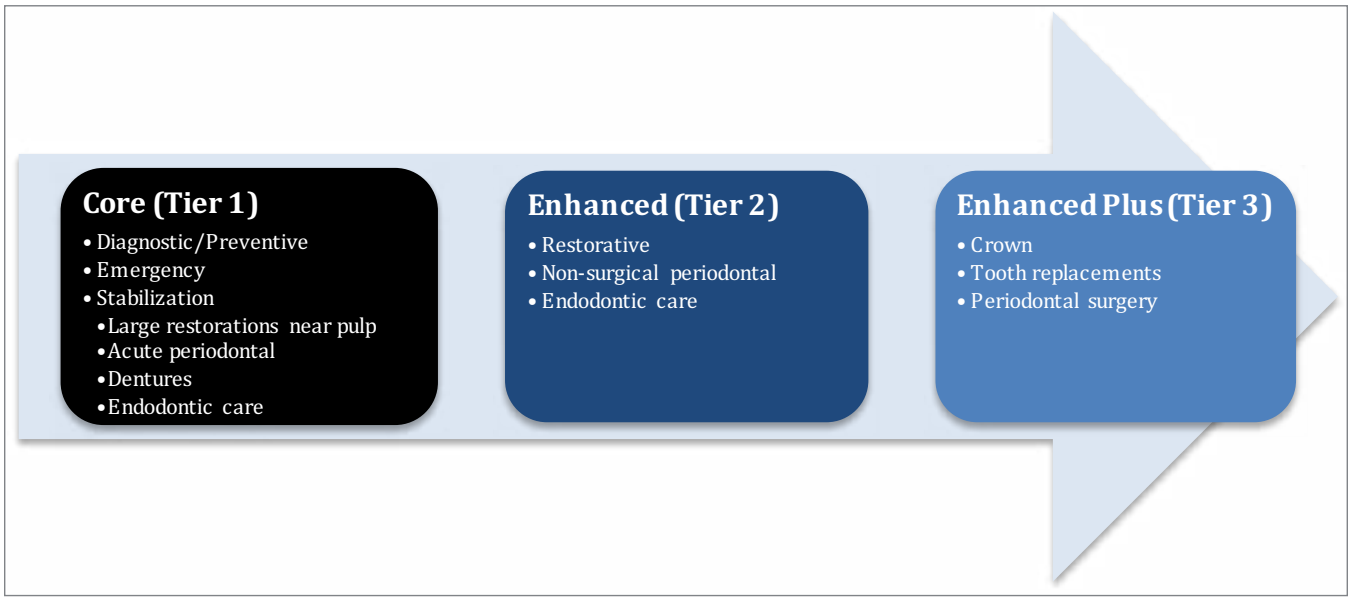
Dentists' overall attitude toward DWP 2.0 was negative and may be related to the decline in reimbursement rates compared to DWP 1.0 as indicated by dentists' responses to this survey.

APPENDIX 1: DWP 2.0 BACKGROUND & METHODS

Beginning in May 2014, the Centers for Medicaid and Medicare Services (CMS) approved Iowa's request to offer dental benefits to adults age 19-64 in Iowa's Medicaid expansion population through a program called the Dental Wellness Plan (DWP). Originally, DWP had a tiered benefit structure whereby members had limited dental benefits upon enrollment but could earn additional benefits by returning for regular periodic recall exams every 6-12 months (see figure below).

Three years later, on May 1, 2017, the State of Iowa proposed a Medicaid State Plan Amendment (SPA), to be effective July 1, 2017.[3] Through this amendment, the DWP was redesigned as an integrated dental program for all Medicaid enrollees aged 19 and over. Prior to May 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 this amendment, the State proposed to offer a single, unified adult dental program – DWP 2.0 – for most adult Medicaid enrollees. This unified dental program was intended to ensure continuity of care as members transition between Medicaid eligibility categories.[4]

Original Dental Wellness Plan Earned Benefits Design



ELIGIBILITY

All Iowa Medicaid enrollees, aged 19 and older, except for the populations listed below receive dental benefits through DWP 2.0.

Medicaid populations excluded from DWP 2.0 include:

1. Persons enrolled in the Program of All-Inclusive Care for the Elderly (PACE)
2. Persons enrolled in the Health Insurance Premium Payment Program (HIPP)
3. Presumptively eligible individuals
4. Nonqualified immigrants receiving time-limited coverage
5. Persons eligible only for the Medicare Savings Program
6. Medically needy
7. Periods of retroactive eligibility

Dental Benefits in DWP 2.0

Along with merging 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

3 Section 1115 Demonstration Amendment. Iowa Wellness Plan. Project #11-W-00289/5. State of Iowa Department of Human Services. May 1, 2017. Available at: https://dhs.iowa.gov/sites/default/files/Iowa_DWP_Draft_1115_Final_05.1.17.pdf. Accessed 8/1/2017.

4 *Ibid*

become eligible for Tiers 2 and 3.[5] Comprehensive dental benefits are available to members in the DWP 2.0 during their first year of enrollment.[6]

Dental Wellness Plan 2.0 dental benefits available to members during their first year of enrollment

Description
Diagnostic/preventive dental services • Exams and education • Cleanings • Radiographs • Fluoride
Emergency services
Restorative services
Non-surgical periodontal
Endodontic care
Crowns
Tooth replacements
Periodontal surgery

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

Dental Wellness Plan 2.0 preventive services for healthy behaviors

CDT Code	Description
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 in presence of generalized moderate or severe gingival inflammation – full mouth
D4910	Periodontal maintenance

Delivery System

Dental benefits in the DWP 2.0 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. These carriers are identified as Carrier 1 and Carrier 2 throughout the report. Beginning August 1, 2017, all adult Medicaid enrollees were transitioned from the then fee-for-service delivery system to one of the two PAHPs; existing Medicaid enrollees and newly eligible individuals were assigned evenly between the two plans. Members were given the opportunity to change PAHPs in their first 90 days of enrollment without cause.

Provider Reimbursement

Whereas the DWP 1.0 program included higher reimbursement to providers compared to traditional Medicaid, the reimbursement level in DWP 2.0 was approximately the same as previous FFS Medicaid. This was partially driven by the fact that combining the Medicaid FFS and Medicaid expansion populations into one dental plan meant that the state could no longer obtain federal match funding.

5 *Ibid.* at 6.
6 *Ibid.* at 6.

METHODS

In December 2017, an online survey was sent by email to all Iowa dentists with an active license (n=1903). The survey was sent by the Iowa Dental Board, which maintains a list of email addresses for 99% of all Iowa dentists. Due to the IDB's inability to share dentist email addresses with outside entities, it was necessary that the organization field the survey directly. An email reminder was sent to the same distribution list one week after initial fielding.

Survey Instrument

Survey questions were modified from a previous survey administered to Iowa private practice dentists in 2016.[7] Additional original survey items were added where relevant to the DWP 2.0 policy change. Surveys were pretested with two Iowa private practice dentists as part of survey development and recommended changes were made accordingly. Survey topics included current and past participation in DWP 1.0 (including Delta Dental and MCNA Dental carriers), and Medicaid, suggestions for program improvement, and dentist and practice characteristics.

Dentists in public health or academic settings, as well as those who are not currently practicing in Iowa were excluded via screening questions at the beginning of the survey.

The survey instrument was reviewed by the Iowa Medicaid Enterprise (IME) prior to distribution. A copy of the survey is located in **Appendix 2**.

Analyses

Descriptive analyses were conducted for all survey items. All results are presented unweighted, and all analyses were conducted using IBM SPSS Version 25.

Response Rates and Response Bias

In total, 48 dentists were screened out and 305 dentists completed the full survey, for a response rate of 21%.[8] Regarding response bias, we found that dentists who participated in the DWP before the policy change may be overrepresented in our results; dentists who do not participate in DWP may have been less likely to complete this survey. A 2016 survey found that 42% of dentists participated in DWP at that time, which is considerably lower than the rate of current survey respondents who reported accepting DWP patients before August 2017 (67%).

Limitations

Limitations to this study are centered on the method of survey administration. In order to be able to quickly field and report on dentists' early experiences with DWP 2.0, it was desirable to use an online survey format. However, because the email came from the IDB directly and could not be individualized to each dentist, recipients may have either ignored the email or thought it did not apply to them. Further, because the survey was fielded in aggregate and we could not track who had completed the survey, we were not able to target reminders to nonrespondents only.

7 Reynolds JC, McKernan SC, Sukalski J, McInroy B, Kuthy RA, Damiano PC. Evaluation of the Dental Wellness Plan: Experiences of Private Practice Dentists after Two Years. University of Iowa Public Policy Center. July 2017. http://ppc.uiowa.edu/publications/evaluation-dental-wellness-plan-experiences-private-practice-dentists-after-two-years

8 The IDB reported that a total of 1,444 dentists in their database with an email address on file and who indicated they were in private practice at the most recent licensure renewal, which serves as the denominator for response rate calculations.

APPENDIX 2: SURVEY INSTRUMENT

Note: The survey instrument was developed and administered completely online; therefore, formatting and skip patterns are not replicated exactly as they were seen in the online instrument.

Cover letter (in body of email message)

Subject line: Survey invitation: Changes to Iowa's Dental Wellness Plan

To: All Iowa licensed dentists

You are invited to participate in a research study to understand dentists' attitudes toward, and experiences with, Iowa's redesigned Medicaid and the Dental Wellness Plan (DWP) after recent changes to the programs. **We are inviting all private practice dentists in Iowa to participate in this survey regardless of participation in the DWP**. The survey will take approximately 5-10 minutes to complete.

If you choose to participate, please click on the link below to access the survey. Your responses will be anonymous. Your answers will be grouped with responses from all participants; individual answers will never be shown. 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.

If you have any questions about this survey, please contact Brooke McInroy by telephone at 1-800-710-8891 or by email at ppc-surveys@uiowa.edu.

By taking a few minutes to respond, you will be adding greatly to our understanding of the impact of recent Medicaid program changes on Iowa dentists. We thank you very much for your consideration to participate in this important study.

Respectfully,

Dr. Peter Damiano
Professor and Director
University of Iowa Public Policy Center

Click here to access the survey <insert link>

2017 DWP Dentist Transition Survey

As indicated, the aim of this survey is to learn about the attitudes and participation of private practice dentists in Iowa toward the redesigned Medicaid DWP program.

We first have a couple of questions to make sure you are eligible for this survey:

1. What is your current practice status?
    a. Practicing in Iowa, full time (30+ hours/week)
    b. Practicing in Iowa, part time (less than 30 hours/week)
    c. Practicing zoutside Iowa (**END OF SURVEY**)
    d. Not currently practicing or retired (**END OF SURVEY**)
2. What is your primary practice setting?
    a. Private practice
    b. Community health center or other public health clinic (**END OF SURVEY**)
    c. Academic institution (**END OF SURVEY**)

CHANGES TO MEDICAID (TITLE XIX) AND DENTAL WELLNESS PLAN

From May 2014 through July 2017, there were two public dental insurance programs in Iowa:

- Traditional **Medicaid** for low-income children and adults
- **Dental Wellness Plan (DWP)** for low-income adults in the Medicaid expansion program

Previously, traditional Medicaid members received comprehensive dental coverage upon enrollment, whereas DWP members were eligible for limited coverage upon enrollment and had to return for regular preventive visits in order to earn additional benefits.

Starting August 1, 2017:

1) All adults in Medicaid and Dental Wellness Plan were moved into the new DWP ("**DWP 2.0**").
2) Medicaid members are now randomly assigned to one of the two DWP 2.0 carriers: Delta Dental of Iowa and MCNA Dental. Members have 90 days to switch carriers if desired.
3) All DWP 2.0 members are now eligible for comprehensive dental coverage their first year in the program.
4) In order 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. If members do not pay the premium, dental coverage will be reduced to emergency services only.
5) Reimbursement rates for DWP 2.0 are approximately the same level as previous traditional Medicaid rates.

1. Were you previously aware of these changes to the Iowa Medicaid and DWP dental programs?
    a. Yes, I was aware of <u>all</u> of these changes
    b. Yes, I was aware of <u>some</u> of these changes (please describe which aspects you were not aware of:_____)
    c. No, I was not aware of any of these changes

As mentioned, there are currently two carriers providing coverage for DWP enrollees: Delta Dental of Iowa and MCNA Dental. The next section will ask about your participation with each carrier.

<u>DWP Delta Dental Participation</u>

2. Are you currently accepting <u>new</u> Dental Wellness Plan patients with coverage through Delta Dental?
    a. Yes, we are accepting <u>all</u> new DWP Delta Dental patients
    b. Yes, we are accepting <u>some</u> new DWP Delta Dental patients
        i. Which patients do you accept? *Select all that apply.*
            1. A set number of new DWP Delta Dental patients
            2. Referrals or family members of existing patients

3. Referrals from other dentists/physicians
4. Emergencies
5. Other, *please describe*: _____

c. No, we are not accepting any new DWP Delta Dental patients

3. Prior to the program changes in August 2017, did you accept **new** DWP Delta Dental patients?
    a. Yes, we accepted all new DWP Delta Dental patients
    b. Yes, we accepted some new DWP Delta Dental patients
    c. No, we did not accept any new DWP Delta Dental patients
4. (if Q2=yes) Are you planning to continue accepting new DWP Delta Dental patients for at least the next 6 months?
    a. Definitely yes
    b. Probably yes
    c. Probably no
    d. Definitely no
5. (if Q2=no & Q3=yes) What is the most important reason that you stopped accepting new DWP Delta Dental patients?
    a. Reimbursement
    b. Administrative issues, *please describe*: _____
    c. DWP patient-related issues, *please describe*: _____
    d. Other, *please describe*: _____
6. (if Q2=no) Even though you are not accepting new DWP Delta Dental patients, do you currently have any DWP Delta Dental patients in your practice?
    a. Yes
    b. No
7. Which best describes your attitude toward Delta Dental's administration of DWP?
    a. Very positive
    b. Somewhat positive
    c. Somewhat negative
    d. Very negative
    e. Don't know/Not sure
8. (if Q7 ≠ don't know/not sure) Please describe your perceptions of Delta Dental's administration of DWP.
9. (if Q2=no and Q6=no) Even though you do not currently accept DWP Delta Dental patients, are you contracted with Delta Dental as a DWP provider?
    a. Yes
    b. No
    c. Don't know/Not sure

DWP MCNA Dental Participation

10. Are you currently accepting **new** Dental Wellness Plan patients with coverage through MCNA Dental?
    a. Yes, we are accepting all new DWP MCNA patients
    b. Yes, we are accepting some new DWP MCNA patients
        i. Which patients do you accept? *Select all that apply.*
            1. A set number of new DWP MCNA patients
            2. Referrals or family members of existing patients
            3. Referrals from other dentists/physicians
            4. Emergencies
            5. Other, *please describe*: _____
    c. No, we are not accepting any new DWP MCNA patients

11. Prior to the program changes in August 2017, did you accept any new DWP MCNA patients?
    a. Yes, we accepted all new DWP MCNA patients
    b. Yes, we accepted some new DWP MCNA patients
    c. No, we did not accept any new DWP MCNA patients
12. (if Q10=yes) Are you planning to continue accepting new DWP MCNA patients for at least the next 6 months?
    a. Definitely yes
    b. Probably yes
    c. Probably no
    d. Definitely no
13. (if Q10=no & Q11=yes) What is the most important reason that you stopped accepting new DWP MCNA patients?
    a. Reimbursement
    b. Administrative issues, *please describe*: _____
    c. DWP patient-related issues, *please describe*: _____
    d. Other, *please describe*: _____
14. (if Q10=no) Even though you are not accepting new DWP MCNA patients, do you currently have any of these patients in your practice?
    a. Yes
    b. No
15. Which best describes your attitude toward MCNA's administration of DWP?
    a. Very positive
    b. Somewhat positive
    c. Somewhat negative
    d. Very negative
    e. Don't know/Not sure
16. (if Q15 ≠ don't know/not sure) Please describe your perceptions of MCNA's administration of DWP.
17. (if Q10=no & Q14=no) Even though you do not currently accept DWP MCNA patients, are you contracted with MCNA as a DWP provider?
    a. Yes
    b. No
    c. Don't know/Not sure

Medicaid (Title XIX) Participation

18. Are you currently accepting **new** Medicaid-enrolled children as patients? (Medicaid only, not including Hawk-I)
    a. Yes, we are accepting all new child Medicaid patients
    b. Yes, we are accepting *some* new child Medicaid patients
        i. Which patients do you accept? *Select all that apply.*
            1. A set number of new child Medicaid patients
            2. Referrals or family members of existing patients
            3. Referrals from other dentists/physicians
            4. Emergencies
            5. Other, *please describe*: _____
    c. No
19. Prior to the program changes in August 2017, did you accept new Medicaid patients?
    a. Yes, we accepted all new Medicaid patients

b. Yes, we accepted some new Medicaid patients

i. Which patients did you accept? *Select all that apply.*

2. A set number of new Medicaid patients
3. Adults only
4. Children only
5. Referrals or family members of existing patients
6. Referrals from other dentists/physicians
7. Emergencies
8. Other, *please describe*: _____

c. No, we did not accept any new Medicaid patients

20. (if Q18=no & Q19=yes) What is the most important reason that you stopped accepting new Medicaid patients?

1. Reimbursement
2. Administrative issues, *please describe*: _____
3. DWP patient-related issues, *please describe*: _____
4. Other, *please describe*: _____

21. (if Q2, Q10, & Q18=no) In June 2017, Iowa Medicaid required all Medicaid providers to renew enrollment in order to maintain active Medicaid provider status. Even though you do not accept new DWP or Medicaid patients, are you currently enrolled as a Medicaid provider?

a. Yes

b. No

i. Were you enrolled as a Medicaid provider prior to the required enrollment renewal in June?

2. Yes
3. No

c. Don't know/Not sure

Your Suggestions for Improving the DWP 2.0 Program

22. What describes your overall attitude toward DWP 2.0?

a. Very positive
b. Somewhat positive
c. Neither positive nor negative
d. Somewhat negative
e. Very negative
f. Don't know/Not sure

23. Please identify the two most important changes that could be made to increase dentists' participation in the DWP 2.0 program without increasing the overall cost of the program.

a. Increase reimbursement for some services and decrease or eliminate it for others

i. (if selected Q23_a) Please select the types of services for which reimbursement should be increased, decreased, or eliminated.

Services	Increase reimbursement	Decrease reimbursement	Eliminate reimbursement
Preventive	☐	☐	☐
Restorative	☐	☐	☐
Periodontics	☐	☐	☐
Endodontics	☐	☐	☐
Oral surgery	☐	☐	☐
Fixed prosthodontics	☐	☐	☐
Removable prosthodontics	☐	☐	☐

b. Reduce administrative burden (Please describe: _____)
c. Decrease payment delays
d. Improve carriers' customer service to providers
e. Reduce broken appointments
f. Reduce patients' intermittent eligibility
g. Increase specialist participation
h. Other: _____

Dentist & Practice Characteristics

24. What is your dental clinical specialty?
    a. General dentist
    b. Endodontics
    c. Oral and maxillofacial surgery
    d. Pediatric dentistry
    e. Prosthodontics
    f. Periodontics
    g. Orthodontics
25. What is your employment situation in your primary practice?
    a. Sole proprietor (i.e., the only owner/shareholder)
    b. Partner (i.e., one of two or more owners/shareholders)
    c. Employee (on a salary, commission, percentage or associate basis)
    d. Independent contractor
26. How many total dentists are in your primary practice, including yourself?
    a. Total number of OWNER dentists (i.e., sole proprietors, partners, or shareholders) _____
    b. Total number of NON-OWNER dentists (i.e., employed dentists, associates, non-shareholders, and independent contractors) _____
27. How many years have you been practicing in your current location? _____ years
28. Who was primarily responsible for making the decision whether your practice would accept Medicaid/DWP patients?
    a. I was
    b. The dentists in the practice as a group
    c. The owner of the practice
    d. The clinic management/administration
    e. Other: _____
29. What is the population of the city that your practice is located in?
    a. <2,500
    b. 2,500-9,999
    c. 10,000-49,999
    d. 50,000 or more
30. What is your age? _____ years
31. What is your gender?
    a. Female
    b. Male
32. What is your race/ethnicity?
    a. American Indian/Alaska Native
    b. Asian

c. Black/African American
d. Hispanic/Latino
e. Middle Eastern/North African
f. Native Hawaiian or other Pacific Islander
g. White
h. Other race or origin: _____

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

APPENDIX 3: OPEN-ENDED COMMENTS

WERE YOU PREVIOUSLY AWARE OF THESE CHANGES TO THE IOWA MEDICAID AND DWP DENTAL PROGRAMS?

All survey respondents

Yes, I was aware of some of these changes (please describe which aspects you were not aware of:

4) In order 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. If members do not pay the premium, dental coverage will be reduced to emergency services only.

1. Some of the benefits were eliminated.
2. #3 and #4.
3. #4.
4. #4- we didn't think this applied of the first year of the combined program.
5. #4 and #5.
6. #4- members must do preventative visit and self-risk assessment every 12 months.
7. $3 charge.
8. $3 per month, ha!
9. $3 copay if not having preventive visit.
10. #4.
11. Confusion about implementation of co-payment.
12. Did not know they needed to have a self-risk assessment completed.
13. Emergency services.
14. How members were separated, not aware of #4.
15. I don't know that they would have to pay a negligible premium if they failed preventive and self-assessment.
16. I didn't know there was a time limit for switch from Delta to MCNA or vice-versa. I didn't know that they still had comprehensive care with a $3 copay if they missed preventive visits or didn't fill out their self-assessment.
17. I was not aware of the self-risk assessment requirement.
18. If they do not complete a self-risk assessment they have to pay a premium.
19. Item 4- no premium means emergency treatment only.
20. Items 1-4.
21. Items 4 and 5 above.
22. Members have to fill out an assessment or pay $3 a month.
23. Members have 90 days to switch carriers, $3 premium.
24. Monthly premium.
25. Patients would have an insurance premium if they did not abide by the guidelines of one hygiene visit and self-assessment completed.
26. Point 4 above.
27. Premium/emergency services provision.
28. Preventive visit/risk assessment/premium charge.
29. Provision number 4.
30. Reducing to emergency services if do not pay the premium.
31. Reduction of benefits if patients does not complete self-assessment form.
32. Self-assessment surveys.
33. That they have to have a preventive visit in order to have no premiums.
34. That they were randomly assigned and that they have to complete the self-assessment and I heard rates were lower.
35. The DWP requirements for coverage.
36. The maintenance of benefits requirement that members must have a preventive visit and self-risk assessment every 12 months.
37. The requirement to keep comprehensive coverage. I would be interested what the data shows so far with this.

Yes, I was aware of some of these changes (please describe which aspects you were not aware of:

2) Medicaid members are now randomly assigned to one of the two DWP 2.0 carriers: Delta Dental of Iowa and MCNA Dental. Members have 90 days to switch carriers if desired.

1. Arbitrary assignment of subscribers into one of the two groups.
2. How members were separated, not aware of #4.
3. How some adults were assigned to the different plans.
4. I didn't know there was a time limit for switch from Delta to MCNA or vice-versa. I didn't know that they still had comprehensive care with a $3 copay if they missed preventive visits or didn't fill out their self-assessment.
5. I was not aware that there were two carriers for DWP 2.0.
6. If a patient started on DWP and was switched to MCNA. I feel that a lot of our patients don't know what they have. I feel if a patient starts on one program, even if there is a lapse in coverage, they should stay on that program. Some of our patients started up on DWP and ended up in MCNA. Like I said most of our patients don't realize exactly what they have, they just say they have Medicaid. Very frustrating!
7. Items 1-4.
8. Members have 90 days to switch carriers, $3 premium.
9. Number 2.
10. Patients are now randomly assigned to one of the two DWP 2.0 carriers.

11. Point number two: one of two carriers randomly assigned.
12. Random assignment.
13. Random assignment to DELTA vs. MCNA; 90 days to switch; every 12 months self-risk assessment.
14. Random assignment, monthly premium for patients.
15. That they were randomly assigned and that they have to complete the self-assessment and I heard rates were lower.
16. The random assignment.

Yes, I was aware of some of these changes (please describe which aspects you were not aware of:

5) Reimbursement rates for DWP 2.0 are approximately the same level as previous traditional Medicaid rates.

1. #4 and #5.
2. I wasn't aware that the reimbursement rates were going to be that low. I was under the impression they would be somewhere between the two previous plans.
3. Items 4 and 5 above.
4. Lower reimbursement. Non covered procedures.
5. That they were randomly assigned and that they have to complete the self-assessment and I heard rates were lower.
6. The fee schedule was less than the original DWP by a lot!!!
7. Though the reimbursement would be closer to the DWP rates.

Yes, I was aware of some of these changes (please describe which aspects you were not aware of:

3) All DWP 2.0 members are now eligible for comprehensive dental coverage their first year in the program.

1. #3.
2. #3 and #4.
3. DWP eligible for service during first year of coverage.
4. Items 1-4.

Yes, I was aware of some of these changes (please describe which aspects you were not aware of:

1) All adults in Medicaid and Dental Wellness Plan were moved into the new DWP ("DWP 2.0").

1. #1, all adults in Medicaid moved into the DWP 2.0.
2. Changes as of August 2017.
3. Items 1-4.

PLEASE DESCRIBE YOUR PERCEPTIONS OF DELTA DENTAL'S ADMINISTRATION OF DWP.

Survey respondents who did NOT answer 'don't know/not sure' for Q7

Reimbursement

1. Poor reimbursement. Too many administrative headaches for front desk and confusion among patients about what is covered. Patients on DWP who obviously have the means to pay for their dental treatment.
2. + Easy online claim submissions, clear guidelines for pre authorizations, efficient claim payments, good communication with patients. - Very low reimbursement rates.
3. A larger population of patients was bundled together and now reimbursement is lower than previous DWP plan and closer or similar to Medicaid fees. The reimbursement does not cover our office overhead to provide care for many services. For removable, the lab fees alone are barely covered. The 2.0 is improved that it feels like less of a monopoly game when explaining to patients, but it is not realistic reimbursement for private offices to be able to provide. Especially challenging in rural areas when can become a larger percentage of patient base.
4. Administration is fine but the reimbursement makes it tough to accept.
5. Although they are easier to work with than Medicaid, this is mostly due to our ability to send information online. The pre-authorizations and requirements to get coverage are difficult. We have had multiple build ups denied due to too much tooth remaining and also crowns denied for not enough tooth structure remaining. It is hard to know what criteria will be used. The reimbursement makes it difficult to provide services. We no longer make dentures or partials, and other procedures are close to being too low to continue.
6. As always, the fee schedule is a real problem. We are basically seeing these patients for free. We pay our hygienists more than we are reimbursed for cleaning procedures. That is a problem. My colleagues who were previously seeing wellness patients are disappointed with the change as well. I know you don't like to talk about money but it's a real problem.
7. At first, they didn't pay for services they said they would. Then they got more specific with the rules and clarified the services they would and would not pay for. Things went more smoothly after the first 6 months. I am very disappointed the program did not continue, and hope it comes back.
8. Can barely cover overhead with reimbursement rates.
9. Cannot afford to accept new DWP. Because of poor fees. Unacceptable.
10. Claims are being paid in a timely manner and are good at answering questions, but they drastically cut reimbursement rates to the levels of Medicaid. It is also hard to find specialist that will treat patients.
11. Classic bait and switch. They got our office to sign up by offering a reimbursement that at least covered overhead. Then they pulled the dropped the reimbursement to the Medicaid level and now are allowed to keep the extra profits since the bonus pool no longer exists. Delta making millions with tax payer dollars is a travesty.

12. Delta Dental does a great job administering a program that has been "broken" by the merging of the Title 19 and "old" DWP programs. The reimbursement is not acceptable and having to deal with two different administrators is unacceptable.
13. Delta dental has been decent to work with, but reimbursement is terrible for some procedures.
14. Delta Dental makes it very difficult to provide the necessary treatment needed for our DWP patients. With their extremely low reimbursement rates I just break even on any treatment that has a lab bill associated with it. Also, when we try to contact Delta Dental about DWP patients they are very hard to get an answer from.
15. Delta Dental pulled the classic bait and switch in which they lured dentists into accepting new patients at compensation that would allow dentists to meet their costs associated with treatment then lowered the reimbursement without any regards to the financial impact of those shouldering the cost of treatment.
16. Delta is fine, it's the reimbursement rates that don't make it possible to see a large number of these patients.
17. Difficult to work with. Low reimbursement.
18. Due to low reimbursements and a high volume of paperwork/online forms to fill. It is not cost effective for an office to accept it. We do take care of all HDC (Handicap Development Center) Patients and have decided to just do that pro bono because we actually lose money overall with the amount of time it takes to submit and fight for reimbursement.
19. DWP was a good program prior to the change made on August 2017. Their reimbursement was adequate. I was seeing nearly 40% DWP patients prior to the change and feel that I cannot abandon them. I will no longer take new patients unless they are screened or it is an emergency. I can't even begin to make a profit by seeing DWP at the new fees. I feel that even though Delta Dental claims they were rule followers in this change that they could have had more say in reimbursement. This program is leaving more patients with little means to access care.
20. Everything was fine until the DWP reimbursement rates went significantly down. I am an Endodontist and accepted all new wellness patients prior to the merger. We no longer treat any DWP patients.
21. Feels like this was intentional from the start of the DWP program. First, get providers on board. Then, cut reimbursement. Providers feel obligated to help the patients they have already been treating.
22. Forget your top heavy administrative programs. Delta dental gets paid first, your goofy state indigent dental provider plan designers second in order to justify their jobs, and the dentists' last if we are lucky. Just how did you think it would work? If you want dental coverage for our indigent population, decide how much you are going to spend every year and pay the dentist to provide it at a fee that won't reek and cause them to retch. Or better yet, mandate that all dentist provide a dollar amount of free dentistry to the indigent or suffer fines and fees. Then see who is left to turn out the lights as your best dentists leave the state in droves. Oh, sorry? My perception of Delta Dental's administration, not much.
23. I am just very disappointed that the state dropped the reimbursement for DWP patients. Many have several issues and I am providing care and losing money for caring for the poor. This has put a burden on me providing care.
24. I don't know that I can blame Delta in particular, but the hoops dentists need to jump through to participate were just too time consuming. Then there's the problem of terrible reimbursement rates!
25. I don't like fighting for reimbursement with pre-op photos or radiographs (neither of those are stated as requited in the manual) of multi surface anterior composites
26. I feel the entire program is flawed. The reimbursement is a joke, often times not even covering overhead and sometimes not covering lab expenses.
27. I feel the original DWP reimbursement was reasonable to treat patients of DWP due to rampant caries, however the new changes allow for crown coverage but at an unreasonable amount. It makes it very hard to keep accepting new patients when we can barely cover our lab fees and overhead fees. We may not be able to continue to see patients if rates don't improve
28. I feel there is more administrative work for very low reimbursement which does not even cover overhead. Prior authorizations are faster and usually able to have issues resolved faster.
29. I think that Delta ruined its reputation by taking on this program. The unrealistic reimbursement is unacceptable.
30. If they want providers to accept more wellness patients, they need to reimburse the doctors more. Most times these are the patients that don't value their treatment because they pay nothing for it and miss a lot of appointments.
31. It is a good principle to reward patient compliance, but the reimbursement is horrible.
32. It is clear that the administrators of this plan care nothing about reimbursing dentists at a fair rate. These reimbursements are absolutely behind the times by about 2 decades. Let's get real and pay dentist to provide this much needed service. Most procedures we get reimbursed at about 30% of our fee. Not going to work!
33. It is hard to cover expenses when reimbursement is low.
34. It is very difficult for an office to accept the large pay reduction from the previous DWP to the current Medicaid like fees. This is sad. I want to take care of everyone but it is hard.
35. It was ridiculous for them to have a program that required 2 year waiting periods for patients to have major restorative work done, and then 2 years into the program remove that wait period and slash their reimbursement down to Medicaid reimbursement. They make it really hard to be a dentist that wants to provide some care to these patients. With their poor reimbursement and poor administration of these new plans they keep coming up with, it's really frustrating to be a provider for them.
36. It's a joke. They take money from the state and purposely deny care to patients by making the reimbursement so low that no private practice can afford to see them. When I asked about it, Delta said some dentists were choosing to just "see a few" patients. Which again, is in Delta's advantage since they get paid by the state whether the patient receives care or not. And by limiting the access to care they are essentially regulating all DWP patients to emergency care only, which further increases their profits.
37. It's very confusing to the patient. Patient and provider education about the plans needs to be improved. And the reimbursement rates are terrible.
38. Low reimbursement.
39. Low reimbursement rates and unnecessary administrative requirements.
40. Low reimbursement. One was even less than my lab bill!
41. Matching Medicaid reimbursement is not a way to get more people to accept DWP. That will make it worse.
42. Medicaid reimbursement has changed less than 3% in the past 20 years. I believe acceptance of Medicaid patients will decrease over time.

43. My experiences with the administration of most programs is that they are clunky and do not provide much freedom. Additionally, the reimbursement rates remain below traditional insurance reimbursement rates which are lower than the fees we actually have to charge to provide the services and comply with the many layers of regulation (HIPAA, infection control, etc.).
44. My impression is that any government funded plans are not very easy to work with, usually very slow with low reimbursement.
45. My opinion is that this was a bait and switch scheme that was developed before the inception of wellness 1.0. Patients that previously did not qualify for Medicaid were offered dental wellness and thus that patient pool was removed from traditional insurance and transferred to wellness. Providers who were once being paid cash or private insurance fees now were being paid on a much lower reimbursement level with wellness, which is acceptable for those patients that truly need the assistance. Now these patients are transferred from wellness 1.0 to wellness 2.0 which ultimately is the same reimbursement as traditional Medicaid. Practitioners who accepted these wellness 1.0 patients feel ethically bound to continue treating them, but are now being reimbursed at a much lower rate than they originally agreed to. This is a bait and switch and I can't help to believe this was Delta's plan from the inception of wellness. I have lost a lot of respect for the folks at delta dental. I will continue to treat these patients I morally and ethically feel compelled to do so. The morals and ethics for the folks behind delta dental certainly is in a different place than my own.
46. Paid a fairly good fee to manage the program and reimbursement is terrible.
47. Patients require more care than is possible. Reimbursement rates too low to sustain continued participation.
48. Pay out went from 75% to 30% of my fees, cannot make any profit!
49. Payment is slow and just like when it was administered by the state, patient eligibility can be an issue. It seems like there are more problems since it was started because some patients stayed on the state run program (i.e., kids and handicapped adults) and we don't know prior to their visit which plan they have. Delta dental is great to work with but the fee schedule sucks. It stinks that we were all lead to believe that the change of adults from Medicaid to DWP would mean fees more like DWP. Basically, all the DWP patients were changed to Medicaid and you just changed the name. It feels like we've been scammed and I'm just trying to do what's best for my patients.
50. Poor communication and reimbursement.
51. Poor customer relations with additional administrative responsibility on providers. The perception is they are trying to make it more difficult to treat this patient base. The reimbursement levels are ridiculously low (below overhead expense).
52. Poorly administered, poor reimbursement.
53. Prior to the new changes, everything was so confusing. As far as the different levels, patients were very confused as to why they had to wait for services to be completed. The whole pre-treatment needing to be completed before the service? Which is still in effect. For example, when a patient broke a tooth, we were not allowed to start treatment the day they were seen because it was not prior-authorized and approved. Bring them back after the approval? If something needed to be done we wanted to start on it right away. We lost a lot of money because of this issue. We are already accepting these patients knowing the reimbursement rate is so low. Not only are we losing what we charged out but as well as our time and money (paying the staff, lab bills, etc.). In my opinion, losing money a lot of the time is what happens. Our attitude towards Iowa Medicaid and DWP has changed so much, simply because all of the red tape you need to go through just to get paid! Don't get me wrong, I feel there are lots of people that benefit from these programs. On the other hand, I feel that the government makes it too easy for a lot of people to be eligible for these programs when they should not be. People coming into the office with top of the line clothes, fancy phones and driving amazing vehicles? I don't understand how this works. I feel like we are paying for some of these people to live a wonderful lifestyle while the rest of us honestly try to make a living. Sometimes this just gets so frustrating and overwhelming. I think that in itself needs to change. I realize this is out of your control but this is another reason we are swayed away from wanting to treat these patients. Some of this people expect things and they usually get it. What is wrong with being allowed to be on government assistance just for a certain amount of time until they can get back on their feet. Why would they want to go get a job and make a living when their lifestyle is much better?
54. Prior to the switch from Title XIX to DWP, the DWP was very confusing and time consuming for dental offices, which is why we were not providers of DWP prior to August. However I still believe the reimbursement rates are far too low, especially on costly items like crowns and dentures, where dentist often lose money on these cases due to the high lab bills. I also believe far too many patients are on the wellness plan.
55. Procedures they say are covered are not. Reimbursement not enough to pay our overhead, nor is it worth the hassle.
56. Reimbursement is awful. It's removed the personal accountability for the patient. The random assignment of patients has left many of our patients with MCNA and we aren't utilizing that insurance at all so many of our existing patients have to change insurances. I find it cumbersome and poorly thought out.
57. Reimbursement is poor. Difficult to get procedures approved.
58. Reimbursement is too low for private offices to afford seeing these patients.
59. Reimbursement rates are not similar to previous and more treatment gets denied for poor reasons.
60. Reimbursement rates are so low that it is fiscally impossible to see these patients in a private practice setting, yet it is still profitable for Delta Dental.
61. Reimbursement rates have lowered to the point it is making continued participation doubtful.
62. Reimbursement should be raised.
63. Reimbursements dropped which makes it more difficult to provide care to more DWP individuals since it pays comparably to Medicare now.
64. Slow to pay, the hoops required to jump through for payment requires a lot of time both for the front office and rest of the staff, lost x-rays by Delta Dental claiming we didn't send them, very poor cooperation for prior authorizations. I feel like they are very quick to deny payment on everything. The payment rate is a whole issue alone.
65. That their goal is to deny as many claims as possible and not reimburse us the little amount that we get now.
66. The administration is fine- the reduction in reimbursement is limiting our ability to continue to provide services to these members.
67. The change in fee schedule after implementing the program is very bait and switch- not a fan of this at all.
68. The contract has a non-discrimination clause that prohibits dentists from limiting the number of DWP that they can see.

At the reimbursement rates, it is not financially feasible to take unlimited DWP patients and stay in business to serve the other patients in our communities. Delta says they won't enforce that clause, but the state can choose to enforce anything in the contract. Delta also placed a gag order in the contract. They specifically state that any dentist who signs the contract cannot say anything negative about Delta Dental or their DWP. Opinions and feedback matter. The fact that you are asking for dentists to give feedback means that someone cares what dentists think. Someone thinks the services and coverage patients get actually matters. Make no mistake, the fact that the contract states this will skew the information you are able to obtain from DWP dentists. They can't talk or they could be held liable for Delta losing the contract in the future or whatever other damages Delta wants to blame on them for speaking up. I was disappointed the state of Iowa let a private company put such a statement in the contract. Very disturbing.

69. The fact that we were tricked into accepting these patients and then you slash the reimbursements to nothing is shady to say the least.
70. The initial plan was good, but then when the reduced all reimbursement rates to basically equal Medicaid rates, we had to stop accepting those patients as new patients.
71. The people are very nice- some parts of the program need to change, i.e., $300 for a partial that the lab bill is $296. We call with a question and get different answers from different people- 90 day submitter statement- but a year to collect-but originally told 90 days to collect. Told we didn't have approval, with the approval in our hand- then told someone, who no longer worked there did not put approvals in the system. Perhaps removing the one year and no payment given would help all of this.
72. The way it is fleshing out is that it was a carrot on a stick program to entice dentists to participate. Reimbursements were a little better than the traditional Medicaid bot now in the conversion they are not. This will not be a successful program until the state pays the fees that are required to keep the overhead considerations in a non-losing format. Requiring patients to maintain checkups to keep the services current is a great method however.
73. The website is very user friendly. If I have a question I can look in the manual or call for advice. The only negative is the fee schedule.
74. They "nickel and dime" They are constantly combining codes (2 perios and 1 BW = FMS for example and then a FMS can't be done if needed later for 5 years, at least not reimbursed) or making restrictions such as 1 comprehensive exam every 3 years despite if with different providers. So a patient may have had a comp exam at another 6 months ago, come to my office and, despite doing a comp exam for a new patient they will not reimburse (and their reimbursement rate is very low to begin with). Also, to find accurate up-to-date info on patients' eligibility is buried in their website, though once you know where to go you can find it. Providing needed care ends up requiring many non-reimbursed codes which are already reimbursed at very low rates.
75. They're doing the best with what they have to work with. Coverage and reimbursement still isn't very clear.
76. This change feels like a "bait and switch" on the part of Medicaid and Delta Dental. Get everyone on board, pay a very nice bonus, then revert to what is basically Medicaid as it always has been. Also, surgical services get bundled and down-coded, e.g. mandibular tori removal gets bundled with alveoloplasty. Too much paperwork.
77. This was a cheap shot at dentists. They reeled them in with a year or two of dentists establishing a relationship with patients and then bam! Drop the fees and let the dentists be the bad guys. It is as simple as that. The dentists were set up to take the fall, not Delta.
78. Those in charge keep making patient care/reimbursement difficult for members (i.e., requiring a pin for Previsor). It is better than Title XIX, but in general, it is worse than it was before the changes.
79. Too low of reimbursement.
80. Too much extra work for the low reimbursement.
81. Too much red tape, seems things are hard to be approved, takes too long to get reimbursed and reimbursement rates are so low I am often paying out of my pocket just to do the dentistry on the patient. There are other more rewarding ways to do charity work, if there is no profit I would rather sponsor a family or do the Donated dental services program.
82. Underfunded with an unacceptable reimbursement level.
83. Very coverage for procedures. Beneficial for patient. Not very good fee schedule but good for patient.
84. Very displeased with the recent changes and really had to soul search so to speak if I would continue to accept these patients. This program and interference with Dental and State/Federal regulations make it increasing complex and difficult to administer. I am on the fence if I will continue this service and only do it to provide care for those in need. I have discussed dropping program all together to not have to deal with the administration hassles that un-necessary occupy my and my team's time. Over-reach and poor reimbursement make it impossible to cover even overhead from this patient pool. If this system continues to move in the direction it does we will be force out of it.
85. Very frustrating how the "DWP 1.0" had higher rates of reimbursement, only to be lowered to Medicaid rates. I honestly hate the insurance.
86. Very low reimbursement rate means that you can only treat so many patients before it begins to have an adverse financial impact on the practice. I personally believe that every doctor should see at least a few state aid patients. If everyone did a small amount (so small that it would have a negligible effect on the practice), no one office would have to see very many, and people who have limited access to care (financially) would have more options.
87. Very poor reimbursement, reviewing dentists often require unrelated/extraneous information to approve claims
88. We believe the program is not set up to help us as a dental office. It is geared more at helping people get dental coverage at a low cost to them in which makes deltas payment to us at a very low rate, especially if you take in to consideration the write offs we would already be taking. We are not comfortable with this program that states the patients have to complete care or we don't get paid in the tier set up. Unfortunately it is hard to make patients take their dental care seriously when they have no responsibility in their own care. For the above reasons we will not be participating in this program now or in the future.
89. We calculated that our office staff was spending roughly 6 hours per week fighting for coverage of routine dental treatment. When combined with the lowered reimbursement our practice could not sustain our relationship with Delta DWP.
90. We have chosen to not be a Delta Dental provider for private paying patients or Medicaid adults, and so Delta will not reimburse us. We believe that Delta's reimbursement rates for private paying patients are too low to provide good care to our patients (we want to choose an excellent lab, spend time with our patients, etc.). We think Delta has a monopoly on

dictating rates in the state of Iowa. Since we are not a Delta provider, our understanding is that we cannot only see DWP patients.

91. We haven't had any issues. The low reimbursement forces a lot of others to be unable to accept DWP.
92. We signed up with the Dental Wellness Program initially without any training or knowledge of the process. When we were trained, we quickly realized the drawbacks to the program and tried to terminate our contract, but were advised that we were obligated to give a 90 day notice. In addition, Wellness patients tend to no show, and the reimbursement for services was poor.

Paperwork required/Pre-authorizations

1. Documentation for dentures when people have no teeth. Can never read x-rays sent by NEA.
2. Poor reimbursement. Too many administrative headaches for front desk and confusion among patients about what is covered. Patients on DWP who obviously have the means to pay for their dental treatment
3. Although they are easier to work with than Medicaid, this is mostly due to our ability to send information online. The pre-authorizations and requirements to get coverage are difficult. We have had multiple build ups denied due to too much tooth remaining and also crowns denied for not enough tooth structure remaining. It is hard to know what criteria will be used. The reimbursement makes it difficult to provide services. We no longer make dentures or partials, and other procedures are close to being too low to continue.
4. Do not like that almost all procedures require pre-authorization. Especially if work was preauthorized prior to the switch
5. Due to low reimbursements and a high volume of paperwork/online forms to fill. It is not cost effective for an office to accept it. We do take care of all HDC (Handicap Development Center). Patients and have decided to just do that pro bono because we actually lose money overall with the amount of time it takes to submit and fight for reimbursement.
6. It is a for profit operation. The administrators use the same tactics they have applied in other states to limit care. These include arbitrary denials, requiring time consuming pre authorizations, etc. for procedures that were covered. The breath of these efforts is to tire clinicians from diagnosing and submitting claims.
7. Just takes a lot of time to either get approval for some procedures or frankly payment.
8. Low reimbursement rates and unnecessary administrative requirements.
9. Obtaining authorization for procedures can at times be frustrating, but administration is more efficient than original Medicaid had been prior to the merger of the two plans.
10. Overall, the program works well. It took my staff a bit to understand the most efficient way to submit preauthorization for procedures.
11. Prior to the new changes, everything was so confusing. As far as the different levels, patients were very confused as to why they had to wait for services to be completed. The whole pre-treatment needing to be completed before the service? Which is still in effect. For example, when a patient broke a tooth, we were not allowed to start treatment the day they were seen because it was not prior-authorized and approved. Bring them back after the approval?? If something needed to be done we wanted to start on it right away. We lost a lot of money because of this issue. We are already accepting these patients knowing the reimbursement rate is so low. Not only are we losing what we charged out but as well as our time and money (paying the staff, lab bills, etc.). In my opinion, losing money a lot of the time is what happens. Our attitude towards Iowa Medicaid and DWP has changed so much, simply because all of the red tape you need to go through just to get paid! Don't get me wrong, I feel there are lots of people that benefit from these programs. On the other hand, I feel that the government makes it too easy for a lot of people to be eligible for these programs when they should not be. People coming into the office with top of the line clothes, fancy phones and driving amazing vehicles? I don't understand how this works. I feel like we are paying for some of these people to live a wonderful lifestyle while the rest of us honestly try to make a living. Sometimes this just gets so frustrating and overwhelming. I think that in itself needs to change. I realize this is out of your control but this is another reason we are swayed away from wanting to treat these patients. Some of this people expect things and they usually get it. What is wrong with being allowed to be on government assistance just for a certain amount of time until they can get back on their feet. Why would they want to go get a job and make a living when their lifestyle is much better?
12. Reimbursement is poor. Difficult to get procedures approved.
13. Slow to pay, the hoops required to jump through for payment requires a lot of time both for the front office and rest of the staff, lost x-rays by Delta Dental claiming we didn't send them, very poor cooperation for prior authorizations. I feel like they are very quick to deny payment on everything. The payment rate is a whole issue alone.
14. The people are very nice- some parts of the program need to change, i.e., $300 for a partial that the lab bill is $296. We call with a question and get different answers from different people- 90 day submitter statement- but a year to collect-but originally told 90 days to collect. Told we didn't have approval, with the approval in our hand- then told someone, who no longer worked there did not put approvals in the system. Perhaps removing the one year and no payment given would help all of this.
15. There could be improvements on the feasibility of prior authorizations and the payout. Many claims are kicked back with a denial after completion, even if they were pre-authorized.
16. They "nickel and dime" They are constantly combining codes (2 perios and 1 BW = FMS for example and then a FMS can't be done if needed later for 5 years, at least not reimbursed) or making restrictions such as 1 comprehensive exam every 3 years despite if with different providers. So a patient may have had a comp exam at another 6 months ago, come to my office and, despite doing a comp exam for a new patient they will not reimburse (and their reimbursement rate is very low to begin with). Also, to find accurate up-to-date info on patients' eligibility is buried in their website, though once you know where to go you can find it. Providing needed care ends up requiring many non-reimbursed codes which are already reimbursed at very low rates.
17. This change feels like a "bait and switch" on the part of Medicaid and Delta Dental. Get everyone on board, pay a very nice bonus, then revert to what is basically Medicaid as it always has been. Also, surgical services get bundled and down-coded, e.g. mandibular tori removal gets bundled with alveoloplasty. Too much paperwork.
18. Too many submissions required. I spend a lot of their money just taking x-rays. Too many denials because more information is needed, but I don't know what kind of information they think they need. They need more clear descriptions of

reasons for denial.

19. Too much administration time required by our staff to get patients treatment they need. Process is slowed down by the administration which further reduces the return on investment and makes it a difficult business model to sustain.
20. Too much red tape, seems things are hard to be approved, takes too long to get reimbursed and reimbursement rates are so low I am often paying out of my pocket just to do the dentistry on the patient. There are other more rewarding ways to do charity work, if there is no profit I would rather sponsor a family or do the donated dental services program.
21. Very poor reimbursement, reviewing dentists often require unrelated/extraneous information to approve claims.
22. We calculated that our office staff was spending roughly 6 hours per week fighting for coverage of routine dental treatment. When combined with the lowered reimbursement our practice could not sustain our relationship with Delta DWP.
23. When the program switched over to the new wellness plan not only did we decide not to see any new pts from that group, we dismissed all previous pt. who are all on wellness. We got burned on a few crowns right away and the paperwork is ridiculous. Until they stop making more work rules and hassle for providers; I doubt it will improve.

Complexity of rules and regulations/Too many restrictions

1. Although they are easier to work with than Medicaid, this is mostly due to our ability to send information online. The Pre-authorizations and requirements to get coverage are difficult. We have had multiple build ups denied due to too much tooth remaining and also crowns denied for not enough tooth structure remaining. It is hard to know what criteria will be used. The reimbursement makes it difficult to provide services. We no longer make dentures or partials, and other procedures are close to being too low to continue.
2. At first, they didn't pay for services they said they would. Then they got more specific with the rules and clarified the services they would and would not pay for. Things went more smoothly after the first 6 months. I am very disappointed the program did not continue, and hope it comes back.
3. Claim requirements changes, adjudication inconsistency, poor understanding of plan limitations by the subscribers
4. Delta Dental's administration of the program has not been in compliance with either the prompt payment act or uncovered claim act in Iowa. Delta Dental routinely denies services that would be covered by Iowa Medicaid. These services were represented to CMS that they would be covered. Delta Dental routinely interferes with the doctor patient relationship. The means in which Delta Dental wishes dentists to practice would by a violation of the standard of care for patients.
5. Delta does well but is stuck with truly moronic and unrealistic rules that were set in place by some non-dental paper pusher or bean counter.
6. I am concerned that Delta Dental will continue to push more restrictions on dentists like they have done with their PPO and Premier programs.
7. I don't know that I can blame Delta in particular, but the hoops dentists need to jump through to participate were just too time consuming. Then there's the problem of terrible reimbursement rates!
8. I opted out of the program entirely in July. When clarity and efficiency return to the administration, I may enroll. Rather than try to comply and follow the myriad R and R's I continue to offer first rate service to my existing (former H and W or XIX) for free. I only lose slightly more $$ than when I was reimbursed, but much more pleasant working conditions for my staff, and a feel good thing.
9. It feels like you gave us the previous plan to get us hooked and then changed the rules because you had no way to pay for it.
10. It's very confusing to the patient. Patient and provider education about the plans needs to be improved. And the reimbursement rates are terrible.
11. Making it harder and harder to do the best thing for the patients, too many restrictions and regulations before the treatment the patient needs is actually covered. Leaving patient in situations where they are receiving palliative care until they reach full benefits. If you need a new Hip, you get a titanium hip in one procedure. If you need a crown, you have to have a filling, then wait a year, then have another separate procedure to place final crown; if it was me or my family, I would want what is the best for my teeth, not what is covered for now and then we have to redo it.
12. Prior to the new changes, everything was so confusing. As far as the different levels, patients were very confused as to why they had to wait for services to be completed. The whole pre-treatment needing to be completed before the service? Which is still in effect. For example, when a patient broke a tooth, we were not allowed to start treatment the day they were seen because it was not prior-authorized and approved. Bring them back after the approval? If something needed to be done we wanted to start on it right away. We lost a lot of money because of this issue. We are already accepting these patients knowing the reimbursement rate is so low. Not only are we losing what we charged out but as well as our time and money (paying the staff, lab bills, etc.). In my opinion, losing money a lot of the time is what happens. Our attitude towards Iowa Medicaid and DWP has changed so much, simply because all of the red tape you need to go through just to get paid! Don't get me wrong, I feel there are lots of people that benefit from these programs. On the other hand, I feel that the government makes it too easy for a lot of people to be eligible for these programs when they should not be. People coming into the office with top of the line clothes, fancy phones and driving amazing vehicles? I don't understand how this works. I feel like we are paying for some of these people to live a wonderful lifestyle while the rest of us honestly try to make a living. Sometimes this just gets so frustrating and overwhelming. I think that in itself needs to change. I realize this is out of your control but this is another reason we are swayed away from wanting to treat these patients. Some of this people expect things and they usually get it. What is wrong with being allowed to be on government assistance just for a certain amount of time until they can get back on their feet. Why would they want to go get a job and make a living when their lifestyle is much better?
13. Should approve more crowns based on risk for fracture/large existing filling.
14. The people are very nice- some parts of the program need to change, i.e., $300 for a partial that the lab bill is $296. We call with a question and get different answers from different people- 90 day submitter statement- but a year to collect-but originally told 90 days to collect. Told we didn't have approval, with the approval in our hand- then told someone, who no longer worked there did not put approvals in the system. Perhaps removing the one year and no payment given would help all of this.
15. The threshold of 26 points on the Salzmann index to be eligible for orthodontic coverage is too high. Too many kids are left untreated that could benefit from treatment from an orthodontic standpoint, and the boost in self confidence that comes

with it.

16. They "nickel and dime" They are constantly combining codes (2 perios and 1 BW = FMS for example and then a FMS can't be done if needed later for 5 years, at least not reimbursed) or making restrictions such as 1 comp exam every 3 years despite if with different providers. So a patient may have had a comp exam at another 6 months ago, come to my office and, despite doing a comp exam for a new patient they will not reimburse (and their reimbursement rate is very low to begin with). Also, to find accurate up-to-date info on patients' eligibility is buried in their website, though once you know where to go you can find it. Providing needed care ends up requiring many non-reimbursed codes which are already reimbursed at very low rates.
17. They just as all dental insurance or insurance companies do not put the patient's welfare first and try to interfere with the payment of needed treatment by having so many loopholes that they can get out of payment.
18. They're doing the best with what they have to work with. Coverage and reimbursement still isn't very clear.
19. Too many submissions required. I spend a lot of their money just taking x-rays. Too many denials because more information is needed, but I don't know what kind of information they think they need. They need more clear descriptions of reasons for denial.
20. Too much red tape, seems things are hard to be approved, takes too long to get reimbursed and reimbursement rates are so low I am often paying out of my pocket just to do the dentistry on the patient. There are other more rewarding ways to do charity work, if there is no profit I would rather sponsor a family or do the donated dental services program.
21. When the program switched over to the new wellness plan not only did we decide not to see any new pts from that group, we dismissed all previous pt. who are all on wellness. We got burned on a few crowns right away and the paperwork is ridiculous. Until they stop making more work rules and hassle for providers; I doubt it will improve.

Claim denials/Payment delays

1. Delta Dental's administration of the program has not been in compliance with either the prompt payment act or uncovered claim act in Iowa. Delta Dental routinely denies services that would be covered by Iowa Medicaid. These services were represented to CMS that they would be covered. Delta Dental routinely interferes with the doctor patient relationship. The means in which Delta Dental wishes dentists to practice would by a violation of the standard of care for patients.
2. Difficult to get paid for services. I do a lot of emergency types of treatments because there are so few real providers.
3. Don't have an opinion. After having multiple claims returned to us unpaid for simple fillings on an elderly nun with Alzheimer's we'd had enough. We dropped our participation and are no longer Medicaid providers.
4. It is a for profit operation. The administrators use the same tactics they have applied in other states to limit care. These include arbitrary denials, requiring time consuming pre authorizations, etc. for procedures that were covered. The breath of these efforts is to tire clinicians from diagnosing and submitting claims.
5. Payment is slow and just like when it was administered by the state, patient eligibility can be an issue. It seems like there are more problems since it was started because some patients stayed on the state run program (i.e., kids and handicapped adults) and we don't know prior to their visit which plan they have. Delta dental is great to work with but the fee schedule sucks. It stinks that we were all lead to believe that the change of adults from Medicaid to DWP would mean fees more like DWP. Basically, all the DWP patients were changed to Medicaid and you just changed the name. It feels like we've been scammed and I'm just trying to do what's best for my patients.
6. Prior to the new changes, everything was so confusing. As far as the different levels, patients were very confused as to why they had to wait for services to be completed. The whole pre-treatment needing to be completed before the service? Which is still in effect. For example, when a patient broke a tooth, we were not allowed to start treatment the day they were seen because it was not prior-authorized and approved. Bring them back after the approval? If something needed to be done we wanted to start on it right away. We lost a lot of money because of this issue. We are already accepting these patients knowing the reimbursement rate is so low. Not only are we losing what we charged out but as well as our time and money (paying the staff, lab bills, etc.). In my opinion, losing money a lot of the time is what happens. Our attitude towards Iowa Medicaid and DWP has changed so much, simply because all of the red tape you need to go through just to get paid! Don't get me wrong, I feel there are lots of people that benefit from these programs. On the other hand, I feel that the government makes it too easy for a lot of people to be eligible for these programs when they should not be. People coming into the office with top of the line clothes, fancy phones and driving amazing vehicles? I don't understand how this works. I feel like we are paying for some of these people to live a wonderful lifestyle while the rest of us honestly try to make a living. Sometimes this just gets so frustrating and overwhelming. I think that in itself needs to change. I realize this is out of your control but this is another reason we are swayed away from wanting to treat these patients. Some of this people expect things and they usually get it. What is wrong with being allowed to be on government assistance just for a certain amount of time until they can get back on their feet. Why would they want to go get a job and make a living when their lifestyle is much better?
7. Reimbursement rates are not similar to previous and more treatment gets denied for poor reasons.
8. Slow to pay, the hoops required to jump through for payment requires a lot of time both for the front office and rest of the staff, lost x-rays by Delta Dental claiming we didn't send them, very poor cooperation for prior authorizations. I feel like they are very quick to deny payment on everything. The payment rate is a whole issue alone.
9. That their goal is to deny as many claims as possible and not reimburse us the little amount that we get now.
10. The people are very nice- some parts of the program need to change, i.e., $300 for a partial that the lab bill is $296. We call with a question and get different answers from different people- 90 day submitter statement- but a year to collect-but originally told 90 days to collect. Told we didn't have approval, with the approval in our hand- then told someone, who no longer worked there did not put approvals in the system. Perhaps removing the one year and no payment given would help all of this.
11. There could be improvements on the feasibility of prior authorizations and the payout. Many claims are kicked back with a denial after completion, even if they were pre-authorized.
12. They are a private company looking to make a profit. They are quick to deny needed treatment, but are able to due to the rules set in place.
13. They are easy to get ahold of when necessary, usually respond quickly. Payment is quick but they are likely to deny neces-

sary procedures because "that's what the manual says".

14. Too many submissions required. I spend a lot of their money just taking x-rays. Too many denials because more information is needed, but I don't know what kind of information they think they need. They need more clear descriptions of reasons for denial.

Customer services/Accessibility of information

1. Delta Dental makes it very difficult to provide the necessary treatment needed for our DWP patients. With their extremely low reimbursement rates I just break even on any treatment that has a lab bill associated with it. Also, when we try to contact Delta Dental about DWP patients they are very hard to get an answer from.
2. Not always knowledgeable; unable to answer questions often.
3. Not easy to work with, difficult to get answers.
4. Online is the best way to get information. Hard to get someone on the phone to talk to.
5. Poor communication and reimbursement.
6. Poor customer relations with additional administrative responsibility on providers. The perception is they are trying to make it more difficult to treat this patient base. The reimbursement levels are ridiculously low (below overhead expense).
7. The people are very nice- some parts of the program need to change, i.e., $300 for a partial that the lab bill is $296. We call with a question and get different answers from different people- 90 day submitter statement- but a year to collect-but originally told 90 days to collect. Told we didn't have approval, with the approval in our hand- then told someone, who no longer worked there did not put approvals in the system. Perhaps removing the one year and no payment given would help all of this.
8. They "nickel and dime" They are constantly combining codes (2 perios and 1 BW = FMS for example and then a FMS can't be done if needed later for 5 years, at least not reimbursed) or making restrictions such as 1 comp exam every 3 years despite if with different providers. So a patient may have had a comp exam at another 6 months ago, come to my office and, despite doing a comp exam for a new patient they will not reimburse (and their reimbursement rate is very low to begin with). Also, to find accurate up-to-date info on patients' eligibility is buried in their website, though once you know where to go you can find it. Providing needed care ends up requiring many non-reimbursed codes which are already reimbursed at very low rates.
9. When you call to speak to customer service the people that are there seem to have no idea what the codes or procedures are.

Issues with contract

1. The contract has a non-discrimination clause that prohibits dentists from limiting the number of DWP that they can see. At the reimbursement rates, it is not financially feasible to take unlimited DWP patients AND stay in business to serve the other patients in our communities. Delta says they won't enforce that clause, BUT the state can choose to enforce anything in the contract. Delta also placed a gag order in the contract. They specifically state that any dentist who signs the contract cannot say anything negative about Delta Dental or their DWP. Opinions and feedback matter. The fact that you are asking for dentists to give feedback means that someone cares what dentists think. Someone thinks the services and coverage patients get actually matters. Make no mistake, the fact that the contract states this will skew the information you are able to obtain from DWP dentists. They can't talk or they could be held liable for Delta losing the contract in the future or whatever other damages Delta wants to blame on them for speaking up. I was disappointed the state of Iowa let a private company put such a statement in the contract. Very disturbing.
2. We signed up with the Dental Wellness Program initially without any training or knowledge of the process. When we were trained, we quickly realized the drawbacks to the program and tried to terminate our contract, but were advised that we were obligated to give a 90 day notice. In addition, Wellness patients tend to no show, and the reimbursement for services was poor.

Specialists availability

1. Coverage for my patients have definitely expanded, but there are no specialist, including oral surgeons that accept their insurance.

Positive Comments

1. Answer questions in a timely manner and good support.
2. Office administrators think website is great.
3. + Easy online claim submissions, clear guidelines for pre authorizations, efficient claim payments, good communication with patients. - Very low reimbursement rates.
4. Adequate.
5. Better than most plans administratively.
6. Claims are being paid in a timely manner and are good at answering questions, but they drastically cut reimbursement rates to the levels of Medicaid. It is also hard to find specialist that will treat patients.
7. Delta Dental does a great job administering a program that has been "broken" by the merging of the Tittle 19 and "old" DWP programs. The reimbursement is not acceptable and having to deal with two different administrators is unacceptable.
8. Delta Dental does a really good job when it comes to administering DWP. Their customer service is usually very helpful and friendly. There are some features that become tedious and can be a hassle, but at the end of the day, it is understandable since ultimately they are servicing state-insured patients.
9. Delta Dental has a lot of people to oversee on this program. Delta Dental does a good job with provider questions and issues.

10. Delta Dental has a very professional and systematic method of providing insurance coverage and informing patients and myself of any changes. If a claim is denied, there is descriptive reasons why, and listed steps to take on how to alleviate problem. If something is questioned, both Delta and myself will work together to determine a fair and reasonable result for the patient.
11. Delta dental has been decent to work with, but reimbursement is terrible for some procedures.
12. Delta Dental has fast approval for pre-authorizations, easy customer service, easy to use website for electronic verification and submission.
13. Delta Dental is the epitome of dental administration. Delta Dental as a whole, has a thorough understanding of how to properly administer DWP. Competence is the key word, when describing Delta Dental.
14. Delta Dental is very receptive to us and process claims in a timely way. They are willing to work with us to the best of their ability.
15. Delta Dental provides excellent service in DWP administration. Service representatives are knowledgeable. They respond quickly with information.
16. Delta dental responds quickly to inquiries and the website is easy to use.
17. Delta Dental seems to be working with the constraints of the programs and is generally doing ok.
18. Delta does a good job.
19. Delta does a good job administering the program. Paperwork and response time are much better than with a Medicaid Enterprises. However, we are not at all happy with the program itself.
20. Delta does well but is stuck with truly moronic and unrealistic rules that were set in place by some non-dental paper pusher or bean counter.
21. Delta has done a great job administering the DWP. It's very unfortunate that the state has cut funding so drastically. Also, Delta did a much better job than MCNA.
22. Delta is very helpful for my front desk staff. They are very knowledgeable when it comes to the dentistry and what is better for the patient. What we like most about Delta is they allow us to do our job, which is what is best for the patient.
23. Delta seemed to be much more user friendly than in previous dealings with Medicaid.
24. Delta's administration is great.
25. Doing the best they can with limited resources. Services should be limited.
26. DWP website is easy to navigate, clear guidelines for what is required for procedure codes to be covered.
27. Easy to work with. Policies are normal delta policies so nothing "extra" to remember. Quick response on payments, prior authorizations and inquires.
28. Fast and helpful.
29. Fast response.
30. Faster and easier to work with than Medicaid.
31. Good insurance for underserved community.
32. Good website, good customer service, fast payment turnaround and prior authorizations.
33. Great customer service!
34. I don't hear any complaints, and my perception would be that they are more responsive to consumer and dentist complaints/issues than traditional Medicaid services.
35. I feel there is more administrative work for very low reimbursement which does not even cover overhead. Prior authorizations are faster and usually able to have issues resolved faster.
36. I think it's a good program.
37. I think they do a good job.
38. I think they do a pretty good job. Most of the time they are very helpful.
39. It has been okay with them. They are more responsive than Medicaid ever was when you call to ask questions. Their website is also more helpful.
40. It is much better than traditional Iowa Medicaid, quicker payments and turnaround time on questions. However, it is not administered as well as traditional Delta Dental policies.
41. It is much easier to communicate with DWP than Medicaid.
42. It is much easier to deal with Delta Dental than Medicaid as far as asking questions and receiving timely accurate responses
43. Less than but almost ok with services.
44. More efficient than state run Medicaid. Practical incentives for patients that enhanced quality of patients. Policies made sense.
45. My main perception is that of the two choices Delta vs MCNA- Delta is decidedly the easier administrator to work with as a provider.
46. Obtaining authorization for procedures can at times be frustrating, but administration is more efficient than original Medicaid had been prior to the merger of the two plans.
47. Online is the best way to get information. Hard to get someone on the phone to talk to.
48. Overall they have been good.
49. Overall, the program works well. It took my staff a bit to understand the most efficient way to submit preauthorization for procedures.
50. Quick return on pre authorizations. Fast payments.
51. Run well.
52. The administration is fine- the reduction in reimbursement is limiting our ability to continue to provide services to these members.
53. The people are very nice- some parts of the program need to change, i.e., $300 for a partial that the lab bill is $296. We call with a question and get different answers from different people- 90 day submitter statement- but a year to collect-but originally told 90 days to collect. Told we didn't have approval, with the approval in our hand- then told someone, who no longer worked there did not put approvals in the system. Perhaps removing the one year and no payment given would help all of this.
54. The representatives can be contacted quickly and they are very helpful. Their web page is easy to use to check on eligibility

and print benefits.
55. The same great Delta Dental customer service that we are accustom to.
56. The website has been extremely easy to use. Any time I have had to call they have been very fast at getting me through to someone and answering my questions.
57. The website is very user friendly. If I have a question I can look in the manual or call for advice. The only negative is the fee schedule.
58. They are easy to get ahold of when necessary, usually respond quickly. Payment is quick but they are likely to deny necessary procedures because "that's what the manual says".
59. They did a great job.
60. They do a great job of administration, claim management, and answering questions/ solving provider issues.
61. They do what they can.
62. Very coverage for procedures. Beneficial for patient. Not very good fee schedule but good for patient
63. Very efficient and clearly understandable.
64. Was less confusing than the old title XIX system.
65. We can access benefits on line easily and can get prior authorizations done quickly. Turnaround in claims is efficient as well. They had several hiccups when first rolled out, but those are getting ironed out.
66. We have been very happy with speed of return of claims. Prior authorizations are done very promptly. Appreciate not having patient bounce from Title XIX to Wellness, etc.
67. We have had excellent service with Medicaid and Delta Wellness but have had a lot of problems with MCNA.
68. Website offers good information and customer service staff knowledgeable when we call.
69. Well structured.

Other Comments

1. Administrators make more money than providers.
2. Before, adult patients on Title 19 had a home with our practice. Now, they have to seek other providers. Many were dependent adults and those whose families are already stretched thin taking care of them. Change is not in their best interest. Creating new programs and not working on what currently needs help has not benefited my patients. I will not participate in any more programs until you fix what is already here.
3. Business office employees are frustrated with how part of program are run.
4. Delta Dental is no friend of the Iowa dentist. Delta is completely devoted to making money for their shareholders.
5. Delta is a for-profit corporation, and as such their primary purpose is to serve Delta's best financial interests.
6. Disappointed with patient's awareness that their plans changed.
7. Feel deceived by the whole process. Someone is getting rich off the poor and it is not the Dentist. Everyone one I see is a loss to the practice.
8. Frustrating in that patients had waiting periods for even minor procedures.
9. Glorified Title XIX.
10. Good. The challenges will be a $3.00 co-pay. People will not understand this. Also both MCNA and Iowa wellness need to be the same for everything. Make it simple.
11. I don't think the self-risk assessment will be of much value. I do not believe that most people in this demographic are not going to change their oral hygiene or dietary habits because they took a survey that told them to do so. Making this a requirement for coverage and then reimbursing dentists for filling out a survey on their risk level does not make much sense to me.
12. I knew all along that the DWP program would not last. Shortly after patients gained full benefits, which took 18 months, the program was dropped.
13. I think this became a plan to make money for Delta.
14. Insufficient patient education about responsibilities, many late cancels and no shows and it has no impact on the subscriber.
15. It is exactly what everyone fears when you privatize government insurance. The insurance provider makes more money the more services they deny. Things that have been slam dunk coverage in the past are not anymore, which means it costs me more administratively to see this group of patients than any other. DWP has been difficult to work with, and this comes from someone who does not have problems with traditional Delta Dental.
16. It was well run until the August changes.
17. It's very confusing to the patient. Patient and provider education about the plans needs to be improved. And the reimbursement rates are terrible.
18. Likely a way to move premier providers to PPO providers and save Delta Dental money.
19. Making it more difficult for general practitioners to treat our patients to the standard of care which we treat all our patients to.
20. Poor and will only get worse. Delta has gone from an insurance company with great relationships with their dentist to a very poor relationship. Delta has now become just an insurance company that cares about profits etc. Delta used to be a more dentist and patients friendly company. That's completely changed over the last few years and I hate to see it.
21. The DWP was sold to Iowa dentists as a potential alternative to Medicaid. It was sold to us that if the DWP went well, potentially the Medicaid system could be transitioned into a DWP model with tiered care based on patient compliance. However, it was transitioned the other way and now we just have more people in the old Medicaid model that does not serve our patients well.
22. They (Delta) get their normal rates for administering plan, while dentists are losing money.
70. They always make money, we don't have that same guarantee.

No Comments

1. No clue.
2. No comment.
3. No interaction with.
4. None.

PLEASE DESCRIBE YOUR PERCEPTIONS OF MCNA'S ADMINISTRATION OF DWP.

Survey respondents who did NOT answer 'don't know/not sure' for Q15

Reimbursement

1. Con artists, acted like they were going to be the better plan but the fees were lower.
2. Even worse reimbursement, terrible to deal with on the phone.
3. Extremely poor communication and reimbursement time.
4. Fees were really cut back. No longer a viable situation for the practice.
5. Have heard very bad reports regarding customer service and reimbursement.
6. Horrible reimbursement.
7. I am an associate. The owner said we don't accept MCNA because the reimbursement is even worse than Delta dental
8. I haven't formulated any perceptions that differ from Delta's administering the plan. My biggest disappointment is the low reimbursement fees. I was under the impression they would now be somewhere between Wellness and Medicaid, not the lowest offered previously. The problem will be finding dentists to accept patients, because overhead costs in most offices is the same percentage as what the program now reimburses to. If it was just 10-20% higher, you would get more participating dentists.
9. Less interested in providers and reimbursement.
10. Low reimbursement.
11. Low reimbursement. Requires pre-authorization for everything. Requires pre and post bitewings for crowns.
12. Low reimbursement rates; required prior authorizations for procedures.
13. Low reimbursement. Not truthful on what will be covered.
14. MCNA specifically states in the contract that dentists who are accepting new patients must also accept unlimited DWP patients. At the reimbursement rates, it is not financially feasible to take unlimited DWP patients and stay in business to serve the other patients in our communities. When MCNA wanted to get the contract in Iowa, they had reps go around to dental offices and literally lie to our staff about what they were doing. They implied that they had the contract with the state before they did and they made statements that were absolutely false.
15. Reimbursement should be raised.
16. Same as with Delta- all the hoops, terrible reimbursement rates.
17. Same opinions as Delta's administration.
18. Same response as before with regard to administration of any program.
19. See previous statement about Delta Dental.
20. Too long to get reimbursed, too many restrictions and traps that could lead to denied coverage, takes too much of the staffs time to follow up, reimbursement rates are so low that there is no profit and often actual costs the provider money to see the patients, there are better and more rewarding ways to provide charity work if there is not going to be any profit.
21. Too low of reimbursement.

Paperwork required/Pre-authorizations

1. After submitting mountains of paperwork to become a provider, they are still very difficult to work with.
2. In my opinion, MCNA was ill prepared to take on the responsibilities of being a competent administrator of DWP. At every level of MCNA's administrative staff, I have seen lack of understanding of the transparent rules set forth by Iowa Medicaid. MCNA has been difficult to work with in the past, present and I fully anticipate in the future. Our office tries very hard to make sense of some of the decisions MCNA makes in regards to preauthorization denials, nonpayment of treatment rendered, noncompliance to Iowa Medicaid's authorized treatment allowed, etc.
3. Low reimbursement. Requires pre-authorization for everything. Requires pre and post bitewings for crowns.
4. Low reimbursement rates; required prior authorizations for procedures.
5. MCNA is dishonest and impossible to work with. They have hidden rules and refuse to pay claims. Radiographs are not paid for but required. They require us to see ever patient. If the patient fails to keep their appointment (the biggest Medicaid problem) we can't do anything about it. Working with MCNA is similar to slavery. They required pano x-rays for edentulous patients. I would rather retire than have to do business with MCNA again. Absolutely the worst company i have dealt with in 30 years of practice. I can't believe the state didn't look into their reputation in Texas. Working for them is like working for a Mafia outfit.
6. MCNA is not a helpful bunch. When you call in your lucky if you find someone who knows what they are talking about. We had to get a point person just to get answers. When it comes to claims submission there are so many unnecessary requirements that are constantly changing we are having a hard time getting payment. The put provisions on everything therefor they don't allow us a providers to do what is best for the patient.
7. MCNA is very difficult to work with, cumbersome amount of paperwork to actually get claims approved (vastly different from Delta Dental), pre-authorization active periods for SRP are 3 months and is prohibitive for many patients to actually get the work done/creates, require x-rays for pay on pre-authorization for a crown seat or will deny claim (no clinical reason for this).
8. Paperwork was more involved with MCNA, but mostly no other dentists in Iowa accept it and we were bombarded with patients.
9. Payments are very slow and too much paper work.
10. Required pre-authorizations for almost everything and denied claims without post-op films. Very poor administration.
11. Same as with Delta- all the hoops, terrible reimbursement rates.
12. Slow response, slow processing of pre-auth. high rate of denial of pre-auth. sometimes do not pay doctors for procedures. Limited time for pre-authorization validate dates.
13. The headache when trying to get a treatment plan authorized, and the patient needs this treatment plant desperately, and it goes to a frontline individual sitting at the computer terminal whom denies it. Then we have to jump through hurdles to try to get the treatment plan authorized. Unacceptable!

14. The pre authorization too short of window to finish procedure. Need to ask extension a lot. Not many oral surgeons take the insurance.
15. They deny more often and need periapicals of most teeth (which seems excessive for some patients).
16. They have their own policies which are different from normal insurance companies so there is always "extra" work to process claims with them. Lots of denials. Turn around takes about 4 weeks or more for payments, prior authorizations. Even if you have an approved prior authorization you still have to send in everything you sent for the prior auth. So many extra steps.
17. They tend to deny charges more frequently than Delta and require more pre authorizations so more time and effort to work with them.
18. Too long to get reimbursed, too many restrictions and traps that could lead to denied coverage, takes too much of the staffs time to follow up, reimbursement rates are so low that there is no profit and often actual costs the provider money to see the patients, there are better and more rewarding ways to provide charity work if there is not going to be any profit.
19. Too many to list. One primary problem is that pretreatment of procedures takes longer to get an approval than it takes for a patient to switch to Delta Dental and get approved. It's seems MCNA has their own list of requirements for procedures that Delta does not and the old XIX system never did.
20. We had problems where people were switched over to wellness and either the patient or we were not informed and treatment was not covered. Extra paperwork, hurdles for staff, etc. We were having to call to verify coverage before every former Title 19 patient and we simply do not have the staff or time to do so. Even the old Title 19 had issues; having to pre-authorization perio maintenance constantly. If you have advanced perio it doesn't just go away in 6 months or a year.

Claim denials/Payment delays

1. Difficult to deal with claims filing, claims on the website are not user friendly; if we have to resubmit the claim for missing an attachment, MCNA notifying you before the 90 days of filing the need to resubmit the claim due to missing information.
2. Difficult to work with sometimes, deny coverage for basic services and make things harder than they need to be.
3. In my opinion, MCNA was ill prepared to take on the responsibilities of being a competent administrator of DWP. At every level of MCNA's administrative staff, I have seen lack of understanding of the transparent rules set forth by Iowa Medicaid. MCNA has been difficult to work with in the past, present and I fully anticipate in the future. Our office tries very hard to make sense of some of the decisions MCNA makes in regards to preauthorization denials, non-payment of treatment rendered, noncompliance to Iowa Medicaid's authorized treatment allowed, etc.
4. MCNA is actually even worse as an insurance carrier than Delta Dental, if this is possible. MCNA routinely violates the Uncovered Service Act and Unpaid claim Acts in Iowa. MCNA places impossible hurdles to submit claims for payments. These are services that Iowa Medicaid represented to CMS as covered services. MCNA's administration of the program is substantial worse than traditional Medicaid.
5. MCNA is very difficult to work with, cumbersome amount of paperwork to actually get claims approved (vastly different from Delta Dental), pre-authorization active periods for SRP are 3 months and is prohibitive for many patients to actually get the work done/creates, require x-rays for pay on pre-authorization for a crown seat or will deny claim (no clinical reason for this)
6. MCNA is very hard to work with in providing care for patients. I cringe when I see a patient that has MCNA because they do not like to approve claims and deny so many treatment plans!
7. MCNA's administration of the program is very poor. At the beginning they seemed to be more poorly informed on patient benefits than my staff and my patients. When discussing with MCNA and the benefits they provide, they would always refer to "the manual". However if you used the manual to provide them with information on a case and how something should be a covered benefit, they wouldn't have another step to take, there is no customer service, only a direction of referring to "the manual". There isn't a common goal of providing patient care in a reasonable and expected manor. I have had a phone conference with their claims department, talking with the dentist who denied the claim, that dentist's supervisor, and a few other individuals to discuss the radiographic appearance of a Porcelain/Zirconia crown. They believed the radiopacity core was metal, and the more radiolucent shell was porcelain, and should be billed as a PFM, I had to explain the zirconia cores are radiopaque as well. This conversation was embarrassing to have, along with many other experiences my staff and I have endured, and my trust in their ability to provide for their beneficiaries is negligible.
8. Payments are very slow and too much paper work.
9. Required pre-authorizations for almost everything and denied claims without post-op films. Very poor administration.
10. Same as above.
11. They are hard to work with and put too many restrictions and are fast to deny payment or treatment.
12. They are not hones. I have had previously approved procedures later denied for payment because they claim the treatment didn't meet standard of care. I don't know how they can determine that from a verbal description. Also denial of claims from delayed submission. My receptionist could tell many more.
13. They deny more often and need periapicals of most teeth (which seems excessive for some patients).
14. They don't have a local representative that you can contact consistently. It takes forever to get disputed claims looked at and paid. Did not pay a bonus pool to offset the reduced fee like Delta.
15. They have their own policies which are different from normal insurance companies so there is always "extra" work to process claims with them. Lots of denials. Turnaround takes about 4 weeks or more for payments, prior authorizations. Even if you have an approved prior authorization you still have to send in everything you sent for the prior auth. So many extra steps.
16. They tend to deny charges more frequently than Delta and require more pre authorizations so more time and effort to work with them.
17. This is the worst excuse of an insurance company we have ever seen. Where is the insurance commissioner when there is blatant fraud being committed buy these bums. They still owe us thousands of dollars in denied and delayed claims. I can't believe they are still allowed in the state of Iowa. Now there are auditing our records after we terminated our contract with them.
18. Too long to get reimbursed, too many restrictions and traps that could lead to denied coverage, takes too much of the staffs time to follow up, reimbursement rates are so low that there is no profit and often actual costs the provider money to see the patients, there are better and more rewarding ways to provide charity work if there is not going to be any profit.

Complexity of rules and regulations/Too many restrictions

1. In my opinion, MCNA was ill prepared to take on the responsibilities of being a competent administrator of DWP. At every level of MCNA's administrative staff, I have seen lack of understanding of the transparent rules set forth by Iowa Medicaid. MCNA has been difficult to work with in the past, present and I fully anticipate in the future. Our office tries very hard to make sense of some of the decisions MCNA makes in regards to preauthorization denials, non-payment of treatment rendered, noncompliance to Iowa Medicaid's authorized treatment allowed, etc.
2. Low reimbursement. Not truthful on what will be covered.
3. MCNA does not even come close when comparing to Delta Dental. Their customer service is usually not very friendly nor helpful. They have multiple additional requirements and "hoops to jump through" to be able to provide what I would consider is basic care in some cases.
4. MCNA is dishonest and impossible to work with. They have hidden rules and refuse to pay claims. Radiographs are not paid for but required. They require us to see ever patient. If the patient fails to keep their appointment (the biggest Medicaid problem) we can't do anything about it. Working with MCNA is similar to Slavery. They required pano x-rays for edentulous patients. I would rather retire than have to do business with MCNA again. Absolutely the worst company I have dealt with in 30 years of practice. I can't believe the state didn't look into their reputation in Texas. Working for them is like working for a Mafia outfit.
5. MCNA is not a helpful bunch. When you call in your lucky if you find someone who knows what they are talking about. We had to get a point person just to get answers. When it comes to claims submission there are so many unnecessary requirements that are constantly changing we are having a hard time getting payment. The put provisions on everything therefor they don't allow us a providers to do what is best for the patient.
6. MCNA is very difficult to work with, cumbersome amount of paperwork to actually get claims approved (vastly different from Delta Dental), pre-authorization active periods for SRP are 3 months and is prohibitive for many patients to actually get the work done/ creates, require x-rays for pay on pre-authorization for a crown seat or will deny claim (no clinical reason for this)
7. Not user-friendly at all. Guidelines for procedure codes make work more difficult to complete.
8. Same as above.
9. Same response as before with regard to administration of any program.
10. They are hard to work with and put too many restrictions and are fast to deny payment or treatment.
11. They are not hones. I have had previously approved procedures later denied for payment because they claim the treatment didn't meet standard of care. I don't know how they can determine that from a verbal description. Also denial of claims from delayed submission. My receptionist could tell many more.
12. Too long to get reimbursed, too many restrictions and traps that could lead to denied coverage, takes too much of the staffs time to follow up, reimbursement rates are so low that there is no profit and often actual costs the provider money to see the patients, there are better and more rewarding ways to provide charity work if there is not going to be any profit.
13. Too many hoops, rules and regulations. Why don't they simply model coverage after the many private business models that exist?
14. Too many to list. One primary problem is that pretreatment of procedures takes longer to get an approval than it takes for a patient to switch to Delta Dental and get approved. It's seems MCNA has their own list of requirements for procedures that Delta does not and the old XIX system never did.
15. Very difficult to deal with and unreasonable as to acceptance of treatment needed. Lots and lots of "hoops" to jump through to get approval or reimbursement.
22. We had problems where people were switched over to wellness and either the patient or we were not informed and treatment was not covered. Extra paperwork, hurdles for staff, etc. We were having to call to verify coverage before every former Title 19 pt. and we simply do not have the staff or time to do so. Even the old Title 19 had issues; having to pre-authorization perio maintenance constantly. If you have advanced perio it doesn't just go away in 6 months or a year.
16. When I looked into signing up, because I liked the concept, they demanded answers to questions I was unwilling to respond to, but more importantly mandated that I have a narcotic's permit. I don't have one because I previously rarely prescribed narcotics and was unwilling to pay the rather large cost of getting one.

Poor recruitment experience

1. Before the change, MCNA representatives were extremely pushy to get us to sign on. It felt like harassment so we opted not to participate.
2. MCNA did not give a good impression when recruiting us for the program and not as easy to work with.
3. MCNA is not user friendly when it comes to becoming credentialed in their network, and I attempted multiple times to obtain credentialing, was rejected multiple times for not having the right paperwork, was rejected when the requested paperwork was submitted, and then again was told other paperwork was required. I have done this multiple times to no avail.
4. MCNA sent representatives to our office to try and get us to enroll with them and they told our front desk person that "she" could sign the office up with them and didn't even need to tell the Doctor nor the Business manager. It was a very shady approach and not appreciated. I find it interesting that MCNA uses Delta Dental's fee schedule, it was obvious when Delta Dental's fee schedule had an error in it when first published and MCNA copied and republished the error as well in "their" own fee schedule. MCNA does not present themselves as a company with integrity.
5. MCNA specifically states in the contract that dentists who are accepting new patients must also accept unlimited DWP patients. At the reimbursement rates, it is not financially feasible to take unlimited DWP patients and stay in business to serve the other patients in our communities. When MCNA wanted to get the contract in Iowa, they had reps go around to dental offices and literally lie to our staff about what they were doing. They implied that they had the contract with the state before they did and they made statements that were absolutely false.
6. Received no help to become a provider- became frustrated with them.
7. Reps were uninformed when recruiting for the MCNA network- very bad first impression.
8. The application to become a provider was ridiculously too invasive. They asked for information that was unnecessary.
9. The original way they set things up to be a provider seemed to be rather "fishy". Was not impressed with the way they contacted up and pressured us into becoming providers. I did not.
10. The reps have lied to us multiple times. They are untrustworthy.

11. They are very "sly" at getting doctors to sign on, then pull out the rug.
12. They were pushy and rude when their reps came to try and get us to sign up. They tried to intimidate us by telling us we had to sign up or we were going to lose all kinds of patients, they were very pushy. They came into the office several times and called even after we said no. Other offices in our area had this exact scenario hope to them. They were also turned off by MCNA and did not sign up due to it.
13. They were very persistent about accepting their coverage and I had no problems with Delta Dental and didn't want to have the hassle of working with both companies.
14. They were very rude and basically threatened us that if we didn't accept MCNA we would not be able to see and Wellness patients which is a lie.
15. Very pushy getting us to sign up with them Daily calls and visits. Wouldn't accept our no. Then they became very rude.
16. When MCNA started courting this office to become a provider they basically used scare tactics to lure us to join. The stopped by about 10 times to get us to sign on. They made claims that were false when compared to Delta Dental. This program is very much like going to a private MSO that the current Medicaid health system has done. The fact that they are based in Florida is enough for me to stay away.

Non-participation

1. Don't participate.
2. I am an associate. The owner said we don't accept MCNA because the reimbursement is even worse than delta dental.
3. I don't understand why we have two insurance providers for DWP. They have different stipulations for pre-authorizations and covered benefits. My staff and I do not have time to figure out the nuances of both insurance companies, therefore we are only enrolled with Delta Dental.
4. I have not heard anything good about MCNA. I chose not to participate with that company because I saw them as an out of state company that was just coming in to take advantage of our DWP population, both as patients and providers. Had they provided services in our state prior to this privately, I may have considered them, but I can't support them skimming money from the state of Iowa over services for these patients.
5. I was told not to use them. I forget why.
6. They have a poor reputation therefore I will not see any patients with MCNA.
7. They seemed to have little knowledge of how their program worked early on. We have not had any contact with them since deciding not to accept MCNA.
8. Unknown. Never accepted a patient from MCNA.
9. We are not working with them because we had no prior experience and they're from out of state.
10. We don't have many patients with MCNA. The few times we have dealt with MCNA, we don't care for MCNA at all.
11. We're not Medicaid providers any longer.
12. When I looked into signing up, because I liked the concept, they demanded answers to questions I was unwilling to respond to, but more importantly mandated that I have a narcotic's permit. I don't have one because I previously rarely prescribed narcotics and was unwilling to pay the rather large cost of getting one.
13. Will not accept patients with MCNA coverage. And I am not aware of any local clinicians who accept this insurance
14. Will not take these patients.

Customer services/Accessibility of information

1. Even worse reimbursement, terrible to deal with on the phone.
2. Extremely poor communication and reimbursement time.
3. Have heard very bad reports regarding customer service and reimbursement.
4. Impossible to work with their administration.
5. MCNA does not even come close when comparing to Delta Dental. Their customer service is usually not very friendly nor helpful. They have multiple additional requirements and "hoops to jump through" to be able to provide what I would consider is basic care in some cases.
6. MCNA is not a helpful bunch. When you call in your lucky if you find someone who knows what they are talking about. We had to get a point person just to get answers. When it comes to claims submission there are so many unnecessary requirements that are constantly changing we are having a hard time getting payment. The put provisions on everything therefor they don't allow us a providers to do what is best for the patient.
7. MCNA's administration of the program is very poor. At the beginning they seemed to be more poorly informed on patient benefits than my staff and my patients. When discussing with MCNA and the benefits they provide, they would always refer to "the manual". However if you used the manual to provide them with information on a case and how something should be a covered benefit, they wouldn't have another step to take, there is no customer service, only a direction of referring to "the manual". There isn't a common goal of providing patient care in a reasonable and expected manor. I have had a phone conference with their claims department, talking with the dentist who denied the claim, that dentist's supervisor, and a few other individuals to discuss the radiographic appearance of a Porcelain/Zirconia crown. They believed the radiopacity core was metal, and the more radiolucent shell was porcelain, and should be billed as a PFM, I had to explain the zirconia cores are radiopaque as well. This conversation was embarrassing to have, along with many other experiences my staff and I have endured, and my trust in their ability to provide for their beneficiaries is negligible.
8. They don't have a local representative that you can contact consistently. It takes forever to get disputed claims looked at and paid. Did not pay a bonus pool to offset the reduced fee like Delta.
9. We had several disabled patients who were randomly switched. The care givers or staff of these patients didn't know where cards were clueless. So trying to work with MCNA to get reimbursement the staff was very rude.

Issues with contract

1. Harder to work with. Did not like the rules of contract.
2. MCNA specifically states in the contract that dentists who are accepting new patients must also accept unlimited DWP patients. At the reimbursement rates, it is not financially feasible to take unlimited DWP patients and stay in business to serve the other patients in our communities. When MCNA wanted to get the contract in Iowa, they had reps go around to dental offices and literally lie to our staff about what they were doing. They implied that they had the contract with the state before they did and they made statements that were absolutely false.

Specialists availability

1. They can't get any local specialists in their network.

Positive Comments

1. Adequate.
2. Well structured.

Other Comments

1. As an Orthodontist, I'm not sure if we are included in the program.
2. Before the change, MCNA representatives were extremely pushy to get us to sign on. It felt like harassment so we opted not to participate.
3. Multiple issues.
4. Not even oral surgeons in any of the surrounding areas accepts it.
5. Our understanding is that this provider is difficult to work with.
6. Patients unaware of their responsibilities and not knowing extent of program, no way to encourage patients to show up/ keep appointments as they have no penalty for no shows.
7. Poor.
8. Regulated.
9. The families keep telling me that they are supposed to have the patient fill out the "dental survey", but a lot of the adults with disabilities are unable to physically or mentally fill out the form. The families are a bit frustrated that MCNA does not recognize in their computers that they are serving an adult with a disability who may have a guardian that is making decisions/filling out forms for them.
10. To take advantage of what little the state has for the dental care of the needy. As mentioned this is something that Branstead and his buddy Rick Perry (the lobbyist and CEO of MCNA) know already. The company has been kicked out of most states but Texas.
11. Were not prepared, did not follow through.
12. MCNA is not user friendly when it comes to becoming credentialed in their network, and I attempted multiple times to obtain credentialing, was rejected multiple times for not having the right paperwork, was rejected when the requested paperwork was submitted, and then again was told other paperwork was required. I have done this multiple times to no avail.
13. Difficult to deal with claims filing, claims on the website are not user friendly; if we have to resubmit the claim for missing an attachment, MCNA notifying you before the 90 days of filing the need to resubmit the claim due to missing information.

No Comments

1. None.
2. None.

PLEASE IDENTIFY TWO MOST IMPORTANT CHANGES THAT COULD BE MADE TO INCREASE DENTISTS' PARTICIPATION IN THE DWP WITHOUT INCREASING THE OVERALL COST OF THE PROGRAM?

All survey respondents

Reduce administrative burden (please describe:_____)

1. Pre-authorization headaches and the need for callbacks when denied.
2. Based on comments from colleagues who participate in the program, the paperwork is extensive and combined with the low fees, it actually costs practices extensively to participate in the program. I choose to treat some of those people at no fee and participate with the DDS program. I costs me far less and allows better care for the people I choose to help.
3. Checking eligibility and recordkeeping.
4. Confusion as to which insurance the patients have at certain times.
5. Do not privatize coverage.
6. Don't fight us on paying for claims.
7. Eliminate explanation of benefits to patients, -it's an enormous waste of time and money that patients tend not to understand. They often call thinking that they are being billed.
8. Enforcement of competency within the MCNA.
9. Excessive pre-authorizations required.
10. Fewer prior authorizations and fewer submissions.

11. Fewer pre-authorizations.
12. Get rid of the healthy behaviors assessment, many of our DWP patients are special needs and cannot fill these surveys out.
13. Getting a random patient audit, I get paid 35 cents on the dollar through a record audit, this alone makes me want to drop the program altogether.
14. Having a single administrator to deal with.
15. Having the need to check before each appointment if the patient is still covered and what services they qualify for as patients almost never know.
16. Improve administrative issues, figuring out payment check to our office and which patients they were sent for.
17. Ensuring patients are eligible every single time they have an appointment.
18. Keep the dentists as the oversight on the patients and not the third party payers.
19. Less paperwork; government bureaucracy at its finest.
20. Claims lost, delayed and rejected for unknown reasons.
21. Make this system comparable to private insurers.
22. Make it easier to submit claims.
23. Missed patient appointments.
24. No "extra coding" (e.g. pregnancy code) and no purchased Rx pads.
25. Number of services requiring prior authorizations, number of denials for situations in which other carriers have no issues.
26. Paperwork.
27. Paperwork and intermittent eligibility.
28. Patient compliance issues.
29. Pointless pre-authorization requirements.
30. Pre-authorization requirements.
31. Program is extremely complicated and we ended up providing a significant amount of treatment with no reimbursement. When the reimbursement amounts dropped with the number of patients we had added to our schedule it resulted in becoming a severe financial burden to our practice.
32. Reduce arbitrary denials of services.
33. Reduce headaches of prior-authorizations.
34. Requirements for pre-authorizations take too much time.
35. Services are either covered or not. Medicaid's requirements were very clear. The paid services should be exactly the same as Medicaid's, not multiple different fee schedules and covered services.
36. Switching from Delta to MCNA without notice.
37. The amount of paperwork to set up and post-op is quite extensive.
38. The minutia that they find to return an authorization or payment for services rendered.
39. The pre-op photos or radiographs for multi-surface anterior composites.
40. Time consuming to check status and get cards from members.
41. Too many pre-authorizations and denials.
42. Too many restrictions.
43. Too many things require an authorization.
44. Too much pre-authorization required.
45. Way too much time spent making sure all rules are followed.
46. You should offer a version of this survey to front desk employees for best information.

Other

1. All covered services should be paid. This should be the same as Medicaid. There needs to be oversight of the MCOs. Currently the MCOs, abuse the providers and patients and there is little to no recourse.
2. All of these are valid responses.
3. All of the above.
4. DWP has paid efficiently but Medicaid is impossible to work with and we have claims over a year old that haven't gotten any payment from Medicaid.
5. Eliminate all government operation of a program.
6. Eliminate the ability of insurance company to decline payments without us jumping through many refiling or attachments etc.
7. Fee schedule! You can't ignore this. The old wellness plan had significantly higher reimbursement.
8. Get rid of the patients' entitlement, they don't pay for it and they think they deserve everything for free and if they don't show up they just don't care. Very frustrating to have to argue with patients not showing up and then argue when they show up that they don't cover implants they think they deserve. Waste of time.
9. Go back to the rate you used to reimburse at. Not pay at Medicaid rates of reimbursement. That doesn't cover the cost of the treatments, therefore most dentists aren't going to enroll, and why would they. These patients are far harder to deal with, have much more comprehensive treatment due to lack of dental care and the state wants/expects dentists to invite these patients into their practice ta 50 percent reduction in reimbursement. There is no incentive for a dentist to take on the burden.
10. Have more participating providers, I was getting patients that would drive 30 miles for an appointment because they couldn't find a 'good' provider near them.
11. I think patients are very confused, and I'm not sure how to navigate the insurance to help them (I'm confused also!).
12. If the state is going to offer orthodontic coverage, try a reimbursement that is 25 percent less than an average fee. Current reimbursement is less than half.
13. Increase reimbursements, some of the reimbursements are ridiculous.
14. Increase reimbursement for all services.
15. Increase reimbursement for services without decreasing it for others.
16. Increase reimbursement rates.

17. Increase reimbursement without decreasing or eliminating it for ethers.
18. Increase reimbursement, cover more procedures.
19. Increase reimbursement, full stop.
20. Increase reimbursement, not elimination or decrease in others.
21. Lower the Salzmann index score for orthodontic coverage.
22. Make patients have to pay $10 per visit and maintain appointments as well as meeting requirements of at least two hygiene visits per year.
23. Make patients pay something for their coverage.
24. Need overall reimbursement to increase.
25. None at this time.
26. Not sure we would be interested in this program, needs to be reworked.
27. Orthodontic approval threshold way too high compared to reimbursement level. Competent practitioners will start opting out of serving orthodontic patients. Orthodontic treatment below standard of care is/will be the result.
28. Our business cannot survive at current reimbursement rates.
29. Patient commitment to attending appointments.
30. Pay for implants. This is a better treatment option than a partial denture, especially for one missing tooth.
31. Provide a single dollar amount per patient per year. No provider enrollment, no pre-authorizations, no gate-keepers.
32. Really, all of the above.
33. Reimbursement is a joke and must be fixed.
34. Reimbursement is why we stopped.
35. Revamp the contract. Remove the gag order, in fact provide a means for dentists to make a complaint or give constructive criticism that is not within the private company running it. Remove concept of having to accept unlimited numbers of patients. Give the private insurance company an incentive to be good to providers and patients, hold them accountable to be responsive. My understanding of block grants is that they get the money and have everything to gain if their patients can't get access to care- that is a broken system.
36. Set the yearly maximum benefit at $1000 similar to Hawk-I.
37. Somehow instill a sense of responsibility in the patient for their dental well-being. Those that have- that are the patients we are willing to see and welcome in our practice, even with the very low reimbursement rates.
38. Take out the provision that we cannot limit the number of patients.
39. Take the millions of dollars of profit that Delta and MCNA are getting and give it back to the program in the form of higher reimbursement.
40. The fees are embarrassingly low for the time, effort, and responsibility of treatment. The fees should return to the fee schedule prior to the program change.
41. There is only one way to make this work – please listen – you need to pay the dentists. We are more than willing to treat these patients- we just need to be paid.
42. Would have to increase reimbursement a minimum of 100 percent over current rates to even consider participation. Current rates are considerably below minimal office overhead expenses. Until this happens participating dentists will continue to decrease at a steady rate.
43. You must make it worthwhile by increasing reimbursement. No other service the state contracts with would offer 30 percent of normal costs and expect anybody to participate. When these people get food the state pays, when they get housing the pay fair rent, not discounted by ridiculous amounts. Pretty soon there will be no participation in these programs. As it is, the real numbers of people (dentists) that are seeing these patients is very low. I'm an oral surgeon and I get "stuck" doing a huge amount of this work mostly on emergency basis and the vast majority of these patients tell us that they can't get into any dentist in the area. This needs fixing. Fast.

WE ARE INTERESTED IN ANY OTHER COMMENTS YOU MAY HAVE ABOUT CHANGES TO THE DENTAL WELLNESS PLAN.?

All survey respondents

Reimbursement

1. It is unfortunate to have to continue to figure out how to treat our patients and still afford to be able to make it financially feasible. I don't like having to treat one group of people differently than others. I would suggest increasing reimbursement for all stabilization procedures and eliminating orthodontic, periodontic, and fixed prosthodontic procedures. In other words, cover preventive, fillings, extractions and nothing else.
2. 1) Simple 2) second molars fill or extract. 3) Less failures. 4) More reimbursement for denture stuff- I lose because my lab bills exceed some payments. 5) More oral surgeons. 6) Maybe a maximum yearly limit except for denture stuff and extractions.
3. Again, the primary issue is with reimbursement. In speaking regularly with a majority of dentists in our area, we agree that a business cannot be operated at a loss. So to raise reimbursement 3-5% is a waste of time. It literally needs to double to get to a point to where there would be consideration of accepting DWP patients.
4. As a dentist who was taking new patients with Title XIX and the DWP, these changes are a step in the wrong direction. Until all dentists are required to accept XIX in Iowa, the reimbursement rates need to improve in order to have dentists accept new patients. With the expansion of the Medicaid population, more patients are flooding an already exhausted pool of dentists. I could no longer afford to keep seeing these patients as they were a majority of my new patient pool and I was the only dentist in town taking new patients with it. I think the reimbursement for disease control treatments should be increased such as restorative, periodontal treatments, and oral surgery. I guess what needs to be determined is do we provide comprehensive treatment for fewer patients or limited treatment for all patients? Limiting dentures, endodontic treatments, and crowns should be considered.
5. As a provider that believes in Public health initiatives I think DWP was a great program that seems to be moving in the

wrong direction as far as helping the patient. I think the wait period for patients originally made sense to weed out the unwilling or non-committed patients. Dropping rates of reimbursement is now going to weed out doctors like myself that want to help these patients but due to my small practice may not be able to continue to handle the load of low reimbursement and staffing and lab fees. It saddens me to see the program move in this direction. I hope more positive changes happen in 2018.

6. As I understand, DWP functions the same as Medicaid for orthodontics. The Salzmann has helped reduce cosmetic coverage, although the ability to get exceptions to policy are limited, especially when patients have a need like an impacted tooth. There are times when orthodontics could save expenses down the road. Reimbursement in orthodontics is so far below cost, most orthodontists are not willing to accept patients unless referred personally by a good referring doctor. When I speak with my dental colleagues, it seems as if there are still several areas that are profitable for them to justify continued acceptance of new patients.
7. By the number of phone calls my staff receives, reducing the DWP reimbursement to Medicaid levels has clearly forced several practitioners to drop the plan.
8. Classic bait and switch. Get dentists to accept new patients then put them on Medicaid with significantly lower reimbursement rates. As a solo practitioner I cannot afford to see any more DWP patients.
9. Cost of the program is always a talking point. I realize there are limited dollars to fund a program. It's hard for dentists to "turn off the spigot" of new Medicaid or Wellness patients into their practice. To mitigate this, I treat the patients I encounter pro bono or I also do 2 "free dental" days a year in my community instead of participating in IMOM. We all have a responsibility to help care for the "least of these" in our communities and we will all have to pitch in, but the cost of running a dental practice is going up due to the regulatory environment we live in, and the reimbursement rates are not going up at the same rate. Dentists cannot support a disproportionate amount of the program.
10. Doctors who are willing to accept Medicaid patients with physical and mental handicaps at a 30% remuneration rate deserve to be treated with respect. MCNA was the most disrespectful company my office has ever done business with. They constantly referred to their ridiculous manual (which they made downloadable in the middle of the night July 14th after the program started) as biblical. I am not going to prepare a crown and have the Medicaid patient be unreachable to seat the crown and absorb the cost. One patient we treated the lab bill for the denture repair was $14 dollars more than they paid. I had several sleepless night over a period of six months from dealing with MCNA and finally said enough is enough. Why does a company that remunerates at 30% (virtually zero profit for the dentist) require 5 times more paperwork. Every single claim we processed with MCNA had some issue. We have 0 problems with Delta. Someone should look into this unethical company.
11. DWP was like a bait and switch program concerning accepting new DWP patients then later reducing fee schedule.
12. Either the reimbursements need to be similar to current fee for service fees or there need to be more clinics that are designed for primarily for the purpose of serving Medicaid/DWP. I would prefer the latter. These programs and there reimbursement levels require different business models to be successful in private practice. It is challenging to mix the two very different business models in the same facility. It is unfair to patients and providers to expect fee for service level treatments at Medicaid level reimbursements. The reimbursements are too low for providers to remain profitable in their business. Fee for service patients would likely be upset if they found out that they are paying way more for treatment than Medicaid is paying for the very same treatments.
13. Eliminate posterior root canals and posterior crowns except stainless steel eliminate periodontic services. Increase payments of preventive and restorative. Increase payments of anterior crowns and removable prosthodontic services.
14. Endodontic: limit to anterior teeth only or eliminate special procedures or limit yearly allowance. Fixed: limit to single units only. Preventive: increase $ on radiographs and don't lump into full mouth (this compromises motivation for proper diagnosis). Thank you for allowing fluoride. Periodontic: Thank you for allowing S&RP without pre authorizations. Eliminate specialty periodontic procedures. Removable: increase fees for permanent partials/completes but either increase or eliminate totally minor procedures like add tooth/add clasp (not profitable with lab fees). Oral Surgery: fees are acceptable for a GP. Eliminate or allow only oral surgeons to do procedures beyond 7210/7140. Some earned benefits would be welcomed. Not enough MCNA providers- consider allowing Delta Dental to administer all DWP; really disappointed in program that oral surgeons are pulling out.
15. I am angered that patients are compelled to travel great distances to receive care and additionally that the state pays for taxi cabs to transport patients to appointments. I talked to one driver and learned that he was paid more for the dental appointment than I was. If you would increase reimbursement patients wouldn't have to travel over an hour for care. What a waste!
16. I believe the plan is run quite well through Delta Dental. However, reimbursement makes it difficult to provide service to patients when for many procedures we break even or even lose money. Ultimately, we are running a business and it does not make sense to provide services where no profit can be made.
17. I feel a responsibility to help take care of Iowa's needy patients and I have for 26 years but these recent changes have made it very difficult to accept the burden on my practice and my financial situation.
18. I found it pleasurable and rewarding to provide services to Medicaid patients. Though I gave away tens of thousands of dollars of work each year- and a high percentage of my income, I felt it was my way of "giving back". I gave directly to the patients, and because the reimbursements were so low, I felt I also gave indirectly to all tax payers. I found satisfaction in this. Now I worry that if I join the Dental Wellness Plan, that this satisfaction will be diminished, my staff will have more paperwork, and I will feel like I am giving to the insurance companies. Thank you.
19. I grew my practice with DWP prior to the changes made July 2017; I felt the rug was pulled out from under me. The reimbursements on the new fee schedule are unsustainable for any private practice. You lose money, especially with services requiring lab bills. Prior to the changes, the reimbursement was low but still profitable enough to have a part in private practice. I have so many patients that have benefitted from DWP and with these changes, they will have nowhere to go except a community health center or the College of Dentistry. My concern for my patients is that they will ultimately stop receiving dental care because they will have nowhere to turn.
20. I hope this survey shows that Delta and MCNA don't have the required network of dentists actually taking DWP patients and changes the program back to the way it was. I was ok with taking a low reimbursement for adult Medicaid when I knew no one was profiting from it. Having my office lose money on DWP patients while Delta makes millions makes no sense.

21. I like doing charity work, but I have too much student debt and too busy of an old farmer patient base to get paid half price and risk a no show at this point in my career.
22. I think that they shouldn't have set reimbursement fees higher than traditional Medicaid, then turn around after a year and reduce them. That is called a bait and switch. Very unethical.
23. I think the changes were in the right direction when it comes to the make-up of the program. There are still many things that need corrected. When it comes to the fees, most if not all, are lower than what traditional Medicaid was and are significantly lower than the old DWP program. Our main problem at our office is the differences within the code requirements. One allows it and the other might but you have 100 hoops to jump through. We'd like to see a more streamlined program with more payback.
24. I want to help the underserved dental community, but I can't afford to do it at the current reimbursement rates. The first DWP plan was a good way to fill the gaps in my schedule while helping those who had been waiting years to see a dentist. I understand the federal and state funding for the program went away. I hope it returns. I don't think it's unreasonable to put a yearly maximum on the plan instead of limiting services.
25. I will soon be retiring, so I am reluctant to accept new Wellness patients, as I don't want to burden the dentists I have sold out to with reimbursement levels less that overhead costs. It will be difficult enough for young dentists even without accepting Wellness patients. We consider it our social responsibility to see these patients, but cannot take as many as have a need. One thought I have always suggested is to give a tax benefit on the fee reduction. That would be some incentive. Also, a user tax on the products most detrimental to the patient's health, such as soft drinks and tobacco products, with all proceeds going to improve reimbursement levels and procedures now currently not covered.
26. If reimbursement can be increased, more dentist would participate. The reimbursement is less than 25% of our fees. If we had an entire practice with Wellness or Medicaid patients, we would not be able to survive due to the high overhead involved with dentistry. Maybe instead of eliminating procedures or decreasing reimbursement, have each participate pay a small fee like insurance (similar to Hawkeye insurance).
27. If reimbursement is not increased soon I think the program will fail due to nonparticipation by dentists.
28. If you would spend less money on surveys and increase the reimbursement rates the problem would be solved and you would not need to survey dentists. The poor deserve care but the dentists can't afford to deliver care and pay their office staff and bills.
29. Increase fees.
30. Increase of reimbursement rates is needed. Lab bills for some services are more than the practice is reimbursed for the service. Patients are canceling without 24 hours' notice and/or failing to show up. Payments are delayed and sometimes they pay nothing for a service after it is provided due to supposedly not having enough information. It is making it difficult for us to want to treat these patients.
31. Increase pay and you will get more providers, simple.
32. Increase reimbursement. Reimburse lab failure fees.
33. Increase reimbursement rates and more dentists would take patients with this insurance.
34. Increase reimbursement, decrease payment delays, stop intermittent coverage. Use just one program.
35. It doesn't pay to see patients on the plan. In fact in many cases we aren't even breaking even. They are not filling out the assessments or they are unaware they need to in order to keep their plan. Patients are confused about their coverage.
36. It seems to me that this is a "cost savings" initiative for Iowa. Make the providers have to do extra paperwork, deny procedures, change coverage without telling pts, providers. I never even got a letter from the state until a couple weeks before everything was changed in July. The reimbursement rates are low, as they were previously, but that's not even the biggest issue. It's the paperwork, rules and confusion. Providers will stop participating making the "access to care" issue even worse.
37. It was disgusting how they designed DWP with more realistic reimbursement schedules then reverted to pathetic Medicaid reimbursement with no discussion of what changes and were being made and why.
38. It's a joke. Not sure how much longer we can afford to lose money.
39. It's really simple: the reimbursement rates are oppressive. I have no problem not receiving what I normally receive for payment from my non-program patients, but I at least need to receive a fair payment. Even half of my normal fees would allow me to see some of these patients who truly need my help. I understand the state needs the funds to fund such a program, but underfunding Medicaid is a joke. Those patients now receive limited and oftentimes poor care because most offices that provide good quality care cannot afford to take them. I do like the tier program that makes the Wellness patients come in for required visits before reaching the next tier of treatment. That's a great idea and more insurance companies should do it because it puts the responsibility back into the patient's hands for preventive services. But at current rates, we simply cannot see a lot of these patients in our private practices.
40. Limit services, these patients should not have access to the same level of care that someone that is working hard and paying for premium dental plan should have. Many hard working people that don't qualify for these subsidized plans have no choice but to have teeth extracted when they bother them because it's all they can afford, people on public assistance should have no other options as well. I would eliminate completely except for children up to the age of 26, and adults over 65, or the disabled that has been verified disabled. Non-disabled adults between 26-65 years have no right to be subsidized by tax payers. Those on the plan in the meantime should have access to preventative, restorative, and extractions/removable pros only, and at re-imbursement rates that are the same as the regular Delta premier/Hawk-I rates, not at reduced rates to the provider, as the provider should not be punished, forcing the provider to share the patients' burden is unacceptable.
41. Make a decision what to pay for, and then reimburse at higher rates. Unfortunately, someone has to make this decision or we will go out of business trying to make things work with too low of reimbursement. Our overhead goes up every year.
42. Need to have better reimbursement and more efficient system for filing procedures. Also better customer service. The patients do not seem appreciative. They should be more aware of value of services they are receiving.
43. Need to increase reimbursements and specialist participation.
44. No one asked the politicians to go work for half, I do not buy my groceries at half price, my accountant does not work for half his normal fees, why do you expect dentists to accept fees that are half their normal fees? In some cases I cannot even break even and the state wants to try to make me the bad guy for not seeing the DWP patients in higher numbers, and I

probably see more Medicaid and DWP patients in my practice than any other in the county.

45. Originally, DWP patients had higher reimbursement rates than Medicaid patients, which is gone.
46. Orthodontic specialists will not, in general, accept title XIX and Hawk-I patients openly due to the prior-authorization red tape, and approximately 50% reimbursement level. Dental overhead runs around 50%. In the past, approved "easier cases" would offset the potential loss of income (or actual loss) experienced with accepting the harder cases. Higher acceptance threshold (Salzmann number) with no automatic approval situations (impacted canines, cleft lip/palate, crossbite) has made it difficult for dentists/orthodontists to justify accepting wellness plan patients. This leaves this demographic grossly underserved. We have patients that have to drive 2 plus hours one way for a 5 minute appointment because there isn't a practitioner closer to their home that will see them. Result of this situation is underqualified general dentists performing orthodontic treatment that is below the standard of care. Some is a money grab, some is a sympathetic practitioner that wants to help a family with no other options to find care for their child. I have taken wellness plan patients openly due to a feeling of obligation of serving the less-well-off. I feel like every practitioner should "do their part." It is easy for me to make that argument when practitioners are making less than they would with full-paying patients. It is much harder to make the argument when they are actually losing money taking on the underserved. Please fix the system to make it doable for good practitioners to accept these programs.
47. Our reimbursements for a procedure hardly pay to flip/tear down a room and pay our employee for that time. Especially, when broken appointments happen more frequently. I understand, we are providing a service to these patients that need more help, but we may have to consider not accepting the insurances.
48. Payments for procedure code D5510 through D5660 are insufficient to cover laboratory costs. The reimbursement rate needs to be increased to meet current laboratory costs.
49. Please pay us. I am very willing to treat all patients. I cannot run a practice if I am getting reimbursed at 30 cents on the dollar. You know this will fix the access to care, so find the funding to do it! We take Title 19 right now out of service to our community, but we do not know how long we will be able to continue this.
50. Prior to the changes we accepted ALL new Delta DWP patients and we gained several great patients that hadn't had a dental home for a long time. I thought the tier system was a great system, it taught them responsibility and encouraged patients to come in every 6 months. With the changes we can barely breakeven on hygiene appointments and are losing money on all composite restorations which is forcing us to send patients to the university to have some of their work done that could be easily completed in our office. We will continue to see the DWP that we gained prior to the changes; however, with the reimbursement rate changes we will continue to see fewer new patients. Again, the administration by Delta has been great to work with. We will not contract with MCNA, they were very misleading in their initial recruitment and Delta's system is so easy to work with.
51. Quit allowing Delta to dictate reimbursement rates. Set the rates and then ask Delta or MCNA determine if they want to run the program or not.
52. Quite honestly, if more practices took part of the burden of seeing these patients I would be more willing to see NEW patients. We were being flooded as more and more practices opted out. We can't stay in business accepting all of these patients due to low reimbursement rates. However, I am willing to help my community. Also, finding specialists to see these patients is very hard or they are so far away patients cannot reasonably make it to see them. We do see any DWP for emergent needs at this point to help eliminate pain.
53. Reimbursement levels are lower than cost to keep our business open. Gives no incentive except for helping people in need. Needs to be restructured like DWP was have some fees higher than Medicaid.
54. Reimbursement rates need to be higher. I really want to treat this population of patients, but as a recent grad and practice owner, fiscally I cannot see a large group of DWP patients and stay in the black. Also, this really felt like a bait and switch with DWP which is my biggest frustration. They got me to sign up for DWP and I began accepting many new DWP patients because the reimbursement rates at least covered my overhead and then once I had a large group of active DWP patients Delta Dental slashed the reimbursements. It seems they knew the whole time that the higher reimbursement rates weren't sustainable, but they wouldn't get anyone to sign up unless there was some incentive, so they made rates high and then once they had dentists enrolled they dropped the reimbursement rates to the low XIX level that they had always planned on paying at. I do not like to feel like I have been tricked by an insurance company.
55. Reimbursements need to be increased on base services and other should be eliminated if necessary to do so. It also seems like a lot of people are on program that don't have a true need. The parameters are either too generous or people are working the system.
56. Same as before. Basically I was involved at 100% prior to the changes. Then the reimbursement was drastically reduced leaving me no other option but to stop taking new DWP when I realized the reimbursement was not sustainable for this small practice. I think it might be better for Delta Dental to actually contract dentists to do the work, pay them a decent salary and have more access points for this patient population.
57. See previous comment regarding reduction of reimbursements. An observation from just my experience: a lot of the Medicaid/DWP patients have little motivation for restorative care. Most of this is attributed to anxiety. Another component seems to be a failure on the part of the general dentist to make a comprehensive plan and present it thoroughly to the patient. A lot of these patients are seen on an emergent basis and planned for the simplest treatment plan if planned at all. Another problem is access to care; community dental clinics plan for prosthetic reconstruction but will not perform the treatment. They send the patient to another office for complete dentures and/or partial dentures. This is very inefficient. I only perform extractions and receive referrals from a large area of the state, so I have seen patterns emerge over the years that do not inspire optimism on my part.
58. The current reimbursement makes Medicaid and DWP patients not profitable for dentists. The hoops we also have to jump through to get treatments approved and or preauthorized make it a headache for front office staff as well. This along with higher no show/broken appointment rates for DWP and Medicaid patients make it impossible for any dentists to see new DWP or Medicaid patients. Reimbursement needs to be competitive with private insurance to overcome the other headaches associated with these programs. It simply is not worth our time to work basically for free and have our front office staff work overtime to handle the administrative obstacles.
59. The Dental Wellness Delta Dental plan was great prior to the reduction in reimbursement. Not one complaint prior. Now it's pretty much straight Medicaid again. I will never enroll with MCNA. Why would the state of Iowa take jobs away from

the people Iowa and give them to Florida, not to mention those people who came to my office tried to bully us into enrolling. And we weren't the only office. A far as I know only one private practice in my area enrolled, the rest were immediately turned off by their tactics.

60. The DWP requires too much time to make sure people are eligible or not. If someone was eligible on the 30th of the month and not on the 1st of the next month but in the process of several appointments we have to stop or alter schedule or get stuck with costs because DWP won't pay and the patient won't pay. The reimbursement rate is less than half- rarely covering cost of material and wages.
61. The fees are too low to provide good service. The fees are too low for the time, effort, skill level, and responsibility. The low reimbursement encourages poor dental service and poor patient relationships.
62. The huge reduction in reimbursement for DWP made it feel like a bait and switch.
63. The new changes absolutely are not beneficial to the providers at all. 1) State suckered dentists in with better reimbursements than XIX and with an incentive to do Previsor. 2) This new change made reimbursements as awful as XIX, put more people on the program, and kept giving the providers conflicting information on who was being switched off XIX. 3) There is now no monetary reason for provider to do Previsor; however, if provider does not make sure that Previsor is done, it's going to cause a huge issue for the provider's office once the first year for the patient is up. A large majority of patients on this program are not going to do the self-assessment which in all actually does not hurt them, it hurts the providers trying to provide service to the patients. As a practice we understand the importance of providing for our community, but when the majority of the community is now on public assistance, we cannot afford to see more of these patients due to the horrible reimbursements. We also cannot afford to have the last minutes holes in our schedule from these patients that just don't feel like coming today for their confirmed appointment or just fail.
64. The program in theory was ok- concentrating on preventative with increased benefits/maintaining benefits. The original reimbursement fees were manageable. The sheer volume of patients added to the practice (with stipulation of no limit on number required to accept according to current agreement wording) with severe reduction in reimbursement fees, added administrative burden, having to provide services we normally refer to specialists because of lack of participating specialists, patients being switched between DWP/Medicaid-coverage guidelines totally different-in mid treatment, extremely high failure rate and the difficulty of the submission requirements/criteria hampering dental treatment with costs higher than reimbursement payment in most cases resulted in too great a burden on practice to participate in the program.
65. The reimbursement fee reduction was huge not insignificant as you describe.
66. The reimbursement is lower than previous Medicaid. They have taken away any patient responsibility. They got many dentists to sign up with the promise of decent reimbursement rates and then pulled the rug out from under us. If it wasn't for my special needs adults that I see on DWP I would drop the plan entirely. When I had to re-credential with Medicaid I sent in my paperwork only to find out months later that paperwork wasn't acceptable for anyone other than new providers. Nobody contacted us to correct the issue, they just took away our ability to see Medicaid patients. You would think if there were two dentists willing to sign up to still see Medicaid Patients that sent in paper instead of filling out an online entry someone could have informed us when they got the paperwork. Iowa is now down two Medicaid providers, one that had been seeing hem for 20 years and the other for a decade.
67. The reimbursement rate was decreased a lot after July, 2017. It dispels the enthusiasm of doing procedures for these insurance patients. A lot of referral have to be given to patients like from me. Patients will take more efforts to find other doctors who would take the referrals and do the procedures. The fee schedule of some procedures are not reasonably quite low, like RCT. Incisal RCTs only a little bit more than $200, even for the molar RCT, only a little bit over $300. Consider the time, effort and responsibility for dentists putting on the RCT, how many dentist would do the RCT with this ridiculously low reimbursement rate for RCT. FMX is only about $40. And full exam costs nothing, like only $20, partial denture only $591. Considering the time of visits and lab fees. Doctors got only very little after dentures delivery. Also, these patients keep changing insurances and eligibility and non-eligibility. Many times, when we, dentists, almost finish the dentures and crowns patient lost their insurances and the dentists/offices got nothing from these work, which is a huge loss. But, neither insurances nor patients notice this problem. The previous model with different level benefits was very good. Do not know why it's changed. The only way to encourage more dentists to see the patients and doing procedures is to increase the reimbursements. Otherwise, more dentist will leave these insurances and patients will have more troubles to find dentist for dental care and treatments.
68. This program went from reimbursing dentists $0.70 on the dollar to roughly $0.45 on the dollar. A typical dental office runs at 55-65% overhead. At $0.45 on the dollar, we are losing money as we see these patients. Private practice dentists are and should stop seeing these patients, this has to change. The University and community health centers have unsustainable wait times for appointments all because the reimbursement rates have dropped so low. It may seem like a simple solution to just cut the rates for the rich dentists but this program is on the brink of catastrophic failure if something doesn't change.
69. This was a great program that provided a lot of relief and care to those in need. The real draw for me was the way we could educate our patients and the requirements allowed us to get our patients into good health. We were able to have many "life changing" procedures as a result of the program and we are saddened that it is no longer available. Call it what you will but the current Dental Wellness program is far from that. The current compensation is just a joke. I hoped this program would have been a model for other need areas in this country. It could have been.
70. To get paid for Medicaid has been a nightmare since I started working 2 years ago. Something needs to change or we will end up dropping Medicaid patients. The reimbursement change has had us consider not taking wellness anymore as well. Please start reimbursing doctors for the work they are doing.
71. We cannot provide treatment for patients at or below our overhead and not pass the fee onto other patients. Dental Wellness Plan should not be subsidized by the dentist or other patients.
72. We were disappointed that the reimbursement coverage was decreased dramatically when it "merged" with the adult Medicaid program. The intermittent coverage is also tough. I had a patient that was approved for a crown, we prepped the tooth in one month, and seated the crown the next month. Meanwhile, he let his coverage lapse so we were left without payment.
73. We will be withdrawing from the program in the next year or two if reimbursements do not rise. Some of the reimbursements do not even cover the lab fee to do the procedure. If cost must be contained, limit the procedures that are covered. Preventive, basic restorative, extractions I believe should be covered. The rest could be optional.

74. When it went to Medicaid reimbursement levels we made plans to phase out.
75. When reimbursements will not cover the Dentist's overhead, he will likely leave the program. While I am willing to donate my time for less fortunate people, I resent "paying my taxes" a second time when I see them. I have to be able to pay my staff and overhead. Comes out of my pockets. Additionally, the program pays unlimited benefits, something that even the best policies do not do for those who are paying for their own Dental Insurance. If only my patients could get the same benefits out of their plans.
76. With a 30% overhead and a reimbursement of 40% it is not surprising that dentists in general are not thrilled with Dental Wellness. I understand prior to July 2017 Wellness was around 70% reimbursement. This reimbursement was at least manageable. I am sure that no one at the University of Iowa Public Policy Center would come one more day to work if their paycheck was reduced by 30%.
77. With reimbursement rates at around 40%, I am finding it hard to provide services and stay afloat financially. It costs me to provide care as my overhead runs between 80-85 %.
78. You should not be decreasing the reimbursement for adult prophy. It is already difficult enough to accept a 70% write off. Now you guys are decreasing prophylactic reimbursement by 7 dollars next year. You guys are making it very challenging to take all of these patients.

Administration/Paperwork required/Pre-authorizations

1. MCNA adopting the rules for debridements and SRP that Delta has. Patients being more aware of what the self-assessment is and being provided with access to complete that if they do not have it at home. Ability to implement missed appointment fees for these patients to decrease the number of missed/cancelled appointments.
2. As with all insurance companies, please trust that my license means that I will not over treat and that I will practice above the standard of care. Please do not act like you can diagnose and prescribe treatment from a desk in a building many miles away from the patient.
3. Doctors who are willing to accept Medicaid patients with physical and mental handicaps at a 30% remuneration rate deserve to be treated with respect. MCNA was the most disrespectful company my office has ever done business with. They constantly referred to their ridiculous manual (which they made downloadable in the middle of the night July 14th after the program started) as biblical. I am not going to prepare a crown and have the Medicaid patient be unreachable to seat the crown and absorb the cost. One patient we treated the lab bill for the denture repair was $14 dollars more than they paid. I had several sleepless night over a period of six months from dealing with MCNA and finally said enough is enough. Why does a company that remunerates at 30% (virtually zero profit for the dentist) require 5 times more paperwork. Every single claim we processed with MCNA had some issue. We have 0 problems with Delta. Someone should look into this unethical company.
4. Education for the patients about what dental program they have. Close to 80% of the patients that come to our office still think they have straight Medicaid, some people think they have dental coverage when they don't and they insurance cards they give us are usually Ameritas or United Healthcare. When asking them for their insurance card for dental they say that this is the only card they received. I feel these patients need to know that the providers are taking a considerable cut in their reimbursement rate. I am extremely happy that the different levels of the program are no longer. Although I feel the rule on approved prior authorizations before the service is completed should not be such an issue.
5. Get rid of need to duplicate and send X-Ray with claim unless you pay for it. Eliminate the rule that allows only one surgery per quadrant (i.e., one alveloplasty is paid but removal of tori is not, thus, no denture) get rid of pre authorization rules, pay for an incision and drainage done on the same day as an extraction.
6. I found it pleasurable and rewarding to provide services to Medicaid patients. Though I gave away tens of thousands of dollars of work each year- and a high percentage of my income, I felt it was my way of "giving back". I gave directly to the patients, and because the reimbursements were so low, I felt I also gave indirectly to all tax payers. I found satisfaction in this. Now I worry that if I join the Dental Wellness Plan, that this satisfaction will be diminished, my staff will have more paperwork, and I will feel like I am giving to the insurance companies. Thank you.
7. I think the changes were in the right direction when it comes to the make-up of the program. There are still many things that need corrected. When it comes to the fees, most if not all, are lower than what traditional Medicaid was and are significantly lower than the old DWP program. Our main problem at our office is the differences within the code requirements. One allows it and the other might but you have 100 hoops to jump through. We'd like to see a more streamlined program with more payback.
8. Improve administrative issues.
9. In regards to Delta vs. MCNA, Delta is prepared to administer dental benefits. MCNA is not. One could just look to see how often a bridge is completed with MCNA vs. Delta. Please look into this and one can find how MCNA does not understand dental terminology/treatment. This is just one instance of the incompetence of MCNA. DWP 2.0 has its improvements. Mainly in the fact that an individuals do not have "Tiers" of benefits. Also, retaining Delta Dental to administer DWP was a fantastic move. I believe the state of Iowa is lucky to have Iowa Medicaid as a whole and also Delta Dental. Our state is one of the few that I feel that provides good medical/dental benefits to those in need of it. I have two main issues with DWP 2.0. First, is the annual survey a patient has to complete to keep their full benefits. My question is why this even exists. I understand one could make the argument that it can promote an individual to take part in their evaluation of dental health. I understand how one could say that it is important to make one understand the benefit of self-reflection. However, by making this as a necessary component of keeping their full benefits, DWP is artificially creating more barriers and obstacles to overcome to obtain full dental benefits that they are eligible to receive. I believe the goal of Iowa Medicaid in regards to dental health was to create a level playing field in Iowa for patients to receive good dental care. How many private insurance member have to take a survey in order to have a restoration completed? Like I said, I understand the philosophical approach of the survey. However, let's take a different approach to self-assessment. Why don't we make it a requirement that the dentist at a recall, goes over oral hygiene assessment directly with the patient. That then will ensure that the patient is receiving adequate education and also a time for self-reflection. My 2nd main complaint about DWP is about the transition.
10. Increase of reimbursement rates is needed. Lab bills for some services are more than the practice is reimbursed for the service. Patients are canceling without 24 hours' notice and/or failing to show up. Payments are delayed and sometimes

they pay nothing for a service after it is provided due to supposedly not having enough information. It is making it difficult for us to want to treat these patients.

11. Increase reimbursement, decrease payment delays, stop intermittent coverage. Use just one program.
12. It seems this program is developed to provide care for those in need who have problems with access to care for whatever reason- then the administration makes it very difficult to provide services to this population. Work to provide care then make it very hard if not impossible to render that care. Title XIX provided for all adults. DWP provides to age 64. Medicare doesn't provide care for oral health that is remotely significant. I'm not sure about this yet but it seems our elderly may lose coverage once they turn 65. If a patient needs a denture repair, reimbursement is less than my lab bill. So I lose money every time I repair a denture for a patient. There's more problems, however that's plenty for now. Send a survey out for front desk employees. See what they have to say. I'm sure you'll bet some beneficial responses.
13. It seems to me that this is a "cost savings" initiative for Iowa. Make the providers have to do extra paperwork, deny procedures, change coverage without telling pts, providers. I never even got a letter from the state until a couple weeks before everything was changed in July. The reimbursement rates are low, as they were previously, but that's not even the biggest issue. It's the paperwork, rules and confusion. Providers will stop participating making the "access to care" issue even worse.
14. Need to have better reimbursement and more efficient system for filing procedures. Also better customer service. The patients do not seem appreciative. They should be more aware of value of services they are receiving.
15. Orthodontic specialists will not, in general, accept title XIX and Hawk-I patients openly due to the prior-authorization red tape, and approximately 50% reimbursement level. Dental overhead runs around 50%. In the past, approved "easier cases" would offset the potential loss of income (or actual loss) experienced with accepting the harder cases. Higher acceptance threshold (Salzmann number) with no automatic approval situations (impacted canines, cleft lip/palate, crossbite) has made it difficult for dentists/orthodontists to justify accepting wellness plan patients. This leaves this demographic grossly underserved. We have patients that have to drive 2 plus hours one-way for a 5 minute appointment because there isn't a practitioner closer to their home that will see them. Result of this situation is underqualified general dentists performing orthodontic treatment that is below the standard of care. Some is a money grab, some is a sympathetic practitioner that wants to help a family with no other options to find care for their child. I have taken wellness plan patients openly due to a feeling of obligation of serving the less-well-off. I feel like every practitioner should "do their part". It is easy for me to make that argument when practitioners are making less than they would with full-paying patients. It is much harder to make the argument when they are actually losing money taking on the underserved. Please fix the system to make it doable for good practitioners to accept these programs.
16. Stop switching patients' eligibility and carriers. Increase reimbursement for services like preventive, restorative, removable pros, and oral surgery. Eliminate all fixed pros services and all endodontic services. If patient fails an appointment stand behind provider that they no longer can be a patient with the dental office. Also stand behind provider that late appointments are considered a failed appointment. Eliminate the hassle for prior authorization for removable procedures. I really feel like the providers take a huge loss, I mean huge. I am all about giving back but I have become quite soured on how this has transpired. I am very unhappy. Patients are expecting the world and they are basically train wrecks when they walk in.
17. The current reimbursement makes Medicaid and DWP patients not profitable for dentists. The hoops we also have to jump through to get treatments approved and or preauthorized make it a headache for front office staff as well. This along with higher no show/broken appointment rates for DWP and Medicaid patients make it impossible for any dentists to see new DWP or Medicaid patients. Reimbursement needs to be competitive with private insurance to overcome the other headaches associated with these programs. It simply is not worth our time to work basically for free and have our front office staff work overtime to handle the administrative obstacles.
18. The program in theory was ok- concentrating on preventative with increased benefits/maintaining benefits. The original reimbursement fees were manageable. The sheer volume of patients added to the practice (with stipulation of no limit on number required to accept according to current agreement wording) with severe reduction in reimbursement fees, added administrative burden, having to provide services we normally refer to specialists because of lack of participating specialists, patients being switched between DWP/Medicaid coverage, guidelines totally different in mid treatment, extremely high failure rate and the difficulty of the submission requirements/criteria hampering dental treatment with costs higher than reimbursement payment in most cases resulted in too great a burden on practice to participate in the program.
19. The reimbursement is lower than previous Medicaid. They have taken away any patient responsibility. They got many dentists to sign up with the promise of decent reimbursement rates and then pulled the rug out from under us. If it wasn't for my special needs adults that I see on DWP I would drop the plan entirely. When I had to re-credential with Medicaid I sent in my paperwork only to find out months later that paperwork wasn't acceptable for anyone other than new providers. Nobody contacted us to correct the issue, they just took away our ability to see Medicaid patients. You would think if there were two dentists willing to sign up to still see Medicaid Patients that sent in paper instead of filling out an online entry someone could have informed us when they got the paperwork. Iowa is now down two Medicaid providers, one that had been seeing hem for 20 years and the other for a decade.
20. There is a very large gap in the quality of care patients with MCNA receive and patients with Delta Dental receive. I would be very concerned w/ any state funds going to MCNA when Delta could be performing the same task at a much better return of care. This can be evaluated w/ fixed partial dentures. Delta Dental approves FPDs, MCNA has a response to check the manual and has yet to approve any FPDs. There are multiple colleagues that accept Delta and don't accept MCNA due to the increased difficulty and lack of problem solving. My personal insight on the annual survey the patients must take to retain their benefits is that this will cause additional barriers for patients. Patients who we see on a routine basis, and find that they are ineligible for insurance usually requires a simple phone call to their social worker, and clarify what needs to be done for full benefits. This simple step is disregarded very often, and we never see the patient again due to lack of concern on the patient's part. Until an emergent situation makes this a priority, the patient will go back to their routine of no care, vs the improved care that has been provided to them the first year of the DWP 2.0. A lot of this has been critical and maybe shines a negative view, but the increased amount of patients that are now on DWP 2.0 vs Medicaid has been very well regarded by the population that made too much money for Medicaid, and not enough to afford private insurance or pay out of pocket. These patients now have access and have been great to bring into the office and develop relationships with. I applaud DWP 2.0 for that.

21. To get paid for Medicaid has been a nightmare since I started working 2 years ago. Something needs to change or we will end up dropping Medicaid patients. The reimbursement change has had us consider not taking wellness anymore as well. Please start reimbursing doctors for the work they are doing.
22. We accepted adult Medicaid patients, without limits, from our county, and we accepted many from surrounding counties as the schedule allowed. The DWP (both versions) administrative requirements are more than we can justify with the staff available. We continue to see children with Medicaid, and will continue to do so until the admin burden increases.

Covered services/Benefits

1. It is unfortunate to have to continue to figure out how to treat our patients and still afford to be able to make it financially feasible. I don't like having to treat one group of people differently than others. I would suggest increasing reimbursement for all stabilization procedures and eliminating orthodontic, periodontic and fixed prosthodontic procedures. In other words, cover preventive, fillings, extractions and nothing else.
2. 1) Simple 2) second molars fill or extract. 3) Less failures. 4) More reimbursement for denture stuff- I lose because my lab bills exceed some payments. 5) More oral surgeons. 6) Maybe a maximum yearly limit except for denture stuff and extractions.
3. A suggestion might be to increase fees across the board but have a yearly maximum. There is rarely an insurance that has no yearly cap, why should a state run program be a free for all. This is why there have been money problems running this program initially.
4. As I understand, DWP functions the same as Medicaid for orthodontics. The Salzmann has helped reduce cosmetic coverage, although the ability to get exceptions to policy are limited, especially when patients have a need like an impacted tooth. There are times when orthodontics could save expenses down the road. Reimbursement in orthodontics is so far below cost, most orthodontists are not willing to accept patients unless referred personally by a good referring doctor. When I speak with my dental colleagues, it seems as if there are still several areas that are profitable for them to justify continued acceptance of new patients.
5. Eliminate posterior root canals and posterior crowns except stainless steel eliminate periodontic services. Increase payments of preventive and restorative. Increase payments of anterior crowns and removable prosthodontics.
6. Endodontic: limit to anterior teeth only or eliminate special procedures or limit yearly allowance. Fixed: limit to single units only. Preventive: increase $ on radiographs and don't lump into full mouth (this compromises motivation for proper diagnosis). Thank you for allowing fluoride. Periodontic: Thank you for allowing S&RP without pre authorizations. Eliminate specialty periodontic procedures. Removable: increase fees for permanent partials/completes but either increase or eliminate totally minor procedures like add tooth/add clasp (not profitable with lab fees). Oral Surgery: fees are acceptable for a GP. Eliminate or allow only oral surgeons to do procedures beyond 7210/7140. Some earned benefits would be welcomed. Not enough MCNA providers- consider allowing Delta Dental to administer all DWP; really disappointed in program that oral surgeons are pulling out.
7. Get rid of need to duplicate and send x-ray with claim unless you pay for it. Eliminate the rule that allows only one surgery per quadrant (i.e., one alveloplasty is paid but removal of tori is not, thus, no denture) get rid of pre authorization rules, pay for an incision and drainage done on the same day as an extraction.
8. I want to help the underserved dental community, but I can't afford to do it at the current reimbursement rates. The first DWP plan was a good way to fill the gaps in my schedule while helping those who had been waiting years to see a dentist. I understand the federal and state funding for the program went away. I hope it returns. I don't think it's unreasonable to put a yearly maximum on the plan instead of limiting services.
9. Implants should be covered, that's my biggest complaint.
10. It is very discouraging that crowns are only covered for teeth that have been fractured or had root canal treatment. Particularly in this patient population, there is often 5 surface decay or recurrent decay on an already heavily restored tooth and it is stressful as the provider to have pursue an alternative just because the tooth isn't broken yet.
11. Limit services, these patients should not have access to the same level of care that someone that is working hard and paying for premium dental plan should have. Many hard working people that don't qualify for these subsidized plans have no choice but to have teeth extracted when they bother them because it's all they can afford, people on public assistance should have no other options as well. I would eliminate completely except for children up to the age of 26, and adults over 65, or the disabled that has been verified disabled. Non-disabled adults between 26-65 years have no right to be subsidized by tax payers. Those on the plan in the meantime should have access to preventative, restorative, and extractions/removable pros only, and at re-imbursement rates that are the same as the regular Delta premier/Hawk-I rates, not at reduced rates to the provider, as the provider should not be punished, forcing the provider to share the patients' burden is unacceptable.
12. Need to put restrictions on adult care, either a yearly maximum or decrease benefits such as endodontics, fixed prosthodontics and evaluate all aspects or this is will not be sustainable by the state. Administrators, Delta and MCNA, will likely see decreased funding and will leave the program, due to the need to follow sound business practices. Not sure DHS really pay much attention to dental, given the medical program problems.
13. Stop switching patients' eligibility and carriers. Increase reimbursement for services like preventive, restorative, removable prosthodontics, and oral surgery. Eliminate all fixed prosthodontic services and all endodontic services. If patient fails an appointment stand behind provider that they no longer can be a patient with the dental office. Also stand behind provider that late appointments are considered a failed appointment. Eliminate the hassle for prior authorization for removable procedures. I really feel like the providers take a huge loss, I mean huge. I am all about giving back but I have become quite soured on how this has transpired. I am very unhappy. Patients are expecting the world and they are basically train wrecks when they walk in.
14. There needs to be a "tier" above Medicaid that patients can join. Many low to middle income families would be able to pay a small premium for their insurance, which would help increase the overall budget. That would allow fees to be increased, which in turn would increase the number of dentists/specialists participating.
15. There should not be any delay in putting crowns on root canaled teeth done by a specialist.
16. This should be just for basic care. Anything else they should have to pay for or find funding.

17. Try to simplify enrollment and work dentists in trying to set fees, reimbursement and what procedures to keep and eliminate. The program should provide preventive, operative, oral surgery, removable prosthetics and emergency care. Fixed prosthetics and periodontics are not items we should be providing routinely.
18. We will be withdrawing from the program in the next year or two if reimbursements do not rise. Some of the reimbursements do not even cover the lab fee to do the procedure. If cost must be contained, limit the procedures that are covered. Preventive, basic restorative, extractions I believe should be covered. The rest could be optional.
19. When reimbursements will not cover the dentist's overhead, he will likely leave the program. While I am willing to donate my time for less fortunate people, I resent "paying my taxes" a second time when I see them. I have to be able to pay my staff and overhead. Comes out of my pockets. Additionally, the program pays unlimited benefits, something that even the best policies do not do for those who are paying for their own dental insurance. If only my patients could get the same benefits out of their plans.

Preference for DWP 1.0

1. As a provider that believes in Public health initiatives I think DWP was a great program that seems to be moving in the wrong direction as far as helping the patient. I think the wait period for patients originally made sense to weed out the unwilling or non-committed patients. Dropping rates of reimbursement is now going to weed out doctors like myself that want to help these patients but due to my small practice may not be able to continue to handle the load of low reimbursement and staffing and lab fees. It saddens me to see the program move in this direction. I hope more positive changes happen in 2018.
2. Consider the bonus pool checks as an incentive. Very disappointed that the bonus pool program was eliminated.
3. Dental Wellness Plan 1.0 worked well.
4. Endodontic: limit to anterior teeth only or eliminate special procedures or limit yearly allowance. Fixed: limit to single units only. Preventive: increase $ on radiographs and don't lump into full mouth (this compromises motivation for proper diagnosis). Thank you for allowing fluoride. Periodontic: Thank you for allowing S&RP without pre authorizations. Eliminate specialty periodontic procedures. Removable: increase fees for permanent partials/completes but either increase or eliminate totally minor procedures like add tooth/add clasp (not profitable with lab fees). Oral Surgery: fees are acceptable for a GP. Eliminate or allow only oral surgeons to do procedures beyond 7210/7140. Some earned benefits would be welcomed. Not enough MCNA providers- consider allowing Delta Dental to administer all DWP; really disappointed in program that oral surgeons are pulling out.
5. I believe the original DWP plan that had the earned benefits made the patient's responsible/accountable for their routine care. It took a while to learn the rules and guidelines of the program, but once they were understood, they had merit in "re-training" the patients to take responsibility for their oral health care.
6. I feel a responsibility to help take care of Iowa's needy patients and I have for 26 years but these recent changes have made it very difficult to accept the burden on my practice and my financial situation.
7. I hope this survey shows that Delta and MCNA don't have the required network of dentists actually taking DWP patients and changes the program back to the way it was. I was ok with taking a low reimbursement for adult Medicaid when I knew no one was profiting from it. Having my office lose money on DWP patients while Delta makes millions makes no sense.
8. I want to help the underserved dental community, but I can't afford to do it at the current reimbursement rates. The first DWP plan was a good way to fill the gaps in my schedule while helping those who had been waiting years to see a dentist. I understand the federal and state funding for the program went away. I hope it returns. I don't think it's unreasonable to put a yearly maximum on the plan instead of limiting services.
9. It was a great plan before they changed it. We were seeing patients who had not been to the dentist in a long time starting to become regular patients.
10. It's really simple: the reimbursement rates are oppressive. I have no problem not receiving what I normally receive for payment from my non-program patients, but I at least need to receive a fair payment. Even half of my normal fees would allow me to see some of these patients who truly need my help. I understand the state needs the funds to fund such a program, but underfunding Medicaid is a joke. Those patients now receive limited and oftentimes poor care because most offices that provide good quality care cannot afford to take them. I do like the tier program that makes the Wellness patients come in for required visits before reaching the next tier of treatment. That's a great idea and more insurance companies should do it because it puts the responsibility back into the patient's hands for preventive services. But at current rates, we simply cannot see a lot of these patients in our private practices.
11. Prior to the changes we accepted all new Delta DWP patients and we gained several great patients that hadn't had a dental home for a long time. I thought the tier system was a great system, it taught them responsibility and encouraged patients to come in every 6 months. With the changes we can barely breakeven on hygiene appointments and are losing money on all composite restorations which is forcing us to send patients to the university to have some of their work done that could be easily completed in our office. We will continue to see the DWP that we gained prior to the changes; however, with the reimbursement rate changes we will continue to see fewer new patients. Again, the administration by Delta has been great to work with. We will not contract with MCNA, they were very misleading in their initial recruitment and Delta's system is so easy to work with.
12. The original Wellness was a good concept. Reimbursement was at least more equitable. Had a lot of success with getting patients back for recall and compliance was good. Overall thought it was a decent program. Grouping all Medicaid patients into the original Wellness pool was a big mistake. They should have left well enough alone with both programs.
13. This was a great program that provided a lot of relief and care to those in need. The real draw for me was the way we could educate our patients and the requirements allowed us to get our patients into good health. We were able to have many "life changing" procedures as a result of the program and we are saddened that it is no longer available. Call it what you will but the current Dental Wellness program is far from that. The current compensation is just a joke. I hoped this program would have been a model for other need areas in this country. It could have been.
14. We felt that the initial DWP Program was good to deal with. We felt the reimbursements were fair and that the levels gave us some leverage in getting the patients to their appointment. We had a low appointment failure rate and patients that were getting good dental care. It was a win/win for us and the patients. The new program was a step backwards and back to the

same as what we had with the state. Very poor judgement to go to the DWP 2.0.

15. The Dental Wellness Delta Dental plan was great prior to the reduction in reimbursement. Not one complaint prior. Now it's pretty much straight Medicaid again. I will never enroll with MCNA. Why would the state of Iowa take jobs away from the people Iowa and give them to Florida, not to mention those people who came to my office tried to bully us into enrolling. And we weren't the only office. A far as I know only one private practice in my area enrolled, the rest were immediately turned off by their tactics.
16. I believe the original DWP plan that had the earned benefits made the patient's responsible/accountable for their routine care. It took a while to learn the rules and guidelines of the program, but once they were understood, they had merit in retraining the patients to take responsibility for their oral health care.

Failed appointments

1. MCNA adopting the rules for debridements and SRP that Delta has. Patients being more aware of what the self-assessment is and being provided with access to complete that if they do not have it at home. Ability to implement missed appointment fees for these patients to decrease the number of missed/cancelled appointments.
2. I know that there is not a lot of money in the budget to pay for this program but it is tough to see these patients as they usually take more time, whether it's missed appointments or phone calls to the insurance company, to see these patients. It becomes harder and harder to rationalize seeing them especially as other insurance companies are having you work harder for the same amount of reimbursement.
3. I like doing charity work, but I have too much student debt and too busy of an old farmer patient base to get paid half price and risk a no show at this point in my career.
4. Increase of reimbursement rates is needed. Lab bills for some services are more than the practice is reimbursed for the service. Patients are canceling without 24 hours' notice and/or failing to show up. Payments are delayed and sometimes they pay nothing for a service after it is provided due to supposedly not having enough information. It is making it difficult for us to want to treat these patients.
5. Make it difficult to get on it. I am serious! DWP for the fortunate ones. Right now patients take it as an entitlement. They think they should get paid for implants or crown to fix cosmetics, braces etc. And they don't value their appointments, too many no shows. If you made it difficult to get, like have to show up in person, take a quiz about the program so you know what you cover or not and you can't get it before you pass the quiz, and then and only then your eligible. And make a strike system, 2 no show appointments and you're not eligible for any coverage for 12 months.
6. Our reimbursements for a procedure hardly pay to flip/tear down a room and pay our employee for that time. Especially, when broken appointments happen more frequently. I understand, we are providing a service to these patients that need more help, but we may have to consider not accepting the insurances.
7. Patients need to be better educated about their coverage, most aren't aware they have "wellness" vs. a regular Delta Dental plan. Would be nice to have some way to report missed or broken appointments. Hard to get patients into endo and oral surgery right now.
8. Stop switching patient's eligibility and carriers. Increase reimbursement for services like preventive, restorative, removable pros, and oral surgery. Eliminate all fixed pros services and all endodontic services. If fail an appointment stand behind provider that they no longer can be a patient with the dental office. Also stand behind provider that late appointments are considered a fail appointment. Eliminate the hassle for prior authorization for removable procedures. I really feel like the providers take a huge loss, I mean huge. I am all about giving back but I have become quite soured on how this has transpired. I am very unhappy. Patients are expecting the world and they are basically train wrecks when they walk in.
9. The current reimbursement makes Medicaid and DWP patients not profitable for dentists. The hoops we also have to jump through to get treatments approved and or preauthorized make it a headache for front office staff as well. This along with higher no show/broken appointment rates for DWP and Medicaid patients make it impossible for any dentists to see new DWP or Medicaid patients. Reimbursement needs to be competitive with private insurance to overcome the other headaches associated with these programs. It simply is not worth our time to work basically for free and have our front office staff work overtime to handle the administrative obstacles.
10. The new changes absolutely are not beneficial to the providers at all. 1) State suckered dentists in with better reimbursements than XIX and with an incentive to do Previsor. 2) This new change made reimbursements as awful as XIX, put more people on the program, and kept giving the providers conflicting information on who was being switched off XIX. 3) There is now no monetary reason for provider to do Previsor; however, if provider does not make sure that Previsor is done, it's going to cause a huge issue for the provider's office once the first year for the patient is up. A large majority of patients on this program are not going to do the self-assessment which in all actually does not hurt them, it hurts the providers trying to provide service to the patients. As a practice we understand the importance of providing for our community, but when the majority of the community is now on public assistance, we cannot afford to see more of these patients due to the horrible reimbursements. We also cannot afford to have the last minutes holes in our schedule from these patients that just don't feel like coming today for their confirmed appointment or just fail.
11. The program in theory was ok- concentrating on preventative with increased benefits/maintaining benefits. The original reimbursement fees were manageable. The sheer volume of patients added to the practice (with stipulation of no limit on number required to accept according to current agreement wording) with severe reduction in reimbursement fees, added administrative burden, having to provide services we normally refer to specialists because of lack of participating specialists, patients being switched between DWP/Medicaid-coverage guidelines totally different-in mid treatment, extremely high failure rate and the difficulty of the submission requirements/criteria hampering dental treatment with costs higher than reimbursement payment in most cases resulted in too great a burden on practice to participate in the program.

Attitudes about DWP/Medicaid population

1. I know that there is not a lot of money in the budget to pay for this program but it is tough to see these patients as they usually take more time, whether it's missed appointments or phone calls to the insurance company, to see these patients. It

becomes harder and harder to rationalize seeing them especially as other insurance companies are having you work harder for the same amount of reimbursement.

2. Make it difficult to get on it. I am serious. DWP for the fortunate ones. Right now patients take it as an entitlement. They think they should get paid for implants or crown to fix cosmetics, braces etc. And they don't value their appointments, too many no shows. If you made it difficult to get, like have to show up in person, take a quiz about the program so you know what you cover or not and you can't get it before you pass the quiz, and then and only then your eligible. And make a strike system. 2 no show appointment and you're not eligible for any coverage for 12 months.
3. Need to have better reimbursement and more efficient system for filing procedures. Also better customer service. The patients do not seem appreciative. They should be more aware of value of services they are receiving.
4. See previous comment regarding reduction of reimbursements. An observation from just my experience: a lot of the Medicaid/DWP patients have little motivation for restorative care. Most of this is attributed to anxiety. Another component seems to be a failure on the part of the general dentist to make a comprehensive plan and present it thoroughly to the patient. A lot of these patients are seen on an emergent basis and planned for the simplest treatment plan if planned at all. Another problem is access to care; community dental clinics plan for prosthetic reconstruction but will not perform the treatment. They send the patient to another office for complete dentures and/or partial dentures. This is very inefficient. I only perform extractions and receive referrals from a large area of the state, so I have seen patterns emerge over the years that do not inspire optimism on my part.
5. Stop switching patients' eligibility and carriers. Increase reimbursement for services like preventive, restorative, removable pros, and oral surgery. Eliminate all fixed pros services and all endodontic services. If fail an appointment stand behind provider that they no longer can be a patient with the dental office. Also stand behind provider that late appointments are considered a fail appointment. Eliminate the hassle for prior authorization for removable procedures. I really feel like the providers take a huge loss. I mean huge. I am all about giving back but I have become quite soured on how this has transpired. I am very unhappy. Patients are expecting the world and they are basically train wrecks when they walk in.
6. There is a very large gap in the quality of care patients with MCNA receive and patients with Delta Dental receive. I would be very concerned with any state funds going to MCNA when Delta could be performing the same task at a much better return of care. This can be evaluated with fixed partial dentures. Delta Dental approves FPDs, MCNA has a response to check the manual and has yet to approve any FPDs. There are multiple colleagues that accept Delta and don't accept MCNA due to the increased difficulty and lack of problem solving. My personal insight on the annual survey the patients must take to retain their benefits is that this will cause additional barriers for patients. Patients who we see on a routine basis, and find that they are ineligible for insurance usually requires a simple phone call to their social worker, and clarify what needs to be done for full benefits. This simple step is disregarded very often, and we never see the patient again due to lack of concern on the patient's part. Until an emergent situation makes this a priority, the patient will go back to their routine of no care, vs the improved care that has been provided to them the first year of the DWP 2.0. A lot of this has been critical and maybe shines a negative view, but the increased amount of patients that are now on DWP 2.0 vs. Medicaid has been very well regarded by the population that made too much money for Medicaid, and not enough to afford private insurance or pay out of pocket. These patients now have access and have been great to bring into the office and develop relationships with. I applaud DWP 2.0 for that.
7. Too easy for patient to qualify. Patient who previously had dental insurance or now have dual insurance are taking advantage of us providers who want to help those who cannot afford it.
8. Too many patients with too little responsibility to the program who feel entitled.
9. We cannot continue to give able bodied people free services. They must accept responsibility for their choices. In other words capable people must have "skin in the game". I give charitable dental work to those who have come upon hard times but are working hard to better themselves.
10. Find a way to increase patient dental education.

Network Adequacy

1. 1) Simple 2) second molars fill or extract. 3) Less failures. 4) More reimbursement for denture stuff- I lose because my lab bills exceed some payments. 5) More oral surgeons. 6) Maybe a maximum yearly limit except for denture stuff and extractions.
2. As a dentist who was taking new patients with Title XIX and the DWP, these changes are a step in the wrong direction. Until all dentists are required to accept XIX in Iowa, the reimbursement rates need to improve in order to have dentists accept new patients. With the expansion of the Medicaid population, more patients are flooding an already exhausted pool of dentists. I could no longer afford to keep seeing these patients as they were a majority of my new patient pool and I was the only dentist in town taking new patients with it. I think the reimbursement for disease control treatments should be increased such as restorative, periodontal treatments, and oral surgery. I guess what needs to be determined is do we provide comprehensive treatment for fewer patients or limited treatment for all patients? Limiting dentures, endodontic treatments, and crowns should be considered.
3. Either the reimbursements need to be similar to current fee for service fees or there need to be more clinics that are designed for primarily for the purpose of serving Medicaid/DW. I would prefer the latter. These programs and there reimbursement levels require different business models to be successful in private practice. It is challenging to mix the two very different business models in the same facility. It is unfair to patients and providers to expect fee for service level treatments at Medicaid level reimbursements. The reimbursements are too low for providers to remain profitable in their business. Fee for service patients would likely be upset if they found out that they are paying way more for treatment than Medicaid is paying for the very same treatments.
4. Endodontic: limit to anterior teeth only or eliminate special procedures or limit yearly allowance. Fixed: limit to single units only. Preventive: increase $ on radiographs and don't lump into full mouth (this compromises motivation for proper diagnosis). Thank you for allowing fluoride. Periodontic: Thank you for allowing S&RP without pre authorizations. Eliminate specialty periodontic procedures. Removable: increase fees for permanent partials/completes but either increase or eliminate totally minor procedures like add tooth/add clasp (not profitable with lab fees). Oral Surgery: fees are acceptable for a GP. Eliminate or allow only oral surgeons to do procedures beyond 7210/7140. Some earned benefits would be welcomed.

Not enough MCNA providers- consider allowing Delta Dental to administer all DWP; really disappointed in program that oral surgeons are pulling out.

5. I have several concerns. One is the assessment the patient is required to fill out to maintain coverage. It sounds good in theory to attempt to create personal responsibility; however, I am concerned of our patients that are in nursing homes or group homes that they may not fully understand or are not fully capable to accomplish this. Also, I'm very disappointed that demographics were not used in the assignment of which carrier the patient was placed on. I searched for an MCNA provider in our area and came up with nobody. We proactively sent letters to our current patients to make sure they were on the Delta Dental plan. Many of our patients had to call and switch. We've been trying to work with another patient, who is kind of on her own and just doesn't quite understand what we are telling her. She can't afford the treatment, and she was placed on MCNA. I realize it was easier to just randomly assign a carrier, but sometimes easier isn't the best option.
6. I hope this survey shows that Delta and MCNA don't have the required network of dentists actually taking DWP patients and changes the program back to the way it was. I was ok with taking a low reimbursement for adult Medicaid when I knew no one was profiting from it. Having my office lose money on DWP patients while Delta makes millions makes no sense.
7. If all dentists would take at least some DWP/Medicaid patients, then the patients would benefit substantially. My office is too busy to meet the demands of all of the DWP/Medicaid patients in the area in which I practice.
8. Quite honestly, if more practices took part of the burden of seeing these patients I would be more willing to see new patients. We were being flooded as more and more practices opted out. We can't stay in business accepting all of these patients due to low reimbursement rates. However, I am willing to help my community. Also, finding specialists to see these patients is very hard or they are so far away patients cannot reasonably make it to see them. We do see any DWP for emergent needs at this point to help eliminate pain.
9. See previous comment regarding reduction of reimbursements. An observation from just my experience: a lot of the Medicaid/DWP patients have little motivation for restorative care. Most of this is attributed to anxiety. Another component seems to be a failure on the part of the general dentist to make a comprehensive plan and present it thoroughly to the patient. A lot of these patients are seen on an emergent basis and planned for the simplest treatment plan if planned at all. Another problem is access to care; community dental clinics plan for prosthetic reconstruction but will not perform the treatment. They send the patient to another office for complete dentures and/or partial dentures. This is very inefficient. I only perform extractions and receive referrals from a large area of the state, so I have seen patterns emerge over the years that do not inspire optimism on my part.

Intermittent Eligibility

1. Increase reimbursement, decrease payment delays, stop intermittent coverage. Use just one program.
2. Stop switching patients' eligibility and carriers. Increase reimbursement for services like preventive, restorative, removable pros, and oral surgery. Eliminate all fixed pros services and all endodontic services. If fail an appointment stand behind provider that they no longer can be a patient with the dental office. Also stand behind provider that late appointments are considered a fail appointment. Eliminate the hassle for prior authorization for removable procedures. I really feel like the providers take a huge loss, I mean huge. I am all about giving back but I have become quite soured on how this has transpired. I am very unhappy. Patients are expecting the world and they are basically train wrecks when they walk in.
3. The DWP requires too much time to make sure people are eligible or not. If someone was eligible on the 30th of the month and not on the 1st of the next month but in the process of several appointments we have to stop or alter schedule or get stuck with costs because DWP won't pay and the patient won't pay. The reimbursement rate is less than half- rarely covering cost of material and wages.
4. The program in theory was ok- concentrating on preventative with increased benefits/maintaining benefits. The original reimbursement fees were manageable. The sheer volume of patients added to the practice (with stipulation of no limit on number required to accept according to current agreement wording) with severe reduction in reimbursement fees, added administrative burden, having to provide services we normally refer to specialists because of lack of participating specialists, patients being switched between DWP/Medicaid-coverage guidelines totally different-in mid treatment, extremely high failure rate and the difficulty of the submission requirements/criteria hampering dental treatment with costs higher than reimbursement payment in most cases resulted in too great a burden on practice to participate in the program.
5. Try to simplify enrollment and work dentists in trying to set fees, reimbursement and what procedures to keep and eliminate. The program should provide preventive, operative, oral surgery, removable prosthetics and emergency care. Fixed prosthetics and periodontics are not items we should be providing routinely.
6. We were disappointed that the reimbursement coverage was decreased dramatically when it "merged" with the adult Medicaid program. The intermittent coverage is also tough. I had a patient that was approved for a crown, we prepped the tooth in one month, and seated the crown the next month. Meanwhile, he let his coverage lapse so we were left without payment.
7. When a patient no longer is eligible for the Delta Dental of Iowa we are unable to get in and review past information or eligibility for past dates. Locks us out as soon as patient is no longer eligible. Not user friendly.

Issues with patients' understanding of plan

1. MCNA adopting the rules for debridements and SRP that Delta has. Patients being more aware of what the self-assessment is and being provided with access to complete that if they do not have it at home. Ability to implement missed appointment fees for these patients to decrease the number of missed/cancelled appointments.
2. Education for the patients about what dental program they have. Close to 80% of the patients that come to our office still think they have straight Medicaid, some people think they have dental coverage when they don't and they insurance cards they give us are usually Ameritas or United Healthcare. When asking them for their insurance card for dental they say that this is the only card they received. I feel these patients need to know that the providers are taking a considerable cut in their reimbursement rate. I am extremely happy that the different levels of the program are no longer. Although I feel the rule on approved prior authorizations before the service is completed should not be such an issue.

3. It doesn't pay to see patients on the plan. In fact in many cases we aren't even breaking even. They are not filling out the assessments or they are unaware they need to in order to keep their plan. Patients are confused about their coverage.
4. Patients need to be better educated about their coverage, most aren't aware they have "wellness" vs. a regular Delta Dental plan. Would be nice to have some way to report missed or broken appointments. Hard to get patients into endo and oral surgery right now.
5. There are pros and cons to the change. I like that patients eligibility isn't constantly flip flopping between DWP and Medicaid. However, the change came very suddenly and with very little forewarning. Most patients do not understand in the slightest how their insurance works. I was provided very little information and it seems that it has been left up to me to do research and educate my patients about their insurance.
6. When 7/1/18 rolls around and patients have not had an exam or done their self-assessment, it is going to be a nightmare. They will not know that their benefits are reduced. They will not pay a monthly premium. The dentist is going to bear the brunt of the fallout. The change on 7/1/17 was bad enough because most patients on DWP don't understand their benefits or even who their carrier was when the change happened. Because I am not participating with MCNA, I turned previous patients away who were randomly assigned MCNA and did not know enough to change to Delta IA who I do participate with. The general population on DWP does not have the knowledge base to understand all the ramifications/changes that continue to take place.
7. As I mentioned before, I had a feeling all along that the original DWP program would not last. I also think that the way it is set up now, by having patients maintain their on-line wellness assessment, will be a limited endeavor. Most, if not all, do not even know of the on-line requirement and possible co-pay(s) that will be assessed.

Attitudes about oral health self-assessment

1. As I mentioned before, I had a feeling all along that the original DWP program would not last. I also think that the way it is set up now, by having patients maintain their on-line wellness assessment, will be a limited endeavor. Most, if not all, do not even know of the on-line requirement and possible co-pay(s) that will be assessed.
2. I have several concerns. One is the assessment the patient is required to fill out to maintain coverage. It sounds good in theory to attempt to create personal responsibility; however, I am concerned of our patients that are in nursing homes or group homes that they may not fully understand or are not fully capable to accomplish this. Also, I'm very disappointed that demographics were not used in the assignment of which carrier the patient was placed on. I searched for an MCNA provider in our area and came up with nobody. We proactively sent letters to our current patients to make sure they were on the Delta Dental plan. Many of our patients had to call and switch. We've been trying to work with another patient, who is kind of on her own and just doesn't quite understand what we are telling her. She can't afford the treatment, and she was placed on MCNA. I realize it was easier to just randomly assign a carrier, but sometimes easier isn't the best option.
3. I think parents of adults with disabilities are very distraught right now. They are worried their dependent children are going to lose their healthcare and dental care. The last thing they need is more mazes in healthcare to navigate. I guess I feel that we as a state should take care of people with disabilities, and somewhat separate them from other adults (I know, that separation is hard to define). I tend to see older adults who are taking care of the middle-aged dependent child. One parent in his 70s called us this week to explain that he doesn't have a computer or internet access. We printed off the dental survey, mailed it to him, and he is going to mail it back to us so we can fax it to MCNA. Change has been very difficult on these families (I am also worried that this is a precursor to privatizing children's dental Medicaid. Oh my!
4. In regards to Delta vs. MCNA, Delta is prepared to administer dental benefits. MCNA is not. One could just look to see how often a bridge is completed with MCNA vs. Delta. Please look into this and one can find how MCNA does not understand dental terminology/treatment. This is just one instance of the incompetence of MCNA. DWP 2.0 has its improvements. Mainly in the fact that an individuals do not have "Tiers" of benefits. Also, retaining Delta Dental to administer DWP was a fantastic move. I believe the state of Iowa is lucky to have Iowa Medicaid as a whole and also Delta Dental. Our state is one of the few that I feel that provides good medical/dental benefits to those in need of it. I have two main issues with DWP 2.0. First, is the annual survey a patient has to complete to keep their full benefits. My question is why this even exists. I understand one could make the argument that it can promote an individual to take part in their evaluation of dental health. I understand how one could say that it is important to make one understand the benefit of self-reflection. However, by making this as a necessary component of keeping their full benefits, DWP is artificially creating more barriers and obstacles to overcome to obtain full dental benefits that they are eligible to receive. I believe the goal of Iowa Medicaid in regards to dental health was to create a level playing field in Iowa for patients to receive good dental care. How many private insurance member have to take a survey in order to have a restoration completed? Like I said, I understand the philosophical approach of the survey. However, let's take a different approach to self-assessment. Why don't we make it a requirement that the dentist at a recall, goes over oral hygiene assessment directly with the patient. That then will ensure that the patient is receiving adequate education and also a time for self-reflection. My 2nd main complaint about DWP is the transition.
5. The new changes absolutely are not beneficial to the providers at all. 1) State suckered dentists in with better reimbursements than XIX and with an incentive to do Previsor. 2) This new change made reimbursements as awful as XIX, put more people on the program, and kept giving the providers conflicting information on who was being switched off XIX. 3) There is now no monetary reason for provider to do Previsor; however, if provider does not make sure that Previsor is done, it's going to cause a huge issue for the provider's office once the first year for the patient is up. A large majority of patients on this program are not going to do the self-assessment which in all actually does not hurt them, it hurts the providers trying to provide service to the patients. As a practice we understand the importance of providing for our community, but when the majority of the community is now on public assistance, we cannot afford to see more of these patients due to the horrible reimbursements. We also cannot afford to have the last minutes holes in our schedule from these patients that just don't feel like coming today for their confirmed appointment or just fail.
6. There is a very large gap in the quality of care patients with MCNA receive and patients with Delta Dental receive. I would be very concerned with any state funds going to MCNA when Delta could be performing the same task at a much better return of care. This can be evaluated with fixed partial dentures. Delta Dental approves FPDs, MCNA has a response to check the manual and has yet to approve any FPDs. There are multiple colleagues that accept Delta and don't accept MCNA due to the increased difficulty and lack of problem solving. My personal insight on the annual survey the patients must

take to retain their benefits is that this will cause additional barriers for patients. Patients who we see on a routine basis, and find that they are ineligible for insurance usually requires a simple phone call to their social worker, and clarify what needs to be done for full benefits. This simple step is disregarded very often, and we never see the patient again due to lack of concern on the patient's part. Until an emergent situation makes this a priority, the patient will go back to their routine of no care, vs the improved care that has been provided to them the first year of the DWP 2.0. A lot of this has been critical and maybe shines a negative view, but the increased amount of patients that are now on DWP 2.0 vs. Medicaid has been very well regarded by the population that made too much money for Medicaid, and not enough to afford private insurance or pay out of pocket. These patients now have access and have been great to bring into the office and develop relationships with. I applaud DWP 2.0 for that.

7. When 7/1/18 rolls around and patients have not had an exam or done their self-assessment, it is going to be a nightmare. They will not know that their benefits are reduced. They will not pay a monthly premium. The dentist is going to bear the brunt of the fallout. The change on 7/1/17 was bad enough because most patients on DWP don't understand their benefits or even who their carrier was when the change happened. Because I am not participating with MCNA, I turned previous patients away who were randomly assigned MCNA and did not know enough to change to Delta IA who I do participate with. The general population on DWP does not have the knowledge base to understand all the ramifications/changes that continue to take place.

Referral to specialists

1. Improved specialist participation.
2. Need to increase reimbursements and specialist participation
3. Patients need to be better educated about their coverage, most aren't aware they have "wellness" vs. a regular Delta Dental plan. Would be nice to have some way to report missed or broken appointments. Hard to get patients into endo and oral surgery right now.
4. Quite honestly, if more practices took part of the burden of seeing these patients I would be more willing to see new patients. We were being flooded as more and more practices opted out. We can't stay in business accepting all of these patients due to low reimbursement rates. However, I am willing to help my community. Also, finding specialists to see these patients is very hard or they are so far away patients cannot reasonably make it to see them. We do see any DWP for emergent needs at this point to help eliminate pain.
5. The program in theory was ok- concentrating on preventative with increased benefits/maintaining benefits. The original reimbursement fees were manageable. The sheer volume of patients added to the practice (with stipulation of no limit on number required to accept according to current agreement wording) with severe reduction in reimbursement fees, added administrative burden, having to provide services we normally refer to specialists because of lack of participating specialists, patients being switched between DWP/Medicaid coverage, guidelines totally different in mid treatment, extremely high failure rate and the difficulty of the submission requirements/criteria hampering dental treatment with costs higher than reimbursement payment in most cases resulted in too great a burden on practice to participate in the program.

Delta Dental vs. MCNA

1. Doctors who are willing to accept Medicaid patients with physical and mental handicaps at a 30% remuneration rate deserve to be treated with respect. MCNA was the most disrespectful company my office has ever done business with. They constantly referred to their ridiculous manual (which they made downloadable in the middle of the night July 14th after the program started) as biblical. I am not going to prepare a crown and have the Medicaid patient be unreachable to seat the crown and absorb the cost. One patient we treated the lab bill for the denture repair was $14 dollars more than they paid. I had several sleepless night over a period of six months from dealing with MCNA and finally said enough is enough. Why does a company that remunerates at 30% (virtually zero profit for the dentist) requires 5 times more paperwork. Every single claim we processed with MCNA had some issue. We have 0 problems with Delta. Someone should look into this unethical company.
2. In regards to Delta vs. MCNA, Delta is prepared to administer dental benefits. MCNA is not. One could just look to see how often a bridge is completed with MCNA vs. Delta. Please look into this and one can find how MCNA does not understand dental terminology/treatment. This is just one instance of the incompetence of MCNA. DWP 2.0 has its improvements. Mainly in the fact that an individuals do not have "Tiers" of benefits. Also, retaining Delta Dental to administer DWP was a fantastic move. I believe the state of Iowa is lucky to have Iowa Medicaid as a whole and also Delta Dental. Our state is one of the few that I feel that provides good medical/dental benefits to those in need of it. I have two main issues with DWP 2.0. First, is the annual survey a patient has to complete to keep their full benefits. My question is why this even exists. I understand one could make the argument that it can promote an individual to take part in their evaluation of dental health. I understand how one could say that it is important to make one understand the benefit of self-reflection. However, by making this as a necessary component of keeping their full benefits, DWP is artificially creating more barriers and obstacles to overcome to obtain full dental benefits that they are eligible to receive. I believe the goal of Iowa Medicaid in regards to dental health was to create a level playing field in Iowa for patients to receive good dental care. How many private insurance member have to take a survey in order to have a restoration completed? Like I said, I understand the philosophical approach of the survey. However, let's take a different approach to self-assessment. Why don't we make it a requirement that the dentist at a recall, goes over oral hygiene assessment directly with the patient. That then will ensure that the patient is receiving adequate education and also a time for self-reflection. My 2nd main complaint about DWP is about the transition.
3. Prior to the changes we accepted all new Delta DWP patients and we gained several great patients that hadn't had a dental home for a long time. I thought the tier system was a great system, it taught them responsibility and encouraged patients to come in every 6 months. With the changes we can barely breakeven on hygiene appointments and are losing money on all composite restorations which is forcing us to send patients to the university to have some of their work done that could be easily completed in our office. We will continue to see the DWP that we gained prior to the changes; however, with the reimbursement rate changes we will continue to see fewer new patients. Again, the administration by Delta has been great

to work with. We will not contract with MCNA, they were very misleading in their initial recruitment and Delta's system is so easy to work with.

4. The Dental Wellness Delta Dental plan was great prior to the reduction in reimbursement. Not one complaint prior. Now it's pretty much straight Medicaid again. I will never enroll with MCNA. Why would the state of Iowa take jobs away from the people Iowa and give them to Florida, not to mention those people who came to my office tried to bully us into enrolling. And we weren't the only office. A far as I know only one private practice in my area enrolled, the rest were immediately turned off by their tactics.
5. There is a very large gap in the quality of care patients w/ MCNA receive and patients with Delta Dental receive. I would be very concerned w/ any state funds going to MCNA when Delta could be performing the same task at a much better return of care. This can be evaluated w/ fixed partial dentures. Delta Dental approves FPDs, MCNA has a response to check the manual and has yet to approve any FPDs. There are multiple colleagues that accept Delta and don't accept MCNA due to the increased difficulty and lack of problem solving. My personal insight on the annual survey the patients must take to retain their benefits is that this will cause additional barriers for patients. Patients who we see on a routine basis, and find that they are ineligible for insurance usually requires a simple phone call to their social worker, and clarify what needs to be done for full benefits. This simple step is disregarded very often, and we never see the patient again due to lack of concern on the patient's part. Until an emergent situation makes this a priority, the patient will go back to their routine of no care, vs the improved care that has been provided to them the first year of the DWP 2.0. A lot of this has been critical and maybe shines a negative view, but the increased amount of patients that are now on DWP 2.0 vs Medicaid has been very well regarded by the population that made too much money for Medicaid, and not enough to afford private insurance or pay out of pocket. These patients now have access and have been great to bring into the office and develop relationships with. I applaud DWP 2.0 for that.

Cost to patients

1. If reimbursement can be increased, more dentists would participate. The reimbursement is less than 25% of our fees. If we had an entire practice with Wellness or Medicaid patients, we would not be able to survive due to the high overhead involved with dentistry. Maybe instead of eliminating procedures or decreasing reimbursement, have each participate pay a small fee like insurance (similar to Hawkeye insurance).
2. This should be just for basic care. Anything else they should have to pay for or find funding.
3. We cannot continue to give able bodied people free services. They must accept responsibility for their choices. In other words capable people must have "skin in the game". I give charitable dental work to those who have come upon hard times but are working hard to better themselves.

Positive comments

1. Endodontic: limit to anterior teeth only or eliminate special procedures or limit yearly allowance. Fixed: limit to single units only. Preventive: increase $ on radiographs and don't lump into full mouth (this compromises motivation for proper diagnosis). Thank you for allowing fluoride. Periodontic: Thank you for allowing S&RP without pre authorizations. Eliminate specialty periodontic procedures. Removable: increase fees for permanent partials/completes but either increase or eliminate totally minor procedures like add tooth/add clasp (not profitable with lab fees). Oral Surgery: fees are acceptable for a GP. Eliminate or allow only oral surgeons to do procedures beyond 7210/7140. Some earned benefits would be welcomed. Not enough MCNA providers- consider allowing Delta Dental to administer all DWP; really disappointed in program that oral surgeons are pulling out.
2. I believe the plan is run quite well through Delta Dental. However, reimbursement makes it difficult to provide service to patients when for many procedures we break even or even lose money. Ultimately, we are running a business and it does not make sense to provide services where no profit can be made.
3. I think the changes were in the right direction when it comes to the make-up of the program. There are still many things that need corrected. When it comes to the fees, most if not all, are lower than what traditional Medicaid was and are significantly lower than the old DWP program. Our main problem at our office is the differences within the code requirements. One allows it and the other might but you have 100 hoops to jump through. We'd like to see a more streamlined program with more payback.
4. It's all good.
5. There are pros and cons to the change. I like that patients eligibility isn't constantly flip flopping between DWP and Medicaid. However, the change came very suddenly and with very little forewarning. Most patients do not understand in the slightest how their insurance works. I was provided very little information and it seems that it has been left up to me to do research and educate my patients about their insurance.
6. Was willing to see new dental wellness. I thought the system worked to educate patients and greatly increased the access to dental care among the underserved.

Other comments

1. As someone who is not a network provider for any insurance company, my policy is that any child or adolescent who needs periodontal services who is on Title 19 or DWP can have reduced or free treatment at my office. All my referring dentists know this and will call to discuss with me prior to sending them in. It is not an ideal way to do things, but it is what I can do to try and help.
2. Either the reimbursements need to be similar to current fee for service fees or there need to be more clinics that are designed for primarily for the purpose of serving Medicaid/DWP. I would prefer the latter. These programs and there reimbursement levels require different business models to be successful in private practice. It is challenging to mix the two very different business models in the same facility. It is unfair to patients and providers to expect fee for service level treatments at Medicaid level reimbursements. The reimbursements are too low for providers to remain profitable in their

business. Fee for service patients would likely be upset if they found out that they are paying way more for treatment than Medicaid is paying for the very same treatments.

3. I am angered that patients are compelled to travel great distances to receive care and additionally that the state pays for taxi cabs to transport patients to appointments. I talked to one driver and learned that he was paid more for the dental appointment than I was. If you would increase reimbursement patients wouldn't have to travel over an hour for care. What a waste.
4. I believe there needs to be more screening for patients to be on the Wellness program. It seems like so many patients that have the plan have the income to pay for PPO insurance but yet continue to be allowed on the DWP.
5. I choose to donate through donated dental services or charity dentistry for patients of need. I don't know much about Medicaid or the changes discussed in this survey.
6. I do have an unusual situation that may skew your study. I have a very active and busy practice working more than full time. As such, we have not accepted new patients for nearly 20 years, we sneak in a rare few per month as a favor e.g. So I do treat your population as they exist in my practice, I did not turn anyone out. But I do not and have not accepted new patients of any sort really for years.
7. I do sincerely believe that there is a sizable portion of the community that needs these services. Having stated that, I would neither have the time nor the patience for getting the dental patients to comply with the oral care parameters as sought by the dental wellness guidelines. With my patients, I simply diagnose and offer treatment to take care of their dental problems. It is my goal to make them realize that their dental issues are their issues and no one else's. I was trained to diagnose and treat and that it what I have done for the last 35 years.
8. I will soon be retiring, so I am reluctant to accept new Wellness patients, as I don't want to burden the dentists I have sold out to with reimbursement levels less that overhead costs. It will be difficult enough for young dentists even without accepting Wellness patients. We consider it our social responsibility to see these patients, but cannot take as many as have a need. One thought I have always suggested is to give a tax benefit on the fee reduction. That would be some incentive. Also, a user tax on the products most detrimental to the patient's health, such as soft drinks and tobacco products, with all proceeds going to improve reimbursement levels and procedures now currently not covered.
9. If all Medicaid and all DWP adults were put into DWP 2.0, why do I still have adults on Medicaid?
10. It can be difficult to identify which carrier a patient will have. We only accept Delta. If we see someone on Medicaid that moves to MCNA we get stuck with the cost of the appointments.
11. It has to be profitable. Otherwise, I will just donate a couple days a year or do some internal good will. If it isn't profitable it isn't worth dealing with. DWP isn't the only way to be a kind dentist. DWP is a business, not a charity so its end results should reflect business, not charity.
12. It seems this program is developed to provide care for those in need who have problems with access to care for whatever reason- then the administration makes it very difficult to provide services to this population. Work to provide care then make it very hard if not impossible to render that care. Title XIX provided for all adults. DWP provides to age 64. Medicare doesn't provide care for oral health that is remotely significant. I'm not sure about this yet but it seems our elderly may lose coverage once they turn 65. If a patient needs a denture repair, reimbursement is less than my lab bill. So I lose money every time I repair a denture for a patient. There's more problems, however that's plenty for now. Send a survey out for front desk employees. See what they have to say. I'm sure you'll bet some beneficial responses.
13. My advice to new dentists is to stay out of this program. I have practiced for forty years and this is the worst I have ever seen this program. I am in it because I feel an obligation to my patients of record, but it costs me money to be involved.
14. Need to put restrictions on adult care, either a yearly maximum or decrease benefits such as endodontics, fixed prosthodontics, and evaluate all aspects or this is will not be sustainable by the state. Administrators, Delta and MCNA, will likely see decreased funding and will leave the program, due to the need to follow sound business practices. Not sure DHS really pay much attention to dental, given the medical program problems.
15. The State should cut out the insurance companies all together. Once the state determines that a patient is eligible, provide a single dollar amount per patient per year. Remove the middleman and allow dentists to practice without all the restrictions. No fee schedule necessary.
16. This is one of the most abused forms of welfare I have ever seen. There is at least 50% fraud among users since they only look at income and not assets. Many of these people have undeclared income or don't even file at all. I'm not sure when Iowa became a welfare state, but we are seeing people coming to Iowa from all over the Midwest and deep south for our "free care"! This system should only get people out of pain and not give them ideal treatment with endo and crowns which continue to rot out of their mouth with Mt dew. We are leaving the program. Dennis Winter DDS UI Class of 83.
17. This research is needed. I hope positive changes can be made. I wanted to accept this plan, I wanted to serve this population. The contracts were just terrible-essentially a blank contract. Delta stated they could change anything in the contract effective immediately upon sending out an e-mail, really? Absolute power of the insurance company is in no one's best interest. They are powerful, they have lots of money, and they can wine and dine the legislatures. But they don't really care about patients. They only care about profits. That is what I learned from this whole thing. Very saddening. This is everyone's hard earned tax dollars. This is care that Iowan's desperately need. They could have done it right, they chose to do it wrong because they never really got what it was that Iowa was trying to do when they created the wellness program. I have wasted so much time going through contracts and being disgusted about the way things were done, but no way to give my input until we see that it got so messed up. Next time, get a group of dentists together, let them tell you what they think, before the plan is put in place. It is simple strategic planning. Those who run the program have to actually want it to work. We as dentists see the patients. We are the ones who can tell you what they need and where to start. Make it easy for them. Provide a forum for discussion. We don't all have to meet in in one location. Perhaps the University Of Iowa College Of Dentistry could coordinate this, but they need to get input from all types of dental practices-community health centers, private practices, academics, specialists, etc.

APPENDIX 4: DESCRIPTIVE TABLES

SQ1: What is your current practice status?	
	N (%)
Practicing in Iowa, full time (30+ hours/week)	278 (91.4)
Practicing in Iowa, part time (less than 30 hours/week)	26 (8.6)
Total Responding	304

Missing = 1

SQ2: What is your primary practice setting?	
	N (%)
Private practice	303 (100)
Community health center or other public health clinic	0
Academic institution	0
Total Responding	303

Missing = 2

Q1: Were you previously aware of these changes to the Iowa Medicaid and DWP dental programs?	
	N (%)
Yes, I was aware of all of these changes	199 (65.2)
Yes, I was aware of some of these changes	78 (25.6)
No, I was not aware of any of these changes	28 (9.2)
Total Responding	305

Missing = 0

Q2: Are you currently accepting new Dental Wellness Plan patients with coverage through Delta Dental?	
	N (%)
Yes, we are accepting all new DWP Delta Dental patients	50 (16.5)
Yes, we are accepting some new DWP Delta Dental patients	68 (22.4)
No, we are not accepting any new DWP Delta Dental patients	185 (61.1)
Total Responding	303

Missing = 2

Q2_b_1: Are you currently accepting new Dental Wellness Plan patients with coverage through Delta Dental? Yes, we are accepting some new DWP Delta Dental patients: *Select all that apply*	
	N (%)
A set number of new DWP Delta Dental patients	21 (30.9)
Not selected	47 (69.1)
Total Responding	68

Missing = 237

Q2_b_2: Are you currently accepting new Dental Wellness Plan patients with coverage through Delta Dental? Yes, we are accepting some new DWP Delta Dental patients: Select all that apply	
	N (%)
Referrals or family members of existing patients	46 (67.6)
Not selected	22 (32.4)
Total Responding	68

Missing = 237

Q2_b_3: Are you currently accepting new Dental Wellness Plan patients with coverage through Delta Dental? Yes, we are accepting some new DWP Delta Dental patients: *Select all that apply*	
	N (%)
Referrals from other dentists or physicians	15 (22.1)
Not selected	53 (77.9)
Total Responding	68

Missing = 237

Q2_b_4: Are you currently accepting new Dental Wellness Plan patients with coverage through Delta Dental? Yes, we are accepting some new DWP Delta Dental patients: *Select all that apply*	
	N (%)
Emergencies	20 (29.4)
Not selected	48 (70.6)
Total Responding	68

Missing = 237

Q2_b_5: Are you currently accepting new Dental Wellness Plan patients with coverage through Delta Dental? Yes, we are accepting some new DWP Delta Dental patients: *Select all that apply*	
	N (%)
Other	10 (14.7)
Not selected	58 (85.3)
Total Responding	68

Missing = 237

Q3: Prior to the program changes in August 2017, did you accept new DWP Delta Dental patients?	
	N (%)
Yes, we accepted all new DWP Delta Dental patients	112 (37.7)
Yes, we accepted some new DWP Delta Dental patients	88 (29.6)
No, we did not accept any new DWP Delta Dental patients	97 (32.7)
Total Responding	297

Missing = 8

Q4: Are you planning to continue accepting new DWP Delta Dental patients for at least the next 6 months?	
	N (%)
Definitely yes	32 (26.9)
Probably yes	55 (46.2)
Probably no	26 (21.8)
Definitely no	6 (5.0)
Total Responding	119

Missing = 186

Q5: What is the most important reason that you stopped accepting new DWP Delta Dental patients?	
	N (%)
Reimbursement	84 (89.4)
Administrative issues	5 (5.3)
DWP patient related issues	3 (3.2)
Other	2 (2.1)
Total Responding	94

Missing = 211

Q6: Even though you are not accepting new DWP Delta Dental patients, do you currently have any DWP Delta Dental patients in your practice?	
	N (%)
Yes	121 (65.4)
No	64 (34.6)
Total Responding	185

Missing = 120

Q7: Which best describes your attitude toward Delta Dental's administration of DWP?	
	N (%)
Very positive	29 (9.5)
Somewhat positive	90 (29.6)
Somewhat negative	76 (25.0)
Very negative	69 (22.7)
Don't know/Not sure	40 (13.2)
Total Responding	304

Missing = 1

Q9: Even though you do not currently accept DWP Delta Dental patients, are you contracted with Delta Dental as a DWP provider?	
	N (%)
Yes	4 (6.3)
No	56 (87.5)
Don't know/Not sure	4 (6.3)
Total Responding	64

Missing = 241

Q10: Are you currently accepting new Dental Wellness Plan patients with coverage through MCNA Dental?	
	N (%)
Yes, we are accepting all new DWP MCNA patients	25 (8.2)
Yes, we are accepting some new DWP MCNA patients	18 (5.9)
No, we are not accepting any new DWP MCNA patients	261 (85.9)
Total Responding	304

Missing = 1

Q10_b_1: Are you currently accepting new Dental Wellness Plan patients with coverage through MCNA Dental? Yes, we are accepting some new DWP MCNA patients: *Select all that apply*	
	N (%)
A set number of new DWP MCNA patients	4 (22.2)
Not selected	14 (77.8)
Total Responding	18

Missing = 287

Q10_b_2: Are you currently accepting new Dental Wellness Plan patients with coverage through MCNA Dental? Yes, we are accepting some new DWP MCNA patients: *Select all that apply*	
	N (%)
Referrals or family members of existing patients	8 (44.4)
Not selected	10 (55.6)
Total Responding	18

Missing = 287

Q10_b_3: Are you currently accepting new Dental Wellness Plan patients with coverage through MCNA Dental? Yes, we are accepting some new DWP MCNA patients: *Select all that apply*	
	N (%)
Referrals from other dentists/physicians	5 (27.8)
Not selected	13 (72.2)
Total Responding	18

Missing = 287

Q10_b_4: Are you currently accepting new Dental Wellness Plan patients with coverage through MCNA Dental? Yes, we are accepting some new DWP MCNA patients: *Select all that apply*	
	N (%)
Emergencies	2 (11.1)
Not selected	16 (88.9)
Total Responding	18

Missing = 287

Q10_b_5: Are you currently accepting new Dental Wellness Plan patients with coverage through MCNA Dental? Yes, we are accepting some new DWP MCNA patients: *Select all that apply*	
	N (%)
Other	3 (16.7)
Not selected	15 (83.3)
Total Responding	18

Missing = 287

Q11: Prior to the program changes in August 2017, did you accept any new DWP MCNA patients?	
	N (%)
Yes, we accepted all new DWP MCNA patients	37 (12.2)
Yes, we accepted some new DWP MCNA patients	39 (12.9)
No, we did not accept any new DWP MCNA patients	227 (74.9)
Total Responding	303

Missing = 2

Q12: Are you planning to continue accepting new DWP MCNA patients for at least the next 6 months?	
	N (%)
Definitely yes	9 (20.9)
Probably yes	23 (53.5)
Probably no	9 (20.9)
Definitely no	2 (4.7)
Total Responding	43

Missing = 262

Q13: What is the most important reason that you stopped accepting new DWP MCNA patients?	
	N (%)
Reimbursement	22 (62.9)
Administrative issues	11 (31.4)
DWP patient related issues	2 (5.7)
Total Responding	35

Missing = 270

Q14: Even though you are not accepting new DWP MCNA patients, do you currently have any of these patients in your practice?	
	N (%)
Yes	52 (20.0)
No	208 (80.0)
Total Responding	260

Missing = 45

Q15: Which best describes your attitude toward MCNA's administration of DWP?	
	N (%)
Very positive	2 (0.7)
Somewhat positive	13 (4.3)
Somewhat negative	56 (18.5)
Don't know/Not sure	139 (45.9)
Total Responding	303

Missing = 2

Q17: Even though you do not currently accept DWP MCNA patients, are you contracted with MCNA as a DWP provider?	
	N (%)
Yes	1 (0.5)
No	188 (90.4)
Don't know/Not sure	19 (9.1)
Total Responding	208

Missing = 97

Q18: Are you currently accepting new Medicaid-enrolled children as patients? (Medicaid only, not including Hawk-I)	
	N (%)
Yes, we are accepting all new child Medicaid patients	80 (26.4)
Yes, we are accepting some new child Medicaid patients	85 (28.1)
No, we are not accepting any new child Medicaid patients	138 (45.5)
Total Responding	303

Missing = 2

Q18_b_1: Are you currently accepting new Medicaid-enrolled children as patients (Medicaid only, not including Hawk-I)? Yes, we are accepting some new child Medicaid patients: *Select all that apply*	
	N (%)
A set number of new child Medicaid patients	14 (16.5)
Not selected	71 (83.5)
Total Responding	85

Missing = 220

Q18_b_2: Are you currently accepting new Medicaid-enrolled children as patients (Medicaid only, not including Hawk-I)? Yes, we are accepting some new child Medicaid patients: *Select all that apply*	
	N (%)
Referrals or family members of existing patients	63 (74.1)
Not selected	22 (25.9)
Total Responding	85

Missing = 220

Q18_b_3: Are you currently accepting new Medicaid-enrolled children as patients (Medicaid only, not including Hawk-I)? Yes, we are accepting some new child Medicaid patients: *Select all that apply*	
	N (%)
Referrals from other dentists/physicians	18 (21.2)
Not selected	67 (78.8)
Total Responding	85

Missing = 220

Q18_b_4: Are you currently accepting new Medicaid-enrolled children as patients (Medicaid only, not including Hawk-I)? Yes, we are accepting some new child Medicaid patients: *Select all that apply*	
	N (%)
Emergencies	29 (34.1)
Not selected	56 (65.9)
Total Responding	85

Missing = 220

Q18_b_5: Are you currently accepting new Medicaid-enrolled children as patients (Medicaid only, not including Hawk-I)? Yes, we are accepting some new child Medicaid patients: *Select all that apply*	
	N (%)
Other	16 (18.8)
Not selected	69 (81.2)
Total Responding	85

Missing = 220

Q19: Prior to the program changes in August 2017, did you accept new Medicaid patients?	
	N (%)
Yes, we accepted all new Medicaid patients	73 (24.1)
Yes, we accepted some new Medicaid patients	123 (40.6)
No, we did not accept any new Medicaid patients	107 (35.3)
Total Responding	303

Missing = 2

Q19_b_1: Prior to the program changes in August 2017, did you accept new Medicaid patients? Yes, we accepted some new Medicaid patients: *Select all that apply*	
	N (%)
A set number of new Medicaid patients	23 (18.9)
Not selected	99 (81.1)
Total Responding	122

Missing = 183

Q19_b_2: Prior to the program changes in August 2017, did you accept new Medicaid patients? Yes, we accepted some new Medicaid patients: *Select all that apply*	
	N (%)
Adults only	3 (2.5)
Not selected	119 (97.5)
Total Responding	122

Missing = 183

Q19_b_3: Prior to the program changes in August 2017, did you accept new Medicaid patients? Yes, we accepted some new Medicaid patients: *Select all that apply*	
	N (%)
Children only	48 (39.3)
Not selected	74 (60.7)
Total Responding	122

Missing = 183

Q19_b_4: Prior to the program changes in August 2017, did you accept new Medicaid patients? Yes, we accepted some new Medicaid patients: *Select all that apply*	
	N (%)
Referrals or family members of existing patients	79 (64.8)
Not selected	43 (35.2)
Total Responding	122

Missing = 183

Q19_b_5: Prior to the program changes in August 2017, did you accept new Medicaid patients? Yes, we accepted some new Medicaid patients: *Select all that apply*	
	N (%)
Referrals from other dentists/physicians	23 (18.9)
Not selected	99 (81.1)
Total Responding	122

Missing = 183

Q19_b_6: Prior to the program changes in August 2017, did you accept new Medicaid patients? Yes, we accepted some new Medicaid patients: *Select all that apply*	
	N (%)
Emergencies	35 (28.7)
Not selected	87 (71.3)
Total Responding	122

Missing = 183

Q19_b_7: Prior to the program changes in August 2017, did you accept new Medicaid patients? Yes, we accepted some new Medicaid patients: *Select all that apply*	
	N (%)
Other	17 (13.9)
Not selected	105 (86.1)
Total Responding	122

Missing = 183

Q20: What is the most important reason that you stopped accepting new Medicaid patients?	
	N (%)
Reimbursement	31 (83.8)
Administrative issues	2 (5.4)
DWP patient related issues	3 (8.1)
Other	1 (2.7)
Total Responding	37

Missing = 268

Q21: In June 2017, Iowa Medicaid required all Medicaid providers to renew enrollment in order to maintain active Medicaid provider status. Even though you do not accept new DWP or Medicaid patients, are you currently enrolled as a Medicaid provider?	
	N (%)
Yes	63 (51.2)
No	53 (43.1)
Don't know/Not sure	7 (5.7)
Total Responding	123

Missing = 182

Q21_b_i: Were you enrolled as a Medicaid provider prior to the required enrollment renewal in June 2017?	
	N (%)
Yes	15 (28.3)
No	38 (71.7)
Total Responding	53

Missing = 252

Q22: What describes your overall attitude toward DWP 2.0?	
	N (%)
Very positive	4 (1.3)
Somewhat positive	33 (10.8)
Neither positive nor negative	28 (9.2)
Somewhat negative	96 (31.5)
Very negative	117 (38.4)
Don't know/Not sure	27 (8.9)
Total Responding	305

Missing = 0

Q23_a: Please identify the two most important changes that could be made to increase dentists' participation in the DWP 2.0 program without increasing the overall cost of the program.	
	N (%)
Increase reimbursement for some services and decrease or eliminate it for others	223 (75.1)
Not selected	74 (24.9)
Total Responding	297

Missing = 8

Q23_b: Please identify the two most important changes that could be made to increase dentists' participation in the DWP 2.0 program without increasing the overall cost of the program.	
	N (%)
Reduce administrative burden	61 (20.5)
Not selected	236 (79.5)
Total Responding	297

Missing = 8

Q23_c: Please identify the two most important changes that could be made to increase dentists' participation in the DWP 2.0 program without increasing the overall cost of the program.	
	N (%)
Decrease payment delays	21 (7.1)
Not selected	276 (92.9)
Total Responding	297

Missing = 8

Q23_d: Please identify the two most important changes that could be made to increase dentists' participation in the DWP 2.0 program without increasing the overall cost of the program.	
	N (%)
Improve carriers' customer service to providers	21 (7.1)
Not selected	276 (92.9)
Total Responding	297

Missing = 8

Q23_e: Please identify the two most important changes that could be made to increase dentists' participation in the DWP 2.0 program without increasing the overall cost of the program.	
	N (%)
Reduce broken appointments	88 (29.6)
Not selected	209 (70.4)
Total Responding	297

Missing = 8

Q23_f: Please identify the two most important changes that could be made to increase dentists' participation in the DWP 2.0 program without increasing the overall cost of the program.	
	N (%)
Reduce patients' intermittent eligibility	59 (19.9)
Not selected	238 (80.1)
Total Responding	297

Missing = 8

Q23_g: Please identify the two most important changes that could be made to increase dentists' participation in the DWP 2.0 program without increasing the overall cost of the program.	
	N (%)
Increase specialist participation	38 (12.8)
Not selected	259 (87.2)
Total Responding	297

Missing = 8

Q23_h: Please identify the two most important changes that could be made to increase dentists' participation in the DWP 2.0 program without increasing the overall cost of the program.	
	N (%)
Other	46 (15.5)
Not selected	251 (84.5)
Total Responding	297

Missing = 8

Q23_a_1: If selected increase reimbursement for some services and decrease or eliminate it for others. Please select the types of services for which reimbursement should be increased, decreased, or eliminated: *Preventive*	
	N (%)
Increase reimbursement	200 (90.1)
Decrease reimbursement	9 (4.1)
Eliminate reimbursement	1 (0.5)
Not selected	12 (5.4)
Total Responding	222

Missing = 83

Q23_a_2: If selected increase reimbursement for some services and decrease or eliminate it for others. Please select the types of services for which reimbursement should be increased, decreased, or eliminated: *Restorative*	
	N (%)
Increase reimbursement	216 (97.3)
Decrease reimbursement	3 (1.4)
Eliminate reimbursement	
Not selected	3 (1.4)
Total Responding	222

Missing = 83

Q23_a_3: If selected increase reimbursement for some services and decrease or eliminate it for others. Please select the types of services for which reimbursement should be increased, decreased, or eliminated: *Periodontics*	
	N (%)
Increase reimbursement	141 (9.9)
Decrease reimbursement	31 (14.0)
Eliminate reimbursement	28 (12.6)
Not selected	22 (9.9)
Total Responding	222

Missing = 83

Q23_a_4: If selected increase reimbursement for some services and decrease or eliminate it for others. Please select the types of services for which reimbursement should be increased, decreased, or eliminated: *Endodontics*	
	N (%)
Increase reimbursement	132 (59.5)
Decrease reimbursement	21 (9.5)
Eliminate reimbursement	48 (21.6)
Not selected	21 (9.5)
Total Responding	222

Missing = 83

Q23_a_5: If selected increase reimbursement for some services and decrease or eliminate it for others. Please select the types of services for which reimbursement should be increased, decreased, or eliminated: *Oral Surgery*	
	N (%)
Increase reimbursement	197 (88.7)
Decrease reimbursement	6 (2.7)
Eliminate reimbursement	1 (0.5)
Not selected	18 (8.1)
Total Responding	222

Missing = 83

Q23_a_6: If selected increase reimbursement for some services and decrease or eliminate it for others. Please select the types of services for which reimbursement should be increased, decreased, or eliminated: *Fixed Prosthodontics*	
	N (%)
Increase reimbursement	120 (54.1)
Decrease reimbursement	21 (9.5)
Eliminate reimbursement	71 (32.0)
Not selected	10 (4.5)
Total Responding	222

Missing = 83

Q23_a_7: If selected increase reimbursement for some services and decrease or eliminate it for others. Please select the types of services for which reimbursement should be increased, decreased, or eliminated: *Removable Prosthodontics*	
	N (%)
Increase reimbursement	170 (76.6)
Decrease reimbursement	8 (3.6)
Eliminate reimbursement	34 (15.3)
Not selected	10 (4.5)
Total Responding	222

Missing = 83

Q24: What is your dental clinical specialty?	
	N (%)
General dentist	276 (90.5)
Endodontist	4 (1.3)
Oral and maxillofacial surgery	10 (3.3)
Pediatric dentistry	4 (1.3)
Prosthodontics	1 (0.3)
Periodontics	2 (0.7)
Orthodontics	8 (2.6)
Total Responding	305

Missing = 0

Q25: What is your employment situation in your primary practice?	
	N (%)
Sole proprietor (i.e., the only owner/shareholder)	169 (55.4)
Partner (i.e., one of two or more owners/shareholders)	60 (19.7)
Employee (on a salary, commission, percentage or associate basis)	67 (22.0)
Independent contractor	9 (3.0)
Total Responding	305

Missing = 0

Q26: How many total dentists are in your primary practice, including yourself?	
	N (%)
Solo practice	95 (35.4)
Group practice	173 (64.6)
Total Responding	268

Missing = 37

Q27: How many years have you been practicing in your current location?	
	N (%)
0-5 years	101 (33.4)
6-10 years	50 (16.6)
11-15 years	27 (8.9)
16-20 years	34 (11.3)
>20 years	90 (29.8)
Total Responding	302

Missing = 3

Q28: Who was primarily responsible for making the decision whether your practice would accept Medicaid/DWP patients?	
	N (%)
I was	182 (60.1)
The dentists in the practice as a group	61 (20.1)
The owner of the practice	34 (11.2)
The clinic management/ administration	16 (5.3)
Other	10 (3.3)
Total Responding	303

Missing = 2

Q29: What is the population of the city that your practice is located in?	
	N (%)
<2,500	34 (11.3)
2,500-9,999	79 (26.2)
10,000-49,999	61 (20.3)
≥50,000	127 (42.2)
Total Responding	301

Missing = 4

Q30: What is your age?	
	N (%)
<30 years	33 (11.3)
30-39 years	75 (25.8)
40-49 years	60 (20.6)
50-59 years	66 (22.7)
60-69 years	53 (18.2)
≥70 years	4 (1.4)
Total Responding	291

Missing = 14

Q31: What is your gender?	
	N (%)
Male	206 (68.4)
Female	95 (31.6)
Total Responding	301

Missing = 4

Q32: What is your race/ethnicity?*	
	N (%)
White	279 (94.9)
Black/African American	1 (0.3)
Hispanic/Latino	5 (1.7)
Asian	8 (2.7)
American Indian/Alaskan Native	5 (1.7)
Middle Eastern/North African	1 (0.3)
Total Responding	294

*Five respondents selected more than one race, hence, numbers and percentages may not sum up to 100%.
Missing = 11