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Centers for Medicare & Medicaid Services
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Children and Adults Health Programs Group

APR 20 2015

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Dear Ms. Lovelady:

The Centers for Medicare & Medicaid Services (CMS) has approved Iowa's Healthy Behaviors evaluation design for the section 1115 demonstrations entitled, "Iowa Wellness Plan" (Project Number 11-W-00289/5) and "Iowa Marketplace Choice Plan" (Project Number 11-W-00288/5).

You may now post the approved evaluation design on the state's Medicaid website pursuant to your Special Terms and Conditions (STCs).

Your project officer for this demonstration is Ms. Leila Ashkeboussi. She is available to answer any questions concerning your section 1115 demonstration. Ms. Ashkeboussi's contact information is:

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Official communications regarding program matters should be sent simultaneously to Mr. James Scott, Associate Regional Administrator for the Division of Medicaid and Children's Health in the Kansas City Regional Office. Mr. Scott's contact information is as follows:

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Healthy Behaviors Evaluation

Background

On January 1, 2014 Iowa implemented the Iowa Health and Wellness Plan (IHAWP). IHAWP expands coverage for low income Iowans through two new programs: the Marketplace Choice and the Wellness Plan:

The **Wellness Plan** provides coverage for adults aged 19-64 years with income up to and including 100 percent of the Federal Poverty Level (FPL). It is administered by the Iowa Medicaid Enterprise (IME). Members will have access to the Medicaid provider network established for this program.

The **Marketplace Choice Plan** provides coverage for adults aged 19-64 years with income from 101-133 percent of the Federal Poverty Level (FPL). The Marketplace Choice Plan allows members to choose certain commercial health plans available on the health insurance marketplace, with Medicaid paying the member's commercial health plan premiums. Currently there is one statewide commercial health plan offered to Marketplace Choice Plan members: Coventry.

IHAWP replaces the IowaCare program with plans that cover more services, offer a broader provider network, and expand coverage to other low income adults in Iowa who were not previously enrolled in IowaCare. Appendix A provides two tables. Table 1 compares benefits, provider networks, and healthy behavior incentives for the three plans: IowaCare, Wellness Plan, and Marketplace Choice Plan. Table 2 compares benefits, provider networks, and healthy behavior incentives for the three plans: Medicaid State Plan, Wellness Plan, and Marketplace Choice Plan.

Healthy Behaviors Programs in Other States

The promotion of preventive measures such as healthy eating, physical activity, and tobacco cessation have continually been noted as a method to curb the rising costs of healthcare and the high rates of morbidity related to chronic disease among millions of individuals in the United States.

Several state Medicaid programs have established programs under the Affordable Care Act (ACA) of 2011 in which individuals are given incentives to perform and maintain recommended behaviors related to preventative care and chronic disease management (Van Vleet & Rudowitz, 2014). Some incentive programs have targeted a wide range of disease prevention methods, while others focus on a specific behavior such as losing weight or tobacco cessation. The incentives themselves (gift cards, cash, or flexible spending account, for example), the mechanism (statewide vs. urban focus), and timing of program implementation have varied as well.

Under the ACA, ten states (California, Connecticut, Hawaii, Minnesota, Montana, Nevada, New Hampshire, New York, Texas, and Wisconsin) were allotted funds to implement Medicaid incentive programs in September 2011 through January 2016. The following provides an overview what has been done by these states along with evaluation methods and key findings from the initial evaluation in 2013.

General Overview of Medicaid Incentives for the Prevention of Chronic Diseases (MIPCD)

Grants

Chronic disease and conditions -- such as heart disease, diabetes, and obesity – are among the most costly, common, and preventable of all health problems in the United States (CDC, 2015). As of 2012, almost half of all adults (117 million people) in the United States had a chronic health condition (CDC, 2015). Many of these chronic health conditions are attributed at least in part to unhealthy behaviors. These behaviors include lack of physical activity, poor nutrition, and use of tobacco and alcohol. Furthermore, these chronic conditions account for a large portion (84%) of the total health care spending for half of the population with a chronic condition (CDC, 2015).

While chronic disease affects the U.S. healthcare system, low-income individuals face large barriers to receiving clinical preventive services (Fox & Shaw, 2014). Each year, it is estimated that 100,000 deaths occurred in the United States because individuals did not receive the preventive care required (Fox & Shaw, 2014). Furthermore, racial minorities face large disparities in health outcomes, access and quality of services, and high risk of unhealthy behaviors. Lastly, individuals with low socioeconomic status not only have barriers to services, but also are more likely to smoke, be obese, and have a chronic condition.

For Medicaid, the use of incentives for healthy behaviors has been a relatively new approach, but this approach has been studied widely. Studies have shown that monetarily incentivizing one-time health behaviors have been very successful (Kane, Johnson & Town, 2004). In 2004, a review of studies found that 15 out of 17 studies on cash or coupon rewards increased the rate of a one-time healthy behavior, such as TB skin test for drug users (Kane et al., 2004). In another study, 90% of drug users returned for TB skin tests when given a \$10 incentive, versus 33% when not given an incentive (Malotte, Rhodes, & Mais, 1998). For changing lifestyle behaviors, such as smoking cessation and weight loss, the successes are less consistent. One recent study found that 16% of those that received a randomized incentive quit smoking versus 5% of those who did not receive the incentive (Volpp, Troxel, Pauly, Glick, Puig, Asch et al., 2009). Much like MIPCD, many programs are choosing to incentivize participation in behavior change programs. Studies have found that these types of incentives have high attendance but result in low rates of sustained behavior change (Follick, Fowler, & Brown, 2004), (Donatelle, Hudson, Dobir, Goodall, Hunsberger, Oswald, 2004). A study demonstrated that over a 10-month time frame, incentives were still effective, but when the incentives ended, the healthy behaviors subsided (Dontalle, Prows, Champeau, & Hudson, 2000).

Over the years, incentives for healthy behaviors have changed. There are two categories of incentives: process incentives and outcome incentives. Process incentives are given to individuals who participate in a wellness activity, such as a gym class, weight loss program, or smoking cessation program. Outcome incentives are benefits for meeting a target risk factor, such as a certain body mass index, blood pressure, or blood sugar threshold.

Prior to the ACA, there were a few programs that attempted to incentivize healthy behaviors. The goal of these programs was to engage individuals to make healthier choices in their lives. Examples of these programs are Idaho's Preventive Health Assistance or Indiana's Healthy Indiana Plan, which are still operating (Van Vleet & Rudowitz, 2014). These programs incentivized individuals through cash, pre-paid debit cards or gift certificates for health purchases like medicines, healthy foods, or gym memberships. To fund these incentive programs, states used their Section 1115 Medicaid demonstration waivers (Van Vleet & Rudowitz, 2014). The evaluation of these programs showed mixed results and some were criticized by members of the health policy community. There was no

clear evidence that the programs decreased healthcare costs and morbidity in these states. Because of this skepticism, some programs have been phased out or policymakers have cut their funding.

In section 4108 of the Affordable Care Act, the Medicaid Incentives for Prevention of Chronic Diseases (MIPCD) program was established. The program offers \$85 million over five years to ten states (California, Connecticut, Hawaii, Minnesota, Montana, Nevada, New Hampshire, New York, Texas, and Wisconsin) to provide incentives to Medicaid beneficiaries who participated in preventive measures for chronic conditions (Van Vleet & Rudowitz, 2014). Within the stipulations of the grant, the state must address at least one of the following preventive measures: tobacco cessation, controlling or reducing weight, lowering blood pressure, and preventing or controlling diabetes. States are currently implementing their programs as grant funding runs through January 1, 2016. A process evaluation was conducted in November 2013, and a final evaluation must be completed by July of 2016. As Iowa brainstorms and constructs their own incentive program, many lessons can be learned from the ten initial state programs.

Current Status of MIPCD Grants

Under the ACA, MIPCD grantees must target at least one of these five designated prevention goals: smoking, diabetes, obesity, high cholesterol, and high blood pressure (Van Vleet & Rudowitz, 2014).

All states are targeting their efforts to adult Medicaid beneficiaries with or at risk of a chronic disease. However, some states chose to focus on special populations within the pool of Medicaid beneficiaries. Other populations chosen were individuals with mental illness and/or substance abuse disorders, racial minorities, mothers of newborns, children, and Medicare and Medicaid dual-eligible beneficiaries.

In addition, states could decide the number of beneficiaries eligible for their program. When the programs rolled out, the states could choose the geographic location of their program implementation. Most states chose to implement the program statewide, while others decided to focus on their major metropolitan area. For example, Minnesota phased in their programming with clinics in the seven counties that encompassed the Minneapolis-St. Paul metro area. Other states chose one county to pilot the program and then expanded county by county statewide (Van Vleet & Rudowitz, 2014).

The incentive structure has varied from state to state as well. Most states are using money or money-equivalents. The most common form of incentives is no-cost treatment (such as nicotine patches) or prevention methods (e.g., gym memberships or membership in Weight Watchers). Some states are offering flexible spending accounts, while others are choosing to address environmental barriers to healthcare access such as transportation and childcare. The dollar amount for each incentive has varied as well. Eight out of the ten states offer incentives that range from \$215-\$600 per enrollee. These MIPCD program entities have varied from state to state with no prescribed program (Van Vleet & Rudowitz, 2014).

Findings in Evaluation of MIPCD Grants

The interim evaluation report was completed by CMS in November 2013. The report concluded that states faced many challenges in implementing the MIPCD programs. Because of this delay, many states were still enrolling individuals into the program during the evaluation period. Only one state has met its enrollment target. This did not allow for any evidence to be collected about the success of the program.

There are several challenges that can be identified from the evaluation. The programs had significant administrative delays including contract delays and limitations, navigating multiple review boards, and difficulties hiring staff. In addition, the programs had difficulty engaging providers. Many of the providers were not covered by Medicaid, did not agree with program requirements, and had challenges incorporating program components into their daily workflow. In addition, the program had a hard time managing the number of providers within each state. Participants in the program were another challenge. First, the program at times could not identify eligible participants for the program due to lack of correct data, such as working telephone number or correct home addresses. Furthermore, the program had difficulty arranging for debit card procurement for participant incentives. Lastly, perceptions of participants toward the program was identified as a barrier (Van Vleet & Rudowitz, 2014).

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

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

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

Starting in 2015, a small monthly contribution may be required depending on family income, although there are no copayments for health care services and prescriptions under the plan. However, IHAWP members may be subject to a copayment of \$8 per visit for using the emergency room for non-emergency services. Some Wellness Plan members will contribute \$5 per month, while Iowa Marketplace Choice Plan members will contribute \$10 per month. Wellness Plan members with individual earnings less than 50 percent of the Federal Poverty Level (\$5,835 per year for an individual, or \$7,865 for a family of 2) will not have monthly contributions. IHAWP members who complete the wellness exam and the HRA will not be responsible for a monthly contribution.

Extensive efforts have been planned to inform enrollees and providers about this program. These efforts include mailings to members, toolkits for providers, and social media engagement. Early survey results of IowaCare members who transitioned into IHAWP found that the vast majority (90%) were not aware that completing a wellness exam would be part of the program to have their contributions waived.

Members earning over 49% of the FPL are given a 30-day grace period after the enrollment year to complete the healthy behaviors in order to have the contribution waived. If members do not complete the behaviors after the grace period has ended, members will receive a billing statement and a request for a hardship exemption form. For members of the Wellness Plan, all unpaid contributions will be considered a debt owed to the State of Iowa but will not, however, result in termination from the Wellness Plan. If, at the time of reenrollment, the member does not reapply for or is no longer eligible for Medicaid coverage and has no claims for services after the last premium payment, the member's debt will be forgiven. For members in Marketplace Choice, unpaid contributions after 90 days result in the termination of the member's enrollment status. The member's outstanding contributions will be considered a collectable debt and subject to recovery. A member whose Marketplace Choice Plan benefits are terminated for nonpayment of monthly contributions must reapply for Medicaid coverage. The IME will permit the member to reapply at any time; however, the member's outstanding contribution payments will remain subject to recovery.

Wellness Exam

The wellness exam is an annual preventive wellness exam (New Patient CPT Codes: 99385 18-39 years of age, 99386 40-64 years of age; Established Patient CPT Codes: 99395 18-39 years of age, 99396 40-64 years of age) from any plan-enrolled physician, Rural Health Clinic (RHC), Federally Qualified Health Center (FQHC) or Advanced Registered Nurse Practitioner (ARNP). The exams are part of the preventive services covered by the plans and therefore do not cost the member anything out-of-pocket. A 'sick visit' can count towards the requirement of the preventive exam, if wellness visit components are included and the modifier 25 is used.

Health Risk Assessment

A health risk assessment (HRA) is a survey tool that can be used by members and providers to evaluate a member's health. The survey asks members about their health and their experiences in receiving health services. IME has identified Assess My Health as one such tool, although providers can select their own tool if it asks similar questions. Assess My Health will take members between 15 and 40 minutes to complete on the computer. Wellness Plan members who complete the assessment will receive a one-page report and their provider will be able to receive a report automatically. Members of the Marketplace Choice Plan will also receive the report, but their provider will not automatically receive the report; Marketplace Choice Plan enrollees must share the report with their provider. This information can be used by providers to develop plans addressing member needs related to health risk determinants.

Provider Incentives

Providers also have incentives available to them, so that they encourage and support their patients in completing the wellness exam and HRA. Providers should be assisting members with the HRA before or during their wellness exam. For every Wellness Plan member who completes the HRA with the assistance of the provider, the provider will receive \$25.00. The only HRA which qualifies for this incentive is the Assess My Health tool. It is not known how many providers will select to use a HRA tool that is not the Assess My Health tool.

Further Behavior Incentives

Based on research indicating incentives can be used to change behavior, a program of incentives will be developed to encourage behavior change among enrollees. To participate in this part of the program, the member must have completed the wellness exam and the HRA, unless they are below 50% of the FPL or are Medically Exempt status. Plans for this part of the program are evolving.

Independent Entity

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

on results; and discuss the generalizability of results.

Research Design

This evaluation will employ multiple levels of analyses, using quantitative and qualitative data. (See Appendices B-E, G for descriptions of all measures and mapping of measures to concepts.) First, univariate and bivariate analyses will be used to compare characteristics of Wellness Plan and Marketplace Choice plan members with the IowaCare and Medicaid State Plan comparison groups. Second, simple rate comparisons will be computed for the population-based outcomes, including interrupted time-series analyses to demonstrate differences in trends between groups. Finally, for hypotheses related to utilization and cost, we will utilize more sophisticated analytic approaches including a difference-in-differences estimation (DID), regression discontinuity design (RDD) and incremental cost effectiveness ratios (ICER). RDD will be coupled with difference-in-differences as a robust method for establishing differences in selected cost and outcome measures attributable to the HBI program.

Survey data and in-depth interviews will be used in this evaluation to capture the experiences of Wellness Plan and Marketplace Choice members, health care providers, ACO leadership and IME program staff. The survey items will draw on existing measures, as well as measures specifically developed for this evaluation. Because of the unique nature of this evaluation, some measures will be required that currently do not exist in the literature. The development of items will consist of formative interviews and vetting the measures with key stakeholders. Univariate and bivariate analysis will be conducted to compare plan members. In-depth interview protocols will be determined by the research questions and hypothesis. The qualitative analysis will be informed by Grounded Theory and closed-coding. The analysis will produce themes and compare themes across groups when appropriate.

Research Questions and Hypotheses

Below are the research questions and associated hypotheses for the evaluation of the HBI program. Detailed tables of the specifications for each measure to be used in the study for each hypothesis are provided in Appendices B-E, G.

While this evaluation is focused on comparing Wellness Plan and Marketplace Choice members to other comparison groups, when available, the research team is mindful of possible differences between these two groups of members. Analyses will be conducted to examine differences between the Wellness Plan and Marketplace Choice members when appropriate.

Question 1 Which activities do members complete?

Hypothesis 1.1 The proportion of Wellness Plan (WP) and Marketplace Choice(MPC) members who complete a wellness exam is greater than the proportion of Medicaid State Plan (MSP) or IowaCare members.

Hypothesis 1.2 The proportion of WP/MPC members who complete a Health Risk Assessment is greater than 50%.

Hypothesis 1.3 The proportion of WP/MPC members who are eligible to participate and complete at least one behavior incentive is greater than 50%.

Hypothesis 1.4 Members (WP/MPC) are most likely to complete the behaviors that require the least amount of effort.

Hypothesis 1.5 Members (WP/MPC) will be least likely to complete incentivized behaviors requiring sustained enrollee participation.

Hypothesis 1.6 Members (WP/MPC) will be most likely to complete incentivized behaviors with the largest real or perceived value.

Question 2 What personal characteristics are predictive of completing at least one behavior incentive, and the number (or extent) of behavior incentives completed?

Hypothesis 2.1 Members (WP/MPC) who have heard of the program from their health care provider are more likely to complete at least 1 behavior.

Hypothesis 2.2 Members (WP/MPC) who are young, white, female, and/or live in metro areas are more likely to complete at least 1 behavior.

Hypothesis 2.3 Members (WP/MPC) with poorer health status are less likely to complete the behaviors when compared to members with better health status.

Hypothesis 2.4 Members who do not pay a contribution (WP members less than 50% FPL) are less likely to complete behaviors compared to those who pay a contribution.

Hypothesis 2.5 Members (WP/MPC) receiving care at federally qualified health centers, rural health

clinics, and public hospitals will be more likely to participate in the incentive programs than members receiving care in other settings.

Question 3 Is engaging in behavior incentives associated with health outcomes?

Hypothesis 3.1 The program will improve WP/MPC members' access to health care.

Hypothesis 3.2 Health outcomes of WP/MPC members will be positively impacted by completing the healthy behaviors.

Question 4 What are the effects of the program on health care providers?

Hypothesis 4.1 Providers use the information from the Health Risk Assessment.

Hypothesis 4.2 Providers are encouraging patients to participate in the behavior incentive program.

Hypothesis 4.3 Providers are receiving their additional reimbursement.

Hypothesis 4.4 Providers are more likely to use the HRA with Wellness Plan members compared to Marketplace Choice Plan members

Hypothesis 4.5 The HRA changes communication between the provider and patient.

Hypothesis 4.6 The HRA changes provider treatment plans.

Hypothesis 4.7 There are barriers to providers using the HRA information.

Question 5 What are the effects of HBI on Medicaid costs?

Hypothesis 5.1 The costs of the program do not exceed the savings

Question 6 What are the implications of disenrollment?

Hypothesis 6.1 Disenrolled members do not understand the disenrollment process.

Hypothesis 6.2 Disenrolled members do not understand premiums.

Hypothesis 6.3 Disenrolled members do not understand the HBI program.

Hypothesis 6.4 Disenrolled members find it difficult to meet their health needs.

Hypothesis 6.5 Disenrolled members are unable to re-enroll due to administration issues.

Question 7 What are members' knowledge and perceptions of the HBI program?

Hypothesis 7.1 Members (WP/MPC) will value incentives offered to complete healthy behaviors.

Hypothesis 7.2 Members (WP/MPC) will be most willing to complete behaviors that have lower costs/barriers compared to those with higher benefits and relevance.

Hypothesis 7.3 Members (WP/MPC) with a greater sense of locus of control will be more willing to participate. Hypothesis 7.4 Members (WP/MPC) understand the logistics (for example- payment, payment options, requirements of the program, ...) of the HBI program.

Hypothesis 7.5 Members (WP/MPC) understand the purpose of HBI and how it is supposed to influence their behavior.

Hypothesis 7.6 Members (WP/MPC) do not report difficulties paying premiums related to payment form accepted by IME.

Question 8 What are the experiences of ACOs related to the Health Behavior Incentives Program?

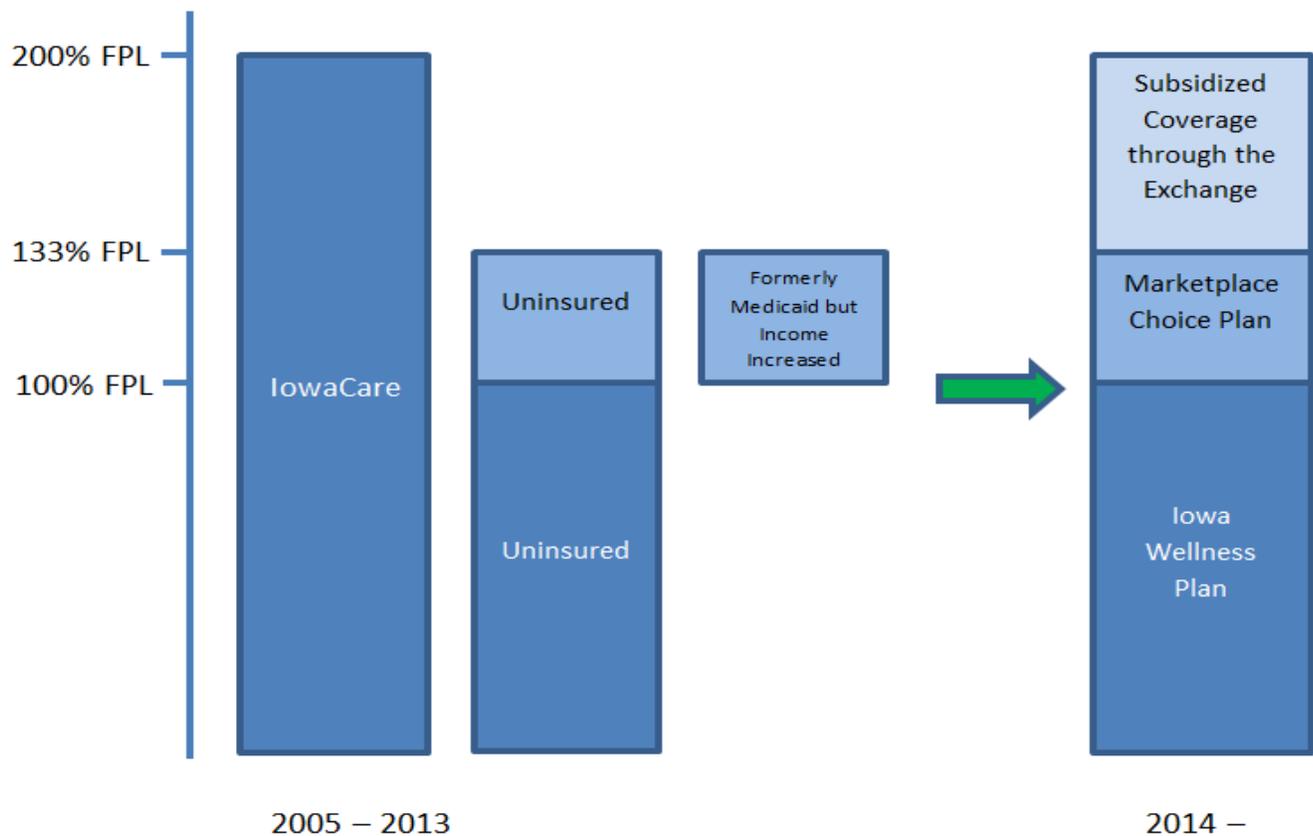
Hypothesis 8.1 ACOs experience barriers to reaching targets for wellness exams and HRA.

Hypothesis 8.2 ACOs promote the HBI program.

Hypothesis 8.3 ACOs experience advantages and successes from the HBI program.

Study Population and Comparison Groups

While Iowa is very fortunate to have more comparable data and comparison populations over time than many other states (e.g., IowaCare), there are still limitations to the comparability across populations due to income, categorical eligibility, and health status. We include all the comparison groups (shown in the figure below) to take advantage of the full range of values for as many variables as possible. Our ability to control for these variables over time and across the groups provides us with the most robust evaluation. At least some, if not all, pre and post demonstration data are available for each of following groups with the exception of those receiving subsidized coverage through the exchange. The data from these groups will be utilized throughout the evaluation as comparison groups where appropriate.



Study Population: Iowa Wellness & Marketplace Choice Plans

The focus of this evaluation is the examination of differences in outcomes between Iowa Wellness and Marketplace Choice Plan members and other comparison groups outlined below. Because there may be differences between the members in the Wellness Plan and the Marketplace Choice Plan, the evaluation will document and compare program outcomes for these groups as well.

Wellness Plan options

The **Wellness Plan** provides coverage for adults aged 19-64 years with income up to and including 100 percent of the Federal Poverty Level (FPL). It is administered by the Iowa Medicaid Enterprise (IME). Members will have access to the Medicaid provider network established for this program. Wellness Plan includes members enrolled via two methods.

- 1) Approximately 43,000 people previously enrolled in IowaCare who had incomes from 0 to 100% FPL
- 2) People who have never been in a public insurance program but meet the income eligibility for the Wellness Plan (0-100% FPL) may actively enroll (most were not categorically eligible before).

Wellness Plan members will have the options listed below depending on their county of residence.

Wellness Plan PCP: Operated through the Iowa Medicaid Enterprise, the PCP option will be available in 88 counties statewide. Members are assigned a primary care provider (PCP) who is reimbursed \$3 per member per month (PMPM) to manage routine and urgent care services and refer patients for specialty care for these patients. PCP assignment within the HMO or PCP is based on history of enrollment with a provider, provider closest to home, and appropriate provider specialty. Members have the option to change the assigned provider.

HMO: Meridian Health Plan is the only Medicaid HMO option in the state, operating in 29 counties in Iowa. It is available to Wellness Plan members in these 29 counties, where approximately half of the members will be initially assigned to the HMO (e.g., the PCP option mentioned below). Members have the option to change from the HMO to an Iowa Wellness Plan PCP available in their county. Meridian began operating in Iowa in March 2012 and now has approximately 41,000 members.

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

Marketplace Choice Plan options

The **Marketplace Choice Plan** provides coverage for adults aged 19-64 years and members enrolled via three methods: 1) approximately 6,700 people previously enrolled in IowaCare who had incomes from 101 to 133% FPL, 2) people who have been enrolled in Medicaid but due to increased income are now eligible for the Marketplace Choice Plan, and 3) those who have never been in a public insurance program but meet the income eligibility for Marketplace Choice (101-133% FPL).

Coventry Health Care is the health plan available to Marketplace Choice enrollees. It is a “diversified national managed care company based in Bethesda, MD”. They are also operating statewide and available on the Health Insurance Marketplace through the federal portal.

CoOpportunity Health was a non-profit co-operative health plan offered on the Health Insurance Marketplace through the federal government portal up until November 1, 2014. It was established with start-up funds provided through the ACA, and operates statewide in Iowa and Nebraska, in alliance with HealthPartners of Minnesota and Midlands Choice provider network. This plan has been recommended for liquidation by the Iowa Insurance Commissioner. Members from this plan have been moved into the FFS Iowa Wellness Plan.

Tentative Assignment Process

All member coverage begins the first of the month of application with PCP, HMO or QHP selection occurring only after eligibility has been determined. All members receive fee-for-service coverage for at least the first 10-45 days before the provider assignment is effective.

Members receive a PCP, HMO or QHP tentative assignment and have 10-45 days until that assignment is effective. The member has a total of 90 days to make a final selection (including the initial 10-45 days mentioned above). During this time, the member may make an alternative PCP selection, if no selection is made the tentative assignment is the default selection. Six months after enrollment, the member has another opportunity to change providers.

Comparison Group 1: Medicaid State Plan (Income Eligible)

Comparison Group 1 is composed of Medicaid State Plan members enrolled due to FPL between 0 and

66%. There are approximately 300,000 adults who will have at least one month of data in the study period. Analyses requiring longer terms of enrollment will naturally have fewer members.

Medicaid State Plan options

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

MediPASS PCCM: Iowa Medicaid State Plan has had a Primary Care Case Management (PCCM) program called MediPASS-(Medicaid Patient Access to Services System) since 1990. This program is available in 93 counties and has approximately 200,000 members. In counties where managed care is available, new enrollees are randomly assigned to a primary care provider (PCP) within either the PCCM (or the HMO if available in the county). PCP assignment within the PCCM is based on history of enrollment with a provider, provider closest to home, and appropriate provider specialty. Members have the option to change their assigned provider. Only members enrolled in Medicaid due to low income are able to enroll in MediPASS.

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

Comparison Group 2: Medicaid State Plan (Disability Determination)

Comparison Group 2 is composed of Medicaid State Plan members enrolled due to disability determination. The FPL for these members may range from 0 to 200%. There are approximately 25,000 adults in this group who will have at least one month of data in the study period. The only payment structure for these members is fee-for-service as they are not eligible for a managed care option.

Comparison Group 3: IowaCare

Comparison group 3 consists of former IowaCare enrollees. IowaCare was a limited provider/limited benefit program that operated from 2005-2013. The provider network included one public hospital in Des Moines, a large teaching hospital in Iowa City and 6 federally qualified health centers. It was for adults, not otherwise eligible for Medicaid, with incomes up to 200% FPL. The Iowa Health and Wellness Plan replaced the IowaCare program, providing the opportunity to utilize previously collected and assimilated administrative and survey data (pre-implementation data) for enrollees from this program. IowaCare enrollees were distributed in three places following the elimination of this program: 1) those with incomes 101-133% FPL were enrolled into Marketplace Choice, 2) those with incomes 0-100% FPL were enrolled in Wellness Plan, and 3) those whose income could not be verified were not enrolled in any program.

Limitations to the study populations

The IowaCare program did not provide prescription drug coverage. Members may have obtained medications from the IowaCare providers. Anecdotal evidence indicates the IowaCare enrollees with University of Iowa Health Care and Broadlawns Medical Center as their medical home were provided medications as part of their care, while those with a FQHC were not able to obtain medications on a regular basis through the medical home. This limits our ability to use the IowaCare data in measures that require data on medication use. In addition, members who are or become dually enrolled in

Medicaid and Medicare will be removed from the analyses, as we will not have accurate claims data.

Data Availability by Plan

Wellness Plan

1. Members shifted from IowaCare contribute pre and post implementation data.
2. Members who were not previously enrolled in a Medicaid program contribute post implementation data only.

Marketplace Choice Plan

1. Members shifted from IowaCare contribute pre and post implementation data.
2. Members shifted from another Medicaid program due to increased income contribute pre and post implementation data (these members would be ineligible for a Medicaid program in the absence of the Wellness Plan).
3. Members who were not previously enrolled in a Medicaid program contribute post implementation data only.

Comparison Groups 1 and 2 (Medicaid State Plan enrollees)

1. Members who have been enrolled in Medicaid before the implementation of the Marketplace Choice may contribute pre and post implementation data.
2. Members who were not previously enrolled in a Medicaid program contribute post implementation data only.

Comparison Group 3 (IowaCare)

1. Members who have been enrolled in IowaCare before the implementation of the Marketplace Choice Plan may contribute pre and post implementation data.
2. Members who were not previously enrolled in IowaCare program contribute post implementation data.

The IowaCare program ended December 31, 2013. The vast majority of these enrollees were auto-enrolled into either the Marketplace Choice or the Wellness Plan as shown in Table 1.

Table 1. Distribution of IowaCare members auto-enrolled in Wellness Plan and Marketplace Choice

	Wellness Plan	Marketplace Choice	
		CoOpportunity Health	Coventry
IowaCare	45,000	3,350	3,350

About 11,000 former IowaCare enrollees were not able to be auto-enrolled into a new plan due to insufficient income information. Table 2 provides the estimated enrollment numbers of each of these groups by payment structure.

Table 2. Study groups and estimated enrollment by payment structure as of February 11, 2014

Medicaid Program	Pre and post data	Pre data only	Post data only
Marketplace Choice Members			
CoOpportunity	3,350†	0	2,000
Coventry	3,350†	0	2,000
Total	6,700	0	4,000
Wellness Plan Members			
HMO	21,000†	3,000	2,500
PCCM	21,000†	3,000	2,500
FFS	3,000†	1,000	1,000
Total	45,000		6,000
Comparison Group 1: Medicaid State Plan members enrolled due to income			
HMO	40,000	10,000	10,000
PCCM	248,000	6,000	6,000
FFS	12,000	4,000	4,000
Total	300,000	20,000	20,000
Comparison Group 2: Medicaid State Plan members enrolled due to disability determination			
FFS	25,000	500	2,000
Total	25,000	500	2,000
Comparison Group 3: Former IowaCare enrollees			
IowaCare	0	70,000	0
Total	0	70,000	0

† Pre-implementation data from IowaCare

Providers

Providers willing to participate in Medicaid programs may opt to participate in one or all of the available health care models. They may contract with Meridian HMO separately from Medicaid or they may contract directly with Medicaid to provide care within the MediPASS PCCM, the Wellness Plan PCP, the traditional fee-for-service model or any combination of these.

Data Availability and Primary Collection

Data Access

The PPC has worked hand in hand with the State of Iowa to ensure that the assurances needed to obtain data are firmly in place. The PPC has a data sharing Memorandum of Understanding (MOU)

with the State of Iowa to utilize Medicaid claims, enrollment, encounter and provider data for approved research activities. All research activities must be approved by the University of Iowa Institutional Review Board and the Iowa Department of Human Services. Additional data agreements will be initiated as needed, though at present none are anticipated.

Administrative data

The Iowa evaluation provides a unique opportunity to optimize several sources of data to assess the effects of innovative coverage options. The PPC is home to a Medicaid Data Repository encompassing over 100 million claims, encounter, and eligibility records for all Iowa Medicaid enrollees for the period January 2000 through the present. Data are assimilated into the repository on a monthly basis. Ninety-five percent of medical and pharmaceutical claims are completely adjudicated within 3 months of the first date of service, while the 'run out' for institutional claims is 6 months. PPC staff has extensive experience with these files as well as with CMS adult core measures and HEDIS measures. In addition, the database allows members to be followed for long periods of time over both consecutive enrollment months and periods before and after gaps in coverage. When the enrollment database was started in 1965, Iowa made a commitment to retain a member number for at least 3 years and to never reuse the same Medicaid ID number. This allows long term linkage of member information including enrollment, cost and utilization.

The collection and assimilation of health care encounters for Wellness Plan and Marketplace Choice Plan members coupled with Medicaid fee schedules provides more unique opportunities to estimate differences in cost. This will be a valuable comparison versus using plan premiums and much more timely for 1st year estimates of cost differences and the potential impact on subsequent years' premiums.

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

Healthy behavior data

The evaluation team will need access to data related to the completion of the incentivized healthy behaviors. Data on the completion of the wellness exam will be available to the team through the Medicaid administrative claims database, but the completion of the Health Risk Assessment and the other healthy behaviors are not currently a part of these Medicaid data. To actually assess the impact of the HRA and other healthy behaviors, data will be required about what behaviors enrollees complete and when these are completed.

Consumer data

The guiding framework for the consumer data is understanding how consumers weigh the costs and benefits of participation in the incentive program. The Health Belief Model provides a systematic way to examine health behavior decision-making (Becker, 1974). The model suggests that individuals weigh the perceived benefits, barriers, and self-efficacy to performing a behavior, as well as the perceived susceptibility and severity of the negative health outcome which could result from not performing the behavior. This model will be used to inform the qualitative and quantitative data collection and analysis for the consumer data.

Enrollee Survey

The PPC has worked with the developers of the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) survey and utilized CAHPS survey measures for over 15 years to conduct enrollee surveys for the Iowa Medicaid Enterprise (IME). This experience provides the team with the knowledge and skills to successfully gather information from enrollees. Additionally the team has experience using qualitative formative data to inform the development of surveys.

To inform the development of the survey items, a qualitative data collection will be conducted before each survey is designed. The qualitative data will provide information about experiences, perceptions, barriers, and motivators needed in order to ensure the survey items and response categories reflect the enrollees' experiences. Specifically the interview protocol will contain the components of the Health Belief Model (perceived susceptibility, perceived severity, perceived benefits, perceived barriers, self-efficacy and cues to action). The interview will explore enrollees' knowledge, perception and experience with the health behavior incentive program. A sample of 50 enrollees will be sent a recruitment letter asking them to participate in an in-depth telephone interview. The findings from the interviews will be used to inform survey questions.

The surveys will include CAHPS measures and supplemental items. The supplemental items will address issues specific to the healthy behaviors. We will assess enrollees' awareness of the program and its components. Their overall perceptions of the program will be documented. Specific to each behavior, we will examine their perceptions of the behavior and the incentives. Barriers and motivators to completing the specific behaviors will be documented. We include several demographic and self-reported health items to be used as adjustment variables in the analyses.

The first survey will serve as a method for collecting data on the experiences of enrollees with the wellness exam and HRA incentive/disincentive program, as a pretest to the expanded healthy behavior incentive program, and as a method for collecting information about perceptions surrounding incentivizing healthy behaviors. The second survey will continue to provide information about enrollees' experiences with the wellness exam and HRA, and will be used to gather information about the expanded healthy behavior incentive program.

We will use a mail-back survey methodology with an opportunity for members to complete the survey online. Surveys will be mailed to a plan-stratified and healthy behavior incentive participation-stratified random sample of enrollees who have been in their current plan for at least the previous last six months. Only one person will be selected per household to reduce the relatedness of the responses and respondent burden.

The final sample sizes will be determined based on enrollment in each program and participation in the healthy behaviors incentive program.

In an effort to maximize response rates for the mailed survey, both a premium and an incentive are used during the first mailing. Each survey packet will include a \$2 bill. In addition, survey identification numbers of respondents completing the questionnaire within the first four weeks of the study are entered into a random drawing for one of ten \$25 Wal-Mart gift cards.

Iowa's Medicaid survey response rates mirror the national experience of declining response rates on surveys. For this evaluation we will work to increase the number of surveys that are completed by drawing larger sample sizes as directed by NCQA for Medicaid samples (n=1,350 per group). New, real-time tracking methods have been developed to closely track the response rates. Should they

appear to be low, we will institute telephone follow-up and additional emphasis on the multimodal approaches. In addition, for the evaluation we will be working with The University of Iowa IRB to develop recruitment materials allowing us to link claims and survey data.

Linking of survey data to claims data

The team will continue to explore the possibilities of linking survey data with claims data. The team is consulting with the University of Iowa Institutional Review Board to better understand how the linking would impact the consent process. Currently, survey participants are presented the elements of consent and returning the survey is considered a sign of consent. Consent is waived for claims data analysis. If written informed consent is required, the team will need to consider the implications for response rates, the ability to detect changes with small effect sizes, and the additional costs. The team is investigating options such as linking survey and claims data on a specific group of members (e.g., diabetics), as opposed to the entire sample. The team will report back to IME and CMS as this portion of the evaluation develops over the next 6 weeks.

Disenrollment in-depth interviews

In-depth telephone interviews will be conducted with a sample of those that have been disenrolled. A total of 100 disenrolled members will be asked to participate. Using standard qualitative methods, data collection will end when saturation has been reached. Saturation is the point at which no new information is being gleaned from new respondents. Potential participants will be sent a letter asking them to participate in an in-depth telephone interview. The letter will be followed up with a telephone call inquiring about interest to participate. Interested participants will be interviewed via telephone. The interviews will be conducted by trained qualitative researchers. The interviews will be recorded and transcribed. The interview protocol will consist of open-ended questions that will assess the research questions listed above. The transcripts will be coded using both Grounded Theory and closed coding methods. The team of coders will code and compare a sample of the transcripts to establish inter-coder reliability before coding begins.

Enrollee Qualitative Interviews

To inform the survey development, in-depth qualitative interviews will be conducted with enrollees from the following categories:

	Completed no healthy behaviors	Completed wellness exam only	Completed HRA only	Completed wellness exam and HRA only	Completed one expanded healthy behavior	Completed more than one expanded healthy behavior
WP/MPC	10	10	10	10	10	10

The interview protocols will be open-ended in order to elicit the widest range of responses and to capture the narratives of the enrollees.

Provider assessments

The purpose of the provider assessments is to understand how the healthy behavior incentive program influences provider behavior. We are interested in determining if providers talk about the

program with their patients, if they use the information from HRAs, if they are receiving their incentives, and how the program impacts their communication and relationship with their patients. This information will be gathered through two surveys and two sets of in-depth interviews with providers and/or clinic managers.

Provider surveys

Health care providers will be surveyed twice during the study period. The first survey will establish providers' knowledge of and experience with the incentive program, focusing on the wellness exam and HRA. The second survey will include items about the expanded incentive program. The PPC has experience successfully surveying health care providers and will use multiple methods to collect survey data including mail back, online, fax, and telephone.

Provider in-depth interviews

To gain more detailed information about how the provider and clinics are interacting with the program and enrollees, in-depth interviews will be conducted with health care providers and/or clinic managers. The interviews will be conducted over the telephone, recorded and transcribed.

ACO assessment

In-depth interviews with ACO leaders who are integral to the Healthy Behavior Incentives program will be conducted. The interviews will be conducted in 2015 to assess the experiences of the past year related to the wellness exam and the HRA. In late 2016, interviews will focus on the expanded health behaviors. The interview protocols will be designed to assess barriers, the role of the ACO and advantages and successes. The interviews will be conducted over the telephone or in person. They will be recorded and transcribed.

Data analyses

The six major analytic strategies within this evaluation are described in detail below:

1. Process measures
2. Means testing
3. Interrupted time-series design
4. Multivariate modelling
 - a. Regression Discontinuity Design (RDD)
 - b. Difference-in-Differences (DID)
5. Incremental cost effectiveness
6. Qualitative analyses

Process Measures

Process measures are designed to describe the state of the program or some aspect of the program, but do not lend themselves to testing. Process measures include frequencies and descriptive statistics.

Means Testing

Many of the outcome measures are population-based, making it impossible to model the outcomes and their predictors. For these population measures, means testing for the groups before and after implementation will provide us with an understanding of the programmatic effects.

Interrupted Time-Series Design

While the DID approach is ideal for detecting whether the intervention has had an effect among those in the treatment group while controlling for a variety of other variables, we will graphically present the results of an interrupted time-series design to determine the overall trends in certain population based outcome measures among participants and non-participants. For example, this will be useful in helping us to determine whether there is any worsening of outcomes over time among non-participants that occurs after the program is implemented, apart from any downward trends that were already occurring prior to implementation.

Multivariate Modelling

Measures from the Medicaid Adult Core Set, NCQA HEDIS, and survey will be modelled using logistic regression, DID and RDD. Many of our outcomes are population-based; however, through modification of the protocols they will also be measured as individual outcomes most often through a dichotomous variable indicating whether or not the member had a service (e.g., person with type 1 or type 2 diabetes receiving a Hemoglobin A1c) or experienced an outcome (e.g., asthma exacerbation).

RDD is particularly useful for estimates of effects for members who are very close to a program qualification threshold. The selection of members from comparison groups around the financial threshold strengthens the analyses by pinpointing program effects for a limited range of members assumed to have similar traits.

Claims data including medical, inpatient, outpatient, encounter, and prescription claims will be used to determine PMPM costs for the study period (January 2011-present). Claims data typically require a 3-6 month run out period to ensure that at least 95% of claims have been adjudicated. This varies by claim type with medical claims requiring 3 months and inpatient claims requiring at least 6 months. PMPM costs will be calculated for all services (total cost), medical care, inpatient care, emergency care, and prescriptions. Though the question of whether the program provides savings can be adequately assessed through the analyses of total PMPM cost, looking at subsets of PMPM costs can help us understand how and in what domains the PMPM costs were most significantly affected. These calculations provide the basis for cost effectiveness analyses.

For the modeling, we will employ RDD and DID. For programs where a natural comparison group exists, DID methods are very useful. RDD is used to offer estimates around specific program thresholds. For program groups where no natural comparisons exist, regression controlling for observed patient or area characteristics will be utilized. The specific analysis technique will depend on the distribution of the dependent variable (e.g., OLS for continuous variables and logistic regression for dichotomous variables). When appropriate, person, program or area fixed effects will be used to control for time-invariant individual (or program or area) effects and year effects. Each method has strengths and weaknesses, but combined should offer a robust analysis of program effects on costs and outcomes.

We will model PMPM costs using a fixed effects regression modeling technique for the cost categories

listed above from 2011 to present including person and time fixed effects for the period. Members will enter the regression for any months in which they are enrolled in one of the plans/programs: The Wellness Plan, Marketplace Choice Plan, Medicaid State Plan due to income level, or Medicaid State Plan due to disability determination. Sensitivity analyses will include varying the groups included in the analyses and varying the time component for DID.

$$PMPM_{it} = \alpha_i + \beta_1 Group_{it} * POST_t + \beta_2 Group_{it} + \beta_3 Post_t + x'\beta_4 + \beta_{5t} Year_t + u_{it}$$

Where $POST_t$ is a dummy variable for observations after the program has taken effect, α_i identifies individual fixed effects, and $YEAR_t$ captures time trends.

PMPM cost-PMPM costs for members in the PCCM/PCP or under the FFS payment structure will be calculated using the cost of all services plus any care coordination fees. For members in the Marketplace Choice Plan and HMO members, PMPM will be calculated using two methods. First, the analyses will be completed with PMPM costs calculated as the monthly premium. Second, Marketplace Choice Plan PMPM costs will be calculated as though the member had not been enrolled in the QHP (Qualified Health Plan) by applying the Medicaid fee schedule to QHP encounter data in an effort to estimate what the actual costs to Medicaid would have been without this marketplace option.

Group-represents a series of indicator variables that provide study group comparisons. The variables will capture whether the individual was in the program of interest. As part of the interrupted time series design, we can also capture whether an individual has switched programs in a given month. We will use dummy indicators for whether during the month a member was in the Marketplace Choice (0,1), Wellness Plan (0,1), IowaCare (0,1), enrolled in Medicaid due to disability determination (0,1), or enrolled in Medicaid due to low income (0,0).

X represents a matrix of covariates including:

Payment structure-series of dichotomous variables that provide payment structure comparisons. The variables will indicate whether during the month a member was in the HMO (0, 1), PCCM (0, 1), or fee-for-service (0, 0).

Age-calculated monthly

Age squared-to allow for a curvilinear relationship between age and costs

Gender

Race-within the Medicaid data 30% of enrollees/members do not identify a race. Previous analyses have indicated that this option does not appear to have a race-based bias or systematic component. We will perform the analyses with this group identified as race 'Undisclosed' and without this group.

Number of chronic conditions-The Health Home program in Iowa Medicaid utilizes seven diagnoses to establish member participation: mental health condition, substance use disorder, asthma, diabetes, heart disease, overweight, and hypertension. A count of these conditions will serve as the chronic conditions measure though the severity of impairment will be unattainable.

Risk adjustment-Risk stratification provides an adjustment for the model to determine whether there are high risk groups of enrollees whose costs are more likely to be reduced through the Wellness Plan. If the group benefitting from the program is small the change in cost may not be evident in generalized models. By adjusting for risk we will be able to elucidate these PMPM cost differences for potentially smaller groups. We are investigating using a modified King's Fund

Combined Model algorithm which utilizes inpatient stays, emergency department visits and outpatient visits in the previous 12 months to construct risk strata (http://www.kingsfund.org.uk/sites/files/kf/field/field_document/PARR-combined-predictive-model-final-report-dec06.pdf). Additionally, we will attempt to develop risk stratification based on medical diagnoses, physical diseases and disorders. We will determine the exact method of stratifying the enrollees (e.g., Elixhauser, Quan, etc.) once we are able to analyze the data and determine whether we are able to construct risk stratification for each month and how we will provide a risk stratification mechanism for the control groups.

Inclusion in other reform initiatives-The analyses will include whether the enrollee/member is participating in any other reform initiatives provided through the Medicaid program including health home for the chronically ill, integrated health home, or other initiatives that may develop over the course of the evaluation.

Rural/urban-Rural-urban continuum codes (RUCC) provided through the US Department of Agriculture will be included. We will also test the model with the county of residence as a covariate; however, past analyses indicate that the RUCC is sufficient.

Income-Percent poverty will be included as it appears on the enrollment files.

The difference in PMPM costs in Year 1 between those in the Marketplace Choice and those not in Marketplace Choice times the number of enrollee months in Marketplace Choice provides an estimate of cost savings in Year 1. Savings will be adjusted downward by administrative costs. Application of the PMPM savings amount for Year 1 as adjusted by administrative costs to estimated enrollee months in Marketplace Choice for Years 2 and 3 should provide future savings estimates. All cost savings will be adjusted for inflation.

Incremental Cost Effectiveness

Cost effectiveness analyses combine the costs of care with quality and access to determine whether changes in cost, even if positive, resulted in better quality and/or access providing either cost-savings or at least a better value for each additional dollar spent. A difficulty with cost effectiveness analyses is handling the lag time of effects. For example, though dollars are shifted to preventive care allowing people with diabetes to access primary care to include foot exams, eye exams, cholesterol testing and Hemoglobin A1c in an effort to control the disease and mitigate long term effects, changes in health may not appear in the form of reduced hospitalizations or avoidable emergency room visits for over a year. Therefore, analyses related to cost effectiveness will tend to highlight initial preventive care costs in the first year for outcomes that may improve with lagged effects in year 2 or year 3 of the demonstration. Incremental cost effectiveness (ICER) is established by taking the difference in outcome between the study group and the control groups over the difference in cost between the study group and the control groups. As we analyze year 2 and beyond we will vary the discount rate in our cost-effectiveness analysis to be sensitive to these lagged effects and their impact on program effectiveness. Survey measures can add depth to these analyses by noting improvements in the pathways that suggest future improvements in outcomes. Costs will include Medicaid claims, capitation, and administrative costs for the study and comparison groups.

The measures we anticipate using for the ICER follow with the formulas to calculate ratios for HBI participants (HBI) defined as those who completed at least 1 healthy behavior versus non-participants (NP) defined as those who did not complete any healthy behavior. These ratios provide a challenge to the evaluation team in trying to determine the definition of a 'true' participant. Can an individual who has had a well-exam that would have occurred regardless of the program be

considered a 'participant'? Further discussion with CMS and the State of Iowa will be needed to refine this construct.

Measure 11A Adult access to preventive/ambulatory health services

$$\frac{\text{Total Cost}_{(HBI)} - \text{Total Cost}_{(NP)}}{\text{Adult Access}_{(HBI)} - \text{Adult Access}_{(NP)}}$$

$$\frac{\text{Primary Care Cost}_{(HBI)} - \text{Primary Care Cost}_{(NP)}}{\text{Adult Access}_{(HBI)} - \text{Adult Access}_{(NP)}}$$

$$\frac{\text{Inpatient Cost}_{(HBI)} - \text{Inpatient Cost}_{(NP)}}{\text{Adult Access}_{(HBI)} - \text{Adult Access}_{(NP)}}$$

This outcome measure will be utilized as the denominator for 3 ratios with numerators for total cost, primary care cost, and inpatient cost. We would anticipate that health care coverage through a program that encourages well visits would reduce total costs, despite a rise in primary care costs. This decrease is anticipated to derive from fewer hospitalizations through the early detection and timely monitoring and management of diseases and chronic conditions.

Measure 31A Non-emergent ED use

$$\frac{\text{Total Cost}_{(HBI)} - \text{Total Cost}_{(NP)}}{\text{Non-emergent ED Use}_{(HBI)} - \text{Non-emergent ED Use}_{(NP)}}$$

$$\frac{\text{Primary Care Cost}_{(HBI)} - \text{Primary Care Cost}_{(NP)}}{\text{Non-emergent ED Use}_{(HBI)} - \text{Non-emergent ED Use}_{(NP)}}$$

$$\frac{\text{ED Cost}_{(HBI)} - \text{ED Cost}_{(NP)}}{\text{Non-emergent ED Use}_{(HBI)} - \text{Non-emergent ED Use}_{(NP)}}$$

$$\frac{\text{Specialist Cost}_{(HBI)} - \text{Specialist Cost}_{(NP)}}{\text{Non-emergent ED Use}_{(HBI)} - \text{Non-emergent ED Use}_{(NP)}}$$

This outcome measure will be utilized as the denominator for four ratios with numerators for total cost, primary care cost, ED cost and specialist cost. Access to comprehensive care should result in increased access to and cost of primary care and specialist care, however, this increased access to less costly care options should also result in lower ED costs and lower total costs.

Measure 36 Admission rate for diabetes short-term complications and asthma

$$\frac{\text{Total Cost}_{(HBI)} - \text{Total Cost}_{(NP)}}{\text{Admission Rate}_{(HBI)} - \text{Admission Rate}_{(NP)}}$$

$$\frac{\text{Inpatient Cost}_{(HBI)} - \text{Inpatient Cost}_{(NP)}}{\text{Admission Rate}_{(HBI)} - \text{Admission Rate}_{(NP)}}$$

This outcome measure will be utilized as the denominator for two ratios with numerators for total cost and inpatient cost. Access to comprehensive care should result in reduced admissions for these manageable chronic conditions. We anticipate that the total costs and inpatient costs will be reduced.

Qualitative Analyses

Interviews -Qualitative data will be digitally recorded and transcribed. The transcripts will be coded using a combination of open (Grounded Theory) and closed coding. Nvivo 10 will be used for coding and analysis. Three trained coders will code the transcripts. Intercoder reliability will be established. The analysis will focus on identifying salient themes and the relationships between the themes that are relevant to the evaluation.

Limitations

As with all evaluations, there will be limitations to the interpretation of these results and possible biases if comparison groups are not similar to the treatment groups. Survey data, for example, are based on self-reported information and the recall of the enrollee. Response bias is also a potential. Non-response bias tests will be conducted to determine if the characteristics of respondents differ significantly from non-respondents. Administrative data are collected for billing and tracking purposes and may not always accurately reflect the service provided.

Much of the success of this evaluation depends heavily on the ability to receive timely data on the HRA and other healthy behaviors from IME and the as yet undetermined vendor. Currently the evaluation is designed with the receipt of previous year's HRA data on May/June of every year. We are also assuming data will be available about the other healthy behaviors by May/June of 2016. If the data are not available as outlined in the timeline, data collections and analysis will be delayed. We will propose a new timeline for data collection, analysis and reports based on a delayed receipt of the data. If the data are not available to us for the evaluation, we will have to rely on self-report through survey data. This would require us to redesign the evaluation to collect more data from enrollees at earlier time points. It also may require us to increase the number of enrollees we survey, because we will not be able to sample based on completion of healthy behaviors. An additional limitation is related to the current lack of concrete information about the other healthy behaviors that will be part of the program. The specific health outcomes which will be analyzed in the claims data and the survey questions will be tailored to the specific healthy behaviors. Once a vendor has been selected for this portion of the program, we will work with the vendor to establish which behaviors and incentives are being incorporated into the program. At that time, the evaluation will be revised and submitted by IME to CMS for review and approval.

Operationalization of Research Questions and Hypotheses

Understanding the effects of new programs on the access to health care, utilization of health care, and outcomes of health care is a complex undertaking requiring a variety of methods and analytical approaches. This evaluation incorporates population-based outcomes as well as individual assessments in an attempt to provide a balanced evaluation. The research questions, hypotheses, methods, and analyses proposed below represent our current understanding of the program and its incentives. However, we believe that additional information may yield to changes in the measures or analyses. Such changes will only be implemented in collaboration with the State of Iowa DHS and CMS.

Question 1 Which activities do enrollees complete?

Hypothesis 1.1 The proportion of Wellness Plan (WP) members and Marketplace Choice (MPC) members who complete a wellness exam is greater than the proportion of Medicaid State Plan

(MSP) or IowaCare members who complete an exam.

Measure 1 Proportion of members who had a preventive care visit

Protocol-NCQA HEDIS AAP

Data source-Administrative

Analyses-Means tests between WP/MPC members and three comparison groups before and after implementation

Hypothesis 1.2 The proportion of WP/MPC members who complete a Health Risk Assessment is greater than 50%.

Measure 2 Proportion of WP/MPC members completing HRA

Protocol-Original

Data source-Administrative

Analyses- Descriptives regarding the rate of completion for WP/MPC members

Hypothesis 1.3 The proportion of WP/MPC members who are eligible to participate complete at least one behavior incentive is greater than 50%.

Measure 3 Whether a WP/MPC member completed a healthy behavior

Protocol-Original

Data source-Administrative

Analyses-Descriptives regarding the rate of completion for WP/MPC members

Hypothesis 1.4 Members (WP/MPC) are most likely to complete the behaviors that require the least amount of effort.

Measure 4 Respondent report of how easy it is for them to obtain a yearly physical exam

Protocol-Original items

Data source-Member Survey

Analyses- Analysis comparing those who have completed the healthy behaviors and those who did not

Hypothesis 1.5 Members (WP/MPC) will be least likely to complete incentivized behaviors requiring sustained participation.

Measure 5 Completion of healthy behavior by perceived sustained effort

Protocol-Original

Data source-Administrative, Consumer survey

Analyses- Means tests of rates of completion of healthy behaviors by survey estimated sustained effort for WP/MPC members

Hypothesis 1.6 Member (WP/MPC) will be most likely to complete incentivized behaviors with the largest real or perceived value.

Measure 6 Completion of healthy behavior by value of behavior

Protocol-Original

Data source-Administrative, Consumer survey

Analyses- Means tests of rates of completion of healthy behaviors by survey estimated value of behavior for WP/MPC members

Measure 7 Completion of healthy behavior by value of incentive

Protocol-Original

Data source-Administrative, Consumer survey

Analyses- Means tests of rates of completion of healthy behaviors by survey estimated value of incentive for WP/MPC members

Question 2 What personal characteristics are predictive of completing at least one behavior incentive, and the number (or extent) of behavior incentives completed?

Hypothesis 2.1 Members (WP/MPC) who have heard of the program from their health care provider are more likely to complete at least 1 behavior.

Measure 8 Reported completion of healthy behavior by source of information

Protocol-Original

Data source-Consumer survey, Administrative

Analyses- Logistic regression modeling of HBI participation

Hypothesis 2.2 Members (WP/MPC) who are young, white, female, and/or live in metro areas are more likely to complete at least 1 behavior.

Measure 9 Completion of healthy behavior by demographic characteristics

Protocol-Original

Data source-Administrative

Analyses- Logistic regression modeling of HBI participation

Hypothesis 2.3 Members (WP/MPC) with poorer health status are less likely to complete behaviors compared to members with better health status.

Measure 10 Health Status by completion of healthy behavior

Protocol-Original

Data source-Administrative

Analyses- Logistic regression modeling of HBI participation

Hypothesis 2.4 Members who do not pay a contribution (WP members less than 50% FPL) are least likely to complete behaviors compared to those who pay a contribution.

Measure 11 Proportion of members who complete the healthy behaviors prior to the application of the premium payment

Protocol-Original
Data source-Administrative
Analyses-Means tests between MPC members and WP members

Measure 12 Proportion of members who complete the healthy behaviors only after the application of the premium payment

Protocol-Original
Data source-Administrative
Analyses-Means tests between MPC members and WP members

Measure 13 Proportion of members who are disenrolled due to the application of a premium payment as a result of not completing the healthy behaviors

Protocol-Original
Data source-Administrative
Analyses-Process measures for MPC members

Hypothesis 2.5 Members (WP/MPC) receiving care at federally qualified health centers, rural health clinics, and public hospitals will be more likely to participate in the incentive programs than enrollees receiving care in other settings.

Measure 14 Completion of healthy behavior by type of provider

Protocol-Original
Data source-Administrative
Analyses- Logistic regression modeling of HBI participation

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

Hypothesis 3.1 The program will improve WP/MPC members' access to health care.

Measure 15 Adults access to primary care

15A Percent of members who had an ambulatory care visit

Protocol-NCQA HEDIS AAP
Data source-Administrative
Analyses-Means tests between WP/MPC members and three comparison groups before and after implementation

15B Whether a member had an ambulatory or preventive care visit

Protocol-NCQA HEDIS AAP adapted as individuals

Data source-Administrative

Analyses-RDD comparing MPC members and WP members at the threshold

DID for WP/MPC members and three comparison groups before and after implementation

Measure 16 Access to and unmet need for urgent care

Composite of two questions 1) rating of timely access to urgent care and 2) needed urgent care but could not get it for any reason.

Protocol-CAHPS 5.0; NHIS

Data source-Member Survey

Analyses-Means tests between WP/MPC members and three comparison groups after implementation

Measure 17 Access to and unmet need for routine care

Composite of two questions 1) rating of timely access to routine care and 2) needed routine care but could not get it for any reason.

Protocol-CAHPS 5.0; NHIS

Data source-Member Survey

Analyses-Means tests between WP/MPC members and three comparison groups after implementation

Measure 18 Getting timely appointments, care, and information

Composite of 3 questions 1) member experience with getting appointments for care in a timely manner, 2) time spent waiting for their appointment, and 3) receiving timely answers to their questions.

Protocol-CAHPS 5.0

Data source-Member Survey

Analyses- Analysis comparing those who have completed the healthy behaviors and those who did not

Measure 19 Prescription medication

Access to and unmet need for prescription medication

Protocol-CAHPS 4.0; NHIS

Data source-Member Survey

Analyses- Analysis comparing those who have completed the healthy behaviors and those who did not

Measure 20 Comprehensive diabetes care: Hemoglobin A1c

20A Percent of members with type 1 or type 2 diabetes who had Hemoglobin A1c testing

Protocol-NCQA HEDIS CDC; NQF 0057, Adult core measure #19

Data source-Administrative

Analyses-Means testing between WP/MPC members and the three comparison groups before and after implementation

20B Whether a member with type 1 or type 2 diabetes had Hemoglobin A1c testing

Protocol-NCQA HEDIS CDC; NQF 0057, Adult core measure #19 adapted for individuals

Data source-Administrative

Analyses-RDD comparing MPC members and WP members at the threshold DID for WP/MPC members and three comparison groups before and after implementation

Measure 21 Comprehensive diabetes care: LDL-C screening

21A Percent of members with type 1 or type 2 diabetes who had LDL-C screening

Protocol-NCQA HEDIS CDC; NQF 0063, Adult core measure #18

Data source-Administrative

Analyses-Means testing between WP/MPC members and the three comparison groups before and after implementation

21B Whether a member with type 1 or type 2 diabetes had LDL-C screening

Protocol-NCQA HEDIS CDC; NQF 0063, Adult core measure #18 adapted for individuals

Data source-Administrative

Analyses-RDD comparing MPC members and WP members at the threshold DID for WP/MPC members and three comparison groups before and after implementation

Measure 22 Preventive care

Access to and unmet need for preventive care

Protocol-Original item; NHIS

Data source-Member Survey

Analyses-Analysis comparing those who have completed the healthy behaviors and those who did not

Measure 23 Ambulatory Care

This measure summarizes utilization of outpatient visits and emergency department visits as a rate per 1,000 member months for members age 19-64 years enrolled for at least 1 month during the measurement year.

Protocol-NCQA HEDIS AMB

Data source-Administrative

Analyses-Means testing between WP/MPC members and the three comparison

Measure 24 Regular source of care – Personal Doctor

The percent who respond that they currently have a personal doctor

Protocol-CAHPS 5.0

Data source-Member Survey

Analyses-Means testing between WP/MPC members and the three comparison groups before and after implementation

Hypothesis 3.2 Health outcomes of WP/MPC members will be positively impacted by completing the healthy behaviors.

Measure 25 Non-emergent ED use

25A Number of non-emergent ED visits per 1,000 member months

Protocol-Original measure

Data source-Administrative

Analyses-Means testing between MPC members and the 4 comparison groups before and after implementation

25B Whether member had a non-emergent ED visit

Protocol-Original measure

Data source-Administrative

Analyses-RDD comparing MPC members and WP members at the threshold DID using MPC and the 4 comparison groups before and after implementation

Measure 26 Follow-up ED visits

26A Percent of members with ED visit within the first 30days after index ED visit

Protocol-Original measure

Data source-Administrative

Analyses-Means testing between MPC members and the 4 comparison groups before and after implementation

26B Whether member had an ED visit within the first 30 days after index ED visit

Protocol-Original measure

Data source-Administrative

Analyses-DID using MPC and the 4 comparison groups before and after implementation

Measure 27 Admission rate for diabetes short-term complications, and asthma

The number of discharges for short-term complications from diabetes or asthma per

100,000 Medicaid members

Protocol-Original measure

Data source-Administrative

Analyses-Means tests between MPC members and four comparison groups before and after implementation

Measure 28 Admission rate for diabetes short-term complications

28A Number of discharges for diabetes short-term complications per 100,000 Medicaid members

Protocol-Adult Core Measures #8, PQI 01

Data source-Administrative

Analyses-Means tests between MPC members and four comparison groups before and after implementation

28B Whether member had an admission for diabetes short-term complications

Protocol-Adult Core Measures #8, PQI 01 adapted for individual

Data source-Administrative

Analyses-DID using MPC and the 4 comparison groups before and after implementation

Measure 29 Admission rate for asthma

29A Number of discharges for asthma per 100,000 Medicaid members

Protocol-Adult Core Measures #11, PQI 15

Data source-Administrative

Analyses-Means tests between MPC members and four comparison groups before and after implementation

29B Whether member had an admission for asthma

Protocol-Adult Core Measures #11, PQI 15 adapted for individual

Data source-Administrative

Analyses-DID using MPC and the 4 comparison groups before and after implementation

Measure 30 Inpatient utilization-general hospital/acute care

This measure summarizes utilization of acute inpatient care and services in the following categories: total inpatient, surgery and medicine using number of discharges per 1000 member months, number of days stay per 1000 member months and average length of stay for all members who were enrolled for at least 1 month during the measurement year

Protocol-NCQA HEDIS IPU

Data source-Administrative

Analyses-Means tests between MPC members and four comparison groups before and after implementation

Measure 31 Plan “all cause” hospital readmissions

For members age 19-64 years who were enrolled for at least on month during the measurement year, the number of acute inpatient stays during the measurement year that were followed by an acute readmission for any diagnosis within 30 days and the predicted probability of an acute readmission

Protocol-NCQA HEDIS PCR; NQF 1768; Adult Core Measures #7

Data source-Administrative

Analyses-Means tests between MPC members and four comparison groups before and after implementation

Measure 32 Rate of 30 day hospital readmissions

30 day readmissions reported in last 6 months

Protocol-Original items

Data source-Member Survey

Analyses- Analysis comparing those who have completed the healthy behaviors and those who did not

Question 4 **What are the effects of the program on health care providers?**Hypothesis 4.1 Providers use the information from the Health Risk Assessment.

Measure 33 Provider reported use of HRA

33A Percent of providers who report using HRA

Protocol-Original

Data source-Provider survey, Provider in-depth interviews

Analyses-Qualitative

33B How providers use HRA

Protocol-Original

Data source- Provider survey, Provider in-depth interviews

Analyses-Qualitative

Hypothesis 4.2 Providers are encouraging patients to participate in behavior incentive programs.

Measure 34 Percent of providers reporting encouraging patients to participate

Protocol-Original

Data source-Survey, In-depth interviews

Analyses-qualitative

Measure 35 Enrollees report providers encouraging them to participate

35A Percent of enrollees reported provider encouraged participation

Protocol-Original

Data source-Consumer survey

Analyses- Means test comparing groups who reported provider encouragement and those that did not

35B Percent of enrollees who reported participation

Protocol-Original

Data source-Consumer survey

Analyses-Means test comparing groups who reported provider encouragement and those that did not

Hypothesis 4.3 Providers are receiving their additional reimbursement.

Measure 36 Percent of providers reporting reimbursement

Protocol-Original

Data source-Provider survey

Analyses-Process

Hypothesis 4.4 Providers are more likely to use the HRA with Wellness Plan members compared to Marketplace Choice Plan members

Measure 37 Providers reporting using HRA

37A Percent of providers who use HRA with Wellness Plan and Marketplace Choice Plan members

Protocol-Original

Data source-Provider survey

Analyses-Process

37B Providers reporting on using HRA

Protocol-Original

Data source-In-depth interview

Analyses-Qualitative analysis

Hypothesis 4.5 The HRA changes communication between the provider and patient.

Measure 38 Providers reported changes in communication with patients due to HRA

Changes in communication due to use of HRA

Protocol-Original

Data source-Provider in-depth interviews

Analyses-Qualitative

Hypothesis 4.6 The HRA changes provider treatment plans.

Measure 39 Provider reported changes in treatment plans due to HRA

Protocol-Original
Data source-Provider in-depth interviews
Analyses-Qualitative

Hypothesis 4.7 There are barriers to providers using the HRA information.

Measure 40 Provider reported barriers to using the HRA information

Protocol-Original
Data source-Provider in-depth interviews
Analyses-Qualitative

Question 5 What are the effects of HBI on Medicaid costs?Hypothesis 5.1 Costs of the program do not exceed the savings

Measure 41 Compare PMPM costs for those who have and have not completed the healthy behaviors in the Iowa Health and Wellness Plan and those in the Medicaid State Plan

Per Member Per Month (PMPM) costs calculated for all costs and for emergency room care

Protocol-Original measure
Data source-Administrative
Analyses-ICER utilizing MPC, WP, and 3 comparison groups before and after implementation as well as HBI participants versus non-participants after implementation
RDD comparing MPC members and WP members at the threshold
DID for MPC, WP members and four comparison groups before and after implementation as well as HBI participants versus non-participants after implementation

Question 6 What are the implications of disenrollment?Hypothesis 6.1 Disenrolled members do not understand the disenrollment process.

Measure 42 Disenrolled member reported understanding of disenrollment process.

Protocol-Original
Data source-Disenrolled in-depth interviews
Analyses-Qualitative

Hypothesis 6.2 Disenrolled members do not understand premiums.

Measure 43 Disenrolled member reported understanding of premiums

Protocol-Original
Data source-Disenrolled in-depth interviews
Analyses-Qualitative

Hypothesis 6.3 Disenrolled members do not understand the HBI program.

Measure 44 Disenrolled member reported understanding of HBI program

Protocol-Original
Data source- Disenrolled in-depth interviews
Analyses-Qualitative

Hypothesis 6.4 Disenrolled members find it difficult to meet their health needs.

Measure 45 Disenrolled member ability to meet health needs

Protocol-Original
Data source- Disenrolled in-depth interviews
Analyses-Qualitative

Hypothesis 6.5 Disenrolled members are unable to re-enroll due to administration issues.

Measure 46 Disenrolled member reporting of challenges related to re-enrollment

Protocol-Original
Data source- Disenrolled in-depth interviews
Analyses-Qualitative

Question 7 What are members' knowledge and perceptions of a healthy behaviors incentive program?

Hypothesis 7.1 Members (WP/MPC) will value incentives offered to complete healthy behaviors.

Measure 47 Members assigned value of the program and behaviors

Protocol-Original measure
Data source-Consumer survey
Analyses-Process

Hypothesis 7.2 Members (WP/MPC) will be most willing to complete behaviors that have lower costs/barriers compared to those with higher benefits and relevance.

Measure 48 Members assessment of the costs, barriers and benefit to program participation

48A Members indicate cost

Protocol-Original measure

Data source-Consumer survey
Analyses-Multivariate analysis predicting intention to complete

48B Members indicate barriers

Protocol-Original measure
Data source-Consumer survey
Analyses- Multivariate analysis predicting intention to complete

48C Members indicate benefits

Protocol-Original measure
Data source-Consumer survey
Analyses- Multivariate analysis predicting intention to complete

Hypothesis 7.3 Members (WP/MPC) with a greater sense of locus of control will be more willing to participate.

Measure 49 Members' perceived locus of control

Protocol-Validated measure
Data source-Consumer survey
Analyses-Means test

Hypothesis 7.4 Members (WP/MPC) understand the logistics (for example- payment, payment options, requirements of the program, ...) of the HBI program.

Measure 50 Members' knowledge of requirements of program

Protocol-Original measure
Data source-In-depth Interviews and Consumer survey
Analyses-Qualitative analysis and Frequencies

Measure 51 Members' knowledge of payment process

Protocol-Original measure
Data source-In-depth Interviews and Consumer survey
Analyses-Qualitative analysis and Frequencies

Hypothesis 7.5 Members (WP/MPC) understand the purpose of HBI and how it is supposed to influence their behavior.

Measure 52 Members' knowledge of purpose of HBI program

Protocol-Original measure
Data source-In-depth Interviews and Consumer survey
Analyses-Qualitative analysis and Frequencies

Measure 53 Members' understanding of how the program influences behavior

Protocol-Original measure
Data source-In-depth Interviews and Consumer survey
Analyses-Qualitative analysis and Frequencies

Hypothesis 7.6 Members (WP/MPC) do not report difficulties paying premiums related to payment form accepted by IME.

Measure 54 Members' experience with premium payment mechanism.

Protocol-Original measure
Data source-In-depth Interviews and Consumer survey
Analyses-Qualitative analysis and Frequencies

Question 8 What are the experience of ACOs related to the Health Behavior Incentives Program?

Hypothesis 8.1 ACOs experience barriers to reaching targets for wellness exams and HRA.

Measure 55 Type and number of barriers to reaching targets for wellness exams and HRA

Protocol-Original
Data source-ACO in-depth interviews
Analyses-Qualitative

Hypothesis 8.2 ACOs promote the HBI program.

Measure 56 Type and level of HBI program promotion

Protocol-Original
Data source-ACO in-depth interviews
Analyses-Qualitative

Hypothesis 8.3 ACOS experience advantages and successes from the HBI program.

Measure 57 Advantages and successes reported from the HBI program

Protocol-Original
Data source-ACO in-depth interviews
Analyses-Qualitative

Budget

PERSONNEL		Calendar Year Budgets		
	Total	CY 2015	CY 2016	CY 2017
Natoshia Askelson, Investigator, Co-PI	-	-	-	-
25%, 33 months	63,185.43	16,310.19	23,091.25	23,783.99
Fringe Benefits	23,246.20	5,936.49	8,509.64	8,800.08
Brad Wright, Investigator, Co-PI	-	-	-	-
20%, 33 months	54,724.61	14,499.66	19,815.25	20,409.71
Fringe Benefits	16,445.57	4,285.63	5,957.43	6,202.51
Sue Curry, Investigator	-	-	-	-
3%, 33 months	34,350.15	9,101.30	12,437.85	12,810.99
Fringe Benefits	10,322.74	2,690.05	3,739.43	3,893.26
David Frisvold, Investigator	-	-	-	-
5%, 33 months	20,615.06	5,462.10	7,464.51	7,688.45
Fringe Benefits	6,195.14	1,614.42	2,244.20	2,336.52
Elizabeth Momany, Investigator	-	-	-	-
8%, 33 months	23,046.68	6,106.37	8,344.98	8,595.33
Fringe Benefits	8,476.66	2,221.08	3,075.31	3,180.27
Pete Damiano, Investigator	-	-	-	-
8%, 33 months	46,915.95	12,430.70	16,987.81	17,497.44
Fringe Benefits	11,110.43	2,874.14	4,036.91	4,199.39
Suzanne Bentler, Investigator	-	-	-	-
10%, 33 months	20,948.54	5,550.46	7,585.26	7,812.82
Fringe Benefits	7,704.96	2,018.88	2,795.34	2,890.74
Brooke McInroy, Survey Coordinator	-	-	-	-
10%, 33 months	11,837.78	3,136.50	4,286.35	4,414.94
Fringe Benefits	4,353.98	1,140.85	1,579.61	1,633.53
Erin Shane, Survey Manager	-	-	-	-
8%, 33 months	13,744.53	3,641.71	4,976.76	5,126.06
Fringe Benefits	5,055.29	1,324.61	1,834.05	1,896.64
Graduate Research Assistant x 2, (TBA)	-	-	-	-
100%, 33	127,559.30	33,797.70	46,187.98	47,573.62
Fringe Benefits	18,147.60	4,498.41	6,608.29	7,040.90
TOTAL PERSONNEL	527,986.62	138,641.24	191,558.20	197,787.17
OTHER DIRECT COSTS	349,023.56	19,406.43	167,308.57	162,308.57
Data collection costs	-	-	-	-
Provider (1500*\$25)	75,000.00	-	37,500.00	37,500.00
Member (1350*3*\$25)	202,500.00	-	101,250.00	101,250.00
Member Incentives ((1350*3*\$2)+(\$25*10))	16,700.00	-	8,350.00	8,350.00
Qualitative data collection ((interviewer costs and transcription (1 hr tape = 4 hrs transcription*50 Interviews*\$20/hr))	35,000.00	9,545.45	12,727.27	12,727.27
Consultant	-	-	-	-
David Bradford (U of GA)	10,000.00	5,000.00	5,000.00	-
CoPH CNS fee (Askelson, N.)	1,380.50	376.50	502.00	502.00
CoPH CNS fee (Wright, B.)	1,104.40	301.20	401.60	401.60
CoPH CNS fee (Curry, S.)	165.66	45.18	60.24	60.24
Office supplies, telephone copying	825.00	225.00	300.00	300.00
Travel & Meeting Costs	3,348.00	913.09	1,217.45	1,217.45
Software	3,000.00	3,000.00	-	-
Modified Total Direct Costs	877,010.18	158,047.67	358,866.77	360,095.74
Graduate Tuition (no F&A)	-	-	-	-
full tuition for two 50% FY GRAs	50,907.04	16,648.00	16,959.92	17,299.12
Total Direct Costs	927,917.22	174,695.67	375,826.69	377,394.86
Facilities & Administration (8.0%)	70,160.81	12,643.81	28,709.34	28,807.66
Total Project Budget	998,078.03	187,339.48	404,536.03	406,202.52

Budget Justification

Natoshia Askelson, MPH, PhD will provide 25% of her time to as Co-Principal Investigator. She will be responsible for co-directing the project. Specifically she will be responsible for the day-to-day operations, including staff supervision, liaison with state and federal policymakers, liaison with external and internal constituencies such as CMS and University personnel, and developing and writing research reports and peer-reviewed manuscripts. She will be the lead on the surveys and the qualitative data collections. She has experience leading multi-disciplinary evaluation teams, including Medicaid evaluations. Her research expertise is in qualitative methods and health behavior. She will be sharing the leadership with Dr. Wright. To ensure a successful completion of the evaluation, Dr. Askelson and Dr. Wright will meet weekly and schedule bi-weekly meetings for the team.

Brad Wright, PhD will provide 20% of his time as Co-Principal Investigator. He will be responsible for co-directing the project. Specifically, he will be responsible for overseeing all quantitative analytic components of the proposed evaluation. In this role, he will provide staff supervision to programmers and analysts, and will liaise with state and federal policymakers. He will also contribute to the development and writing of research reports and peer-reviewed manuscripts. Dr. Wright has experience as the principal investigator of projects funded by both the National Institutes of Health and the Retirement Research Foundation, among others, which have involved quantitative analysis of large nationally comprehensive medical claims datasets. His particular expertise is in disparities in health and health care, the health care safety net, and vulnerable populations, including Medicaid beneficiaries. He holds a primary appointment in the University of Iowa Department of Health Management and Policy, and a secondary appointment in the Public Policy Center.

Sue Curry, PhD will serve as a consultant on the project at 3% of her time. Dr. Curry will provide expertise in incentivizing health behavior changes, including smoking cessation, dietary modification, and compliance with preventive health screenings. She will review survey and qualitative data collection tools, provide input in the analysis and assist in interpreting the findings. Dr. Curry is an internationally recognized scholar in the field of behavioral health and is currently the Dean of the University of Iowa, College of Public Health, a member of the US Preventive Services Task Force and a member of the Institute of Medicine.

David Frisvold, PhD will serve as a consultant on the project at 5% of his time. Dr. Frisvold is a health economist. He will assist in the designing of the economic analysis and interpretation of the findings. He is currently a faculty member in the Department of Economics at the University of Iowa.

Elizabeth T. Momany, PhD will provide 8% of her time. As the Co-PI of the overall evaluation she will assist in the ongoing conceptualization of the data analysis plan, supervise organization, development and management of the claims, encounter, enrollment, and program data, and assist in data analysis. Dr. Momany has had over 20 years of experience with Medicaid claims and encounter data. In addition, she has written or assisted with writing articles and a number of reports detailing the current utilization and outcome experience of the Medicaid program within Iowa.

Peter C. Damiano, DDS, MPH will provide 8% of his effort. He will be a liaison with CMS, national evaluators and the State of Iowa. As the Co-PI of the overall evaluation, he will be responsible for ensuring continuity between the evaluations. Dr. Damiano is uniquely suited for this project through

his previous work conducting studies regarding state programs for low income people. In addition, he directs the Public Policy Center that focuses on health disparities.

Suzanne Bentler, PhD will provide 10% of her time to focus on the development and analyses of the outcomes data. She will work with Dr. Wright to ensure that the outcomes across all the evaluations are consistent.

Brook McInroy, Survey Coordinator at 10% will manage the day-to-day activities of the surveys and qualitative data collections. She will assist with and finalizing the instruments. She will be the liaison evaluation team and the data collection team, including recruiting and organizing qualitative data collections. She will also be responsible for analyzing survey data under the direction of the investigators.

Erin Share, Survey Manager at 8% will manage the survey process including printing, mailing and data entry. She will be responsible for receiving and tracking surveys.

Graduate Research Assistant (TBA) at 50% will provide general support to project aiding in the data preparation, analyses, writing and presentation of findings. The GRA will also be responsible for identifying and managing literature critical to understanding the appropriate methods, data analytic strategies and implications from new work on the current study. The GRAs will collect qualitative data and participate in the analysis of the data.

Provider Surveys

Two waves of provider surveys are budgeted to determine provider experience. We have budgeted \$25 for the cost of each provider survey.

Member Surveys

The project budget includes \$202,500 for two waves of member surveys. We have budgeted \$25 for the cost of each member survey.

Member incentives

Based on previous experience a \$2 incentive and the opportunity to participate in a raffle increases member survey response rates (\$16,700).

Qualitative data collections

A total of \$35,000 has been budgeted for the qualitative data collections. These data collections include the formative interviews, the disenrollment interviews, the provider in-depth interviews and the interviews with ACO leadership. The cost includes the interviewer time, transcription and coding.

Consultant

David Bradford, PhD will serve as a consultant on this project for \$10,000. Dr. Bradford is an economist at the University of Georgia. He has extensive experience in the field of health economics, specifically related to behavioral economics, health care decisions and health insurance choices. He will review analysis plans, provide expertise on the analysis and assist in interpreting the findings.

CNS fees

The College of Public Health has a required computer fee that must be covered on Dr. Askelson (\$1,380.50), Dr. Wright (\$1,104.40) and Dean Curry (\$165.66).

Materials and Supplies

Funds in the amount of \$825 across the 2.75 years are requested for supplies such as copy paper, pens, binders, secure files for data storage, etc.

Travel

We have budgeted \$3,348 for travel across the 2.75 years of the grant. This includes approximately \$250 per year for travel to meet with State program staff and \$1,299 per year to present the data at National meetings or meet with CMS and evaluators from other states.

Software

We have budgeted \$3,000 to cover the cost of qualitative software needed to analyze the data collected for this evaluation.

Graduate Tuition

A total of \$50,907.04 has been budgeted to pay tuition expenses for two 50% Graduate Research Assistants as is required by the current contract. This amount is budgeted to increase by 3% per year.

Timeline

	2015				2016				2017			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Reports												
Interim annual reports				■				■				
Draft final report										■		
Final report-CMS											■	■
Final report-State												■
Claims-based HBI completion (Q1)												
Protocol development		■										
Rates			■	■			■			■		
Administrative data-based HBI completion (Q1)												
Receive & assimilate HRA		■				■				■		
Protocol development			■									
Rates			■				■			■		
Enrollee survey-based HBI completion (Q1)												
Formative interviews			■	■								
Survey development				■								
Survey data collection (wellness exam & HRA)					■	■			■	■		
Survey data collection (other healthy behaviors)					■	■		■	■			
Analysis						■	■			■	■	
Claims-based modeling of HBI completion (Q2)												
Receive & assimilate HRA		■				■				■		

	2015				2016				2017			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Protocol development			■									
Analysis wellness exam & HRA			■	■			■				■	
Receive & assimilate other healthy behaviors				■	■				■	■		
Protocol development				■	■				■	■		
Analysis for other healthy behaviors						■			■	■		
Claims-based outcomes (Q3)												
Data Collection/Assimilation HRA		■				■				■		
Protocol development		■				■				■		
Outcome rates wellness exam and HRA			■	■		■	■			■	■	
Multivariate models wellness exam and HRA				■			■	■			■	■
Data Collection/Assimilation other healthy behaviors						■				■		
Protocol development						■				■		
Outcome rates other healthy behaviors							■	■			■	■
Multivariate models other healthy behaviors							■	■			■	■
Provider in-depth interviews & survey (Q4)												
In-depth interview protocol development		■	■					■	■			
Conduct in-depth interviews			■	■				■	■			
Transcribe & Analyze			■	■				■	■			
Survey protocol development			■	■			■	■				
Survey data collection				■	■			■	■			
Survey analysis					■	■			■	■		
Cost analysis (Q5)												

	2015				2016				2017			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Model design												
Analysis												
Disenrollment in-depth interviews (Q6)												
Protocol development												
Data collection												
Transcription & analysis												
Enrollee survey perceptions of HBI (Q7)												
Formative interviews												
Survey development												
Survey data collection												
Analysis												
ACOs in-depth interviews(Q8)												
Protocol development												
Data collection												
Transcription & analysis												

We look forward to continuing to partner with you and your staff on the Iowa Wellness and Marketplace Choice Plan demonstrations.

Sincerely,

A handwritten signature in black ink that reads "Manning Pellanda". The signature is written in a cursive style with a large, prominent "M" and "P".

Manning Pellanda

Director

Division of State Demonstrations and Waivers

cc: James Scott, ARA, Region VII

Appendix A
Health and Wellness Plan Comparison
to IowaCare and Medicaid State Plan



Benefits Comparison: IowaCare Program & Iowa Health and Wellness Plan

Benefits	IowaCare Program FPL 0-200%	Iowa Health and Wellness Plan	
		Wellness Plan: FPL 0-100%	Marketplace Choice Plan: FPL 101-133%
	Program enrollment closed IowaCare coverage ends December 31, 2013	Program enrollment begins October 1, 2013 Coverage begins January 1, 2014	Program enrollment begins October 1, 2013 Coverage begins January 1, 2014
Ambulatory Patient Services • Physician Services • Primary Care	Only Covered from IowaCare Providers	Covered	Covered
Emergency Services • Emergency Room • Ambulance	Emergency Room Only Covered from Limited IowaCare Providers Ambulance Not Covered	Covered	Covered
Hospitalization	Only covered from Limited IowaCare Providers	Covered	Covered
Mental Health and Substance Use Disorder Services	Not Covered	Covered Services provided by the Iowa Plan	Covered
Rehabilitative and Habilitative Services • Physical Therapy • Occupational Therapy • Speech Therapy	Not Covered	Covered (60 visits covered annually for each therapy)	Covered
Lab Services • X-Rays • Lab Tests	Only Covered from IowaCare Providers	Covered	Covered
Preventive and Wellness Services	Only Covered from IowaCare Providers	Covered	Covered
Prescription Drugs	Not Covered	Covered	Covered
Dental	Not Covered	Covered	Covered

The Iowa Health and Wellness Plan offers comprehensive benefits to members. The plan covers a wide range of medical services, without limits on amount of care received.



Iowa Health and Wellness Plan

Provider Network	IowaCare Program FPL 0-200%	Iowa Health and Wellness Plan	
		Wellness Plan: FPL 0-100%	Marketplace Choice Plan: FPL 101-133%
	Enrollment closed IowaCare coverage ends December 31, 2013	Program enrollment begins October 1, 2013 Coverage begins January 1, 2014	Program enrollment begins October 1, 2013 Coverage begins January 1, 2014
Physician and Primary Care	IowaCare Providers Only <ul style="list-style-type: none"> Broadlawns Medical Center University of Iowa Hospitals and Clinics 6 Federally Qualified Health Centers 	Statewide Medicaid Provider Network <ul style="list-style-type: none"> Includes providers in local communities 	Statewide Commercial Health Plan Network <ul style="list-style-type: none"> Includes providers in local communities
Hospitalization	IowaCare Providers Only <ul style="list-style-type: none"> Broadlawns Medical Center University of Iowa Hospitals and Clinics 6 Federally Qualified Health Centers 	Statewide Medicaid Provider Network <ul style="list-style-type: none"> Includes hospitals in local communities 	Statewide Commercial Health Plan Network <ul style="list-style-type: none"> Includes hospitals in local communities
Emergency Services	IowaCare Providers Only <ul style="list-style-type: none"> Broadlawns Medical Center University of Iowa Hospitals and Clinics 6 Federally Qualified Health Centers 	Statewide Medicaid Provider Network <ul style="list-style-type: none"> Includes emergency room/hospitals in local communities 	Statewide Commercial Health Plan Network <ul style="list-style-type: none"> Includes emergency room/hospitals in local communities
Prescription Drugs	Not Covered by IowaCare	Statewide Medicaid Provider Network <ul style="list-style-type: none"> Includes pharmacies in local communities 	Statewide Commercial Health Plan Network <ul style="list-style-type: none"> Includes pharmacies in local communities
Other Medical Services	IowaCare Providers Only <ul style="list-style-type: none"> Broadlawns Medical Center University of Iowa Hospitals and Clinics 6 Federally Qualified Health Centers 	Statewide Medicaid Provider Network <ul style="list-style-type: none"> Includes providers in local communities 	Statewide Commercial Health Plan Network <ul style="list-style-type: none"> Includes providers in local communities

Members of the Iowa Health and Wellness Plan will have access to a statewide group of providers. Members will be able to visit providers, hospitals and pharmacies in their local community.



Iowa Health and Wellness Plan

Out-of-Pocket Costs	IowaCare Program FPL 0-200%	Iowa Health and Wellness Plan	
		Wellness Plan: FPL 0-100%	Marketplace Choice Plan: FPL 101-133%
	Enrollment closed IowaCare coverage ends December 31, 2013	Program enrollment begins October 1, 2013 Coverage begins January 1, 2014	Program enrollment begins October 1, 2013 Coverage begins January 1, 2014
Copayments	<ul style="list-style-type: none"> \$1-3 for various services Required to pay out-of-pocket for many services not covered by IowaCare program 	<ul style="list-style-type: none"> None, except for \$10 for using the Emergency Room when it is not a medical emergency 	<ul style="list-style-type: none"> None, except for \$10 for using the Emergency Room when it is not a medical emergency
Monthly Contributions	<ul style="list-style-type: none"> Monthly contributions for some members 	<ul style="list-style-type: none"> No monthly contribution for the first year No contributions after the first year if the member Healthy Behavior activities Only for adults with income greater than 50% of the Federal Poverty Level 	<ul style="list-style-type: none"> No monthly contribution for the first year No contributions after the first year if the member Healthy Behavior Activities Only for adults with income greater than 50% of the Federal Poverty Level
Out-of-Pocket Spending Limit	<ul style="list-style-type: none"> Cannot exceed 5% of income 	<ul style="list-style-type: none"> Cannot exceed 5% of income 	<ul style="list-style-type: none"> Cannot exceed 5% of income

Healthy Behaviors	IowaCare Program FPL 0-200%	Iowa Health and Wellness Plan	
		Wellness Plan: FPL 0-100%	Marketplace Choice Plan FPL 101-133%
	Enrollment closed IowaCare coverage ends December 31, 2013	Program enrollment begins October 1, 2013 Coverage begins January 1, 2014	Program enrollment begins October 1, 2013 Coverage begins January 1, 2014
First Year (2014)	Not Applicable	<ul style="list-style-type: none"> Complete Wellness Exam Complete Health Risk Assessment 	<ul style="list-style-type: none"> Complete Wellness Exam Complete Health Risk Assessment
Second Year and Beyond (2015 and Beyond)	Not Applicable	<ul style="list-style-type: none"> Complete a set number of healthy activities 	<ul style="list-style-type: none"> Complete a set number of healthy activities
If Healthy Behaviors Are Completed:	Not Applicable	No monthly contributions required to be paid by member	No monthly contributions required to be paid by member



Benefits Comparison: Medicaid State Plan & Iowa Health and Wellness Plan

Plan Benefits	Medicaid State Plan FPL varies dependent on eligibility category	Iowa Health and Wellness Plan	
		Wellness Plan: FPL 0-100%	Marketplace Choice Plan: FPL 101-133%
		 NOTE: Medically Exempt individuals will be enrolled in the Medicaid State Plan benefit with the option to Opt-out	NOTE: Medically Exempt individuals will be enrolled in the Medicaid State Plan benefit with the option to Opt-out
Ambulatory Patient Services <ul style="list-style-type: none"> Physician Services Primary Care 	Covered	Covered	Covered
Chiropractic	Covered	Covered	Covered
Podiatry	Covered	Covered Routine foot care is generally not covered, however it may be covered as part of a member's overall treatment related to certain health care conditions	Covered Routine foot care is generally not covered, however it may be covered as part of a member's overall treatment related to certain health care conditions
Emergency Services <ul style="list-style-type: none"> Emergency Room Ambulance 	Covered	Covered	Covered
Hospitalization	Covered	Covered	Covered
Rehabilitative and Habilitative Services <ul style="list-style-type: none"> Physical Therapy Occupational Therapy Speech Therapy 	Covered, no limits	Covered <ul style="list-style-type: none"> 60 visits covered annually for each therapy 	Covered
Lab Services <ul style="list-style-type: none"> X-Rays Lab Tests 	Covered	Covered	Covered
Prescription Drugs	Covered	Covered	Covered pursuant to Qualified Health Plan benefit; must meet minimum essential benefits
Home Health	Covered	Covered	Covered
Hospice	Covered Respite: Unlimited but may only be used in 5 day increments	Covered Respite: 15 inpatient and 15 day outpatient lifetime limit	Covered Respite: 15 inpatient and 15 day outpatient lifetime limit



Benefits Comparison: Medicaid State Plan & Iowa Health and Wellness Plan

Plan Benefits	Medicaid State Plan FPL varies dependent on eligibility category	Iowa Health and Wellness Plan	
		Wellness Plan: FPL 0-100%	Marketplace Choice Plan: FPL 101-133%
Skilled Nursing Facility	Covered, no limits	Limited to 120 days annually	Limited to 120 days annually
Dental	Covered	Covered – See Proposal for Accountable Dental Care Plan	Covered – See Proposal for Accountable Dental Care Plan
Other Benefits <ul style="list-style-type: none"> • Bariatric Surgery • Temporomandibular Joint (TMJ) • Eyeglasses • Hearing Aids • Non-Emergency Medical Transportation • Intermediate Care Facility (Nursing Facility) • Intermediate Care Facility for the Intellectually Disabled 	Covered Covered Covered Covered Covered Covered if Level of Care is met Covered if Level of Care is met	Not Covered Not Covered Not Covered Not Covered Not Covered Not Covered Not Covered	Covered Covered Not Covered Not Covered Not Covered Not Covered Not Covered
Delivery System			
Managed Care	MediPASS/HMO - Children and Parents only Fee-for-Service – All other populations	Primary Care Case Management (MediPASS/HMO)	Per QHP plan contracts if applicable
Primary Care Medical Home/Health Home	Chronic Condition Health Home tiered per member per month for persons with chronic conditions	Through payment incentives "\$4-\$10-\$4" plan	Per QHP plan contracts if applicable
Accountable Care Organizations	N/A	Through payment incentives "\$4-\$10-\$4-\$4" plan	Per QHP plan contracts if applicable
Provider Network	Medicaid contracted providers; Medicaid reimbursement methods and policies	Medicaid contracted providers; Medicaid reimbursement methods and policies	QHP contracted provider network; QHP reimbursement methods and contracts



Benefits Comparison: Medicaid State Plan & Iowa Health and Wellness Plan

Mental Health, Substance Abuse Treatment, and Support Services			
Plan Benefits	Medicaid State Plan FPL varies dependent on eligibility category	Iowa Health and Wellness Plan	
		Wellness Plan: FPL 0-100%	Marketplace Choice Plan: FPL 101-133%
	←	NOTE: Medically Exempt individuals will be enrolled in the Medicaid State Plan benefit with the option to Opt-out	NOTE: Medically Exempt individuals will be enrolled in the Medicaid State Plan benefit with the option to Opt-out
Mental Health and Substance Use Disorder Services	Covered - Inpatient/Outpatient services including services provided by: <ul style="list-style-type: none"> • Hospitals • Psychiatrist • Psychologist • Social Workers • Family and Marital Therapists • Licensed Mental Health Counselors 	Covered - Inpatient/Outpatient services provided by: <ul style="list-style-type: none"> • Hospitals • Psychiatrist • Psychologist • Social Workers • Family and Marital Therapists • Licensed Mental Health Counselors *Mental Health Parity Required	Covered - Inpatient/Outpatient services provided by: <ul style="list-style-type: none"> • Hospitals • Psychiatrist • Psychologist • Social Workers • Family and Marital Therapists • Licensed Mental Health Counselors *Mental Health Parity Required
Other Mental Health Services	<ul style="list-style-type: none"> • Behavioral Health Intervention services • Assertive Community Treatment (ACT) 	Not Covered	Not Covered
Additional B3 services covered because of savings from the Managed Care Iowa Plan Waiver	<ul style="list-style-type: none"> • Intensive psychiatric rehab • Community Support Services • Peer Support • Residential Substance Abuse Treatment 	Not Covered	Not Covered
Habilitation - 1915i Home and Community Based Services	<ul style="list-style-type: none"> • An individualized, comprehensive service plan • Home-based habilitation • Day habilitation • Prevocational habilitation • Supported Employment 	Covered <u>after</u> a Medically Frail/Exempt determination; person is moved into regular Medicaid	Covered <u>after</u> a Medically Frail/Exempt determination; person is moved into regular Medicaid



Benefits Comparison: Medicaid State Plan & Iowa Health and Wellness Plan

Mental Health, Substance Abuse Treatment, and Support Services			
Plan Benefits	Medicaid State Plan	Iowa Health and Wellness Plan	
	FPL varies dependent on eligibility category	Wellness Plan: FPL 0-100%	Marketplace Choice Plan: FPL 101-133%
Delivery System			
Managed Care	Mental Health and Substance Abuse services covered through the Iowa Plan, 1915(b) managed care plan (Magellan) – all populations except Medically Needy Iowa Plan benefits are the benefits described above	Mental Health and Substance Abuse services covered through the Iowa Plan Benefits provided through the Iowa Plan are the benefits described above, unless the person is Medically Exempt, in which case benefits are equal to the Medicaid State Plan	Per QHP plan contracts if applicable Benefits are provided by the QHP per QHP plan contracts. Benefits are as described above, unless the person is Medically Exempt, in which case the person will receive Medicaid State Plan benefits through Medicaid and the Iowa Plan
Integrated Health Home	Eligibility based on specified mental health diagnosis IHH provides health home services, including peer support, care coordination, etc. through IHH providers	Only covered under the Medicaid State Plan <u>after</u> a Medically Frail/Exempt determination; person is moved into regular Medicaid	Only covered under the Medicaid State Plan <u>after</u> a Medically Frail/Exempt determination; person is moved into regular Medicaid
Provider Network	Magellan contracted provider network; Medicaid and Magellan reimbursement rates and policies	Magellan contracted provider network; Medicaid and Magellan reimbursement rates and policies	QHP contracted provider network; QHP reimbursement methods and contracts

Appendix B

Measures summary

Hypo. Number	Measure number	Name	Measure description	Source	Data type	Analyses	Research Question								
							1	2	3	4	5	6	7	8	
1.1	1	Completion of preventive visit	Proportion of members completing a preventive visit	NCQA HEDIS AAP	Administrative data	Means test between WP/MPC members and three comparison groups before and after implementation	X								
1.2	2	Completion of Health Risk Assessment	Proportion of members completing HRA	Original items	Administrative data	Descriptive statistics for rate of completion for WP/MPC members	X								
1.3	3	Completion of healthy behavior	Whether a member completed a healthy behavior	Original items	Administrative data	Descriptive statistics for rate of completion for WP/MPC members	X								
1.4	4	Member perception of ease of obtaining a yearly physical exam	Respondent report of how easy it is for them to obtain a yearly physical exam	Original items	Member survey	Analysis comparing WP/MPC members who have completed the healthy behaviors and those who did not	X								

Hypo. Number	Measure number	Name	Measure description	Source	Data type	Analyses	Research Question								
							1	2	3	4	5	6	7	8	
1.5	5	Completion of healthy behavior by perceived sustained effort	Whether a WP/MPC member completed a healthy behavior	Original items	Administrative data; Member survey	Means test of rates of completion of healthy behaviors by survey estimated sustained effort for WP/MPC members	X								
1.6	6	Completion of healthy behavior by value of behavior	Whether a WP/MPC member completed a healthy behavior	Original items	Administrative data; Member survey	Means test of rates of completion of healthy behaviors by survey estimated value of behavior for WP/MPC members	X								
1.6	7	Completion of healthy behavior by value of incentive	Whether a WP/MPC member completed a healthy behavior	Original items	Administrative data; Member survey	Means test of rates of completion of healthy behaviors by survey estimated value of incentive for WP/MPC members	X								

Hypo. Number	Measure number	Name	Measure description	Source	Data type	Analyses	Research Question								
							1	2	3	4	5	6	7	8	
2.1	8	Reported completion of healthy behavior by source of information	Whether a WP/MPC member completed a healthy behavior	Original items	Administrative data; Member survey	Logistic regression modeling of HBI participation		X							
2.2	9	Completion of healthy behavior by demographic characteristics	Whether a WP/MPC member completed a healthy behavior	Original items	Administrative data	Logistic regression modeling of HBI participation		X							
2.3	10	Health status by completion of healthy behavior	Whether a WP/MPC member completed a healthy behavior	Original items	Administrative data	Logistic regression modeling of HBI participation		X							
2.4	11	Completion of healthy behaviors in the specified time period without a monthly premium	Proportion of members who complete the healthy behaviors prior to the application of the premium payment	Original items	Administrative data	Means test between MPC members and WP members		X							
2.4	12	Completion of healthy behaviors only after paying a monthly premium	Proportion of members who complete the healthy behaviors only after the application of the premium payment	Original items	Administrative data	Means test between MPC members and WP members		X							
2.4	13	Disenrollment as a result of not completing the healthy behaviors or not paying the monthly premiums	Proportion of members who are disenrolled due to the application of a premium payment as a result of not completing the healthy behaviors	Original items	Administrative data	Process measures for MPC members		X							
2.5	14	Completion of healthy behavior by type of provider	Whether a WP/MPC member completed a healthy behavior	Original items	Administrative data	Logistic regression modeling of HBI participation		X							

							Research Question							
Hypo. Number	Measure number	Name	Measure description	Source	Data type	Analyses	1	2	3	4	5	6	7	8
3.1	15A	Adults access to primary care	Percent of members who had an ambulatory care visit	NCQA HEDIS AAP	Administrative data	Means test between WP/MPC members and three comparison groups before and after implementation			X					
3.1	15B	Adults access to primary care	Whether a member had an ambulatory or preventive care visit	NCQA HEDIS AAP adapted for individuals	Administrative data	RDD comparing MPC members and WP members at the threshold; DID for WP/MPC members and three comparison groups before and after implementation			X					
3.1	16	Access to and unmet need for urgent care	Composite of two questions 1) rating of timely access to urgent care and 2) needed urgent care but could not get it for any reason	CAHPS 5.0; NHIS	Member survey	Means test between WP/MPC members and three comparison groups after implementation			X					

Hypo. Number	Measure number	Name	Measure description	Source	Data type	Analyses	Research Question								
							1	2	3	4	5	6	7	8	
3.1	17	Access to and unmet need for routine care	Composite of two questions 1) rating of timely access to routine care and 2) needed routine care but could not get it for any reason.	CAHPS 5.0; NHIS	Member survey	Means test between WP/MPC members and three comparison groups after implementation			X						
3.1	18	Getting timely appointments, care, and information	Composite of 3 questions 1) member experience with getting appointments for care in a timely manner, 2) time spent waiting for their appointment, and 3) receiving timely answers to their questions.	CAHPS 5.0	Member survey	Analysis comparing those who have completed the healthy behaviors and those who did not			X						
3.1	19	Prescription medication	Access to and unmet need for prescription medication	CAHPS 5.0; NHIS	Member survey	Analysis comparing those who have completed the healthy behaviors and those who did not			X						

							Research Question							
Hypo. Number	Measure number	Name	Measure description	Source	Data type	Analyses	1	2	3	4	5	6	7	8
3.1	20A	Comprehensive diabetes care: Hemoglobin A1c	Percent of members with type 1 or type 2 diabetes who had Hemoglobin A1c testing	NCQA HEDIS CDC; NQF 0057, Adult core measure #19	Administrative data	Means test between WP/MPC members and three comparison groups before and after implementation			X					
3.1	20B	Comprehensive diabetes care: Hemoglobin A1c	Whether a member with type 1 or type 2 diabetes had Hemoglobin A1c testing	NCQA HEDIS CDC; NQF 0057, Adult core measure #19 adapted for individuals	Administrative data	RDD comparing MPC members and WP members at the threshold; DID for WP/MPC members and three comparison groups before and after implementation			X					
3.1	21A	Comprehensive diabetes care: LDL-C screening	Percent of members with type 1 or type 2 diabetes who had LDL-C screening	NCQA HEDIS CDC; NQF 0063, Adult core measure #18	Administrative data	Means test between WP/MPC members and three comparison groups before and after implementation			X					

Hypo. Number	Measure number	Name	Measure description	Source	Data type	Analyses	Research Question								
							1	2	3	4	5	6	7	8	
3.1	21B	Comprehensive diabetes care: LDL-C screening	Whether a member with type 1 or type 2 diabetes had LDL-C screening	NCQA HEDIS CDC; NQF 0063, Adult core measure #18 adapted for individuals	Administrative data	RDD comparing MPC members and WP members at the threshold; DID for WP/MPC members and three comparison groups before and after implementation			X						
3.1	22	Preventive care	Access to and unmet need for preventive care	NHIS	Member survey	Analysis comparing those who have completed the healthy behaviors and those who did not			X						
3.1	23	Ambulatory care	This measure summarizes utilization of outpatient visits and emergency department visits as a rate per 1,000 member months for members age 19-64 years enrolled for at least 1 month during the measurement year	NCQA HEDIS AMB	Administrative data	Means test between WP/MPC members and three comparison groups before and after implementation			X						

							Research Question							
Hypo. Number	Measure number	Name	Measure description	Source	Data type	Analyses	1	2	3	4	5	6	7	8
3.1	24	Regular source of care—personal doctor	The percent who respond that they currently have a personal doctor	CAHPS 5.0	Member survey	Means test between WP/MPC members and three comparison groups before and after implementation			X					
3.2	25A	Non-emergent ED use	Number of non-emergent ED visits per 1,000 member months	Original items	Administrative data	Means test between MPC members and four comparison groups before and after implementation			X					
3.2	25B	Non-emergent ED use	Whether member had a non-emergent ED visit	Original items	Administrative data	RDD comparing MPC members and WP members at the threshold; DID for WP/MPC members and three comparison groups before and after implementation			X					

							Research Question							
Hypo. Number	Measure number	Name	Measure description	Source	Data type	Analyses	1	2	3	4	5	6	7	8
3.2	26A	Follow-up ED visits	Percent of members with ED visit within the first 30 days after index ED visit	Original items	Administrative data	Means test between MPC members and four comparison groups after implementation			X					
3.2	26B	Follow-up ED visits	Whether member had an ED visit within the first 30 days after index ED visit	Original items	Administrative data	DID using MPC and the 4 comparison groups before and after implementation			X					
3.2	27	Admission rate for diabetes short-term complications and asthma	The number of discharges for short-term complications from diabetes or asthma per 100,000 Medicaid members	Original items	Administrative data	Means test between WP/MPC members and three comparison groups before and after implementation			X					
3.2	28A	Admission rate for diabetes short-term complications	Number of discharges for diabetes short-term complications per 100,000 Medicaid members	Adult Core Measures #8, PQI 01	Administrative data	Means test between WP/MPC members and three comparison groups before and after implementation			X					

							Research Question							
Hypo. Number	Measure number	Name	Measure description	Source	Data type	Analyses	1	2	3	4	5	6	7	8
3.2	28B	Admission rate for diabetes short-term complications	Whether member had an admission for diabetes short-term complications	Adult Core Measures #8, PQI 01 adapted for individual	Administrative data	DID using MPC and the 4 comparison groups before and after implementation			X					
3.2	29A	Admission rate for asthma	Number of discharges for asthma per 100,000 Medicaid members	Adult Core Measures #11, PQI 15	Administrative data	Means test between MPC members and four comparison groups before and after implementation			X					
3.2	29B	Admission rate for asthma	Whether member had an admission for asthma	Adult Core Measures #11, PQI 15 adapted for individual	Administrative data	DID using MPC and the 4 comparison groups before and after implementation			X					

							Research Question							
Hypo. Number	Measure number	Name	Measure description	Source	Data type	Analyses	1	2	3	4	5	6	7	8
3.2	30	Inpatient utilization-general hospital/acute care	This measure summarizes utilization of acute inpatient care and services in the following categories: total inpatient, surgery and medicine using number of discharges per 1000 member months, number of days stay per 1000 member months and average length of stay for all members who were enrolled for at least 1 month during the measurement year	NCQA HEDIS IPU	Administrative data	Means test between MPC members and four comparison groups before and after implementation			X					
3.2	31	Plan "all cause" hospital readmissions	For members age 19-64 years who were enrolled for at least on month during the measurement year, the number of acute inpatient stays during the measurement year that were followed by an acute readmission for any diagnosis within 30 days and the predicted probability of an acute readmission	NCQA HEDIS PCR; NQF 1768; Adult Core Measures #7	Administrative data	Means test between MPC members and four comparison groups before and after implementation			X					

							Research Question							
Hypo. Number	Measure number	Name	Measure description	Source	Data type	Analyses	1	2	3	4	5	6	7	8
3.2	32	Rate of 30 day hospital readmissions	30 day readmissions reported in last 6 months	Original items	Member survey	Analysis comparing those who have completed the healthy behaviors and those who did not			X					
4.1	33A	Provider reported use of HRA	Percent of providers who report using HRA	Original items	Provider survey, Provider in-depth interviews	Qualitative analysis				X				
4.1	33B	Provider reported use of HRA	How providers use HRA	Original items	Provider survey, Provider in-depth interviews	Qualitative analysis				X				
4.2	34	Percent of providers reporting encouraging patients to participate	Percent of providers reporting encouraging patients to participate in behavior incentive programs	Original items	Provider survey, Provider in-depth interviews	Qualitative analysis				X				
4.2	35A	Enrollees report providers encouraging them to participate	Percent of enrollees reported provider encouraged participation	Original items	Consumer survey	Means test comparing groups who reported provider encouragement and those that did not				X				

							Research Question							
Hypo. Number	Measure number	Name	Measure description	Source	Data type	Analyses	1	2	3	4	5	6	7	8
4.2	35B	Enrollees report providers encouraging them to participate	Percent of enrollees who reported participation	Original items	Consumer survey	Means test comparing groups who reported provider encouragement and those that did not				X				
4.3	36	Percent of providers reporting reimbursement	Percent of providers reporting reimbursement	Original items	Provider survey	Process measures				X				
4.4	37A	Providers reporting using HRA	Percent of providers who use HRA with WP and MCP members	Original items	Provider survey	Process measures				X				
4.4	37B	Providers reporting using HRA	Providers reporting on using HRA	Original items	In-depth interview	Qualitative analysis				X				
4.5	38	Providers reported changes in communication with patients due to HRA	Changes in communication due to use of HRA	Original items	In-depth interview	Qualitative analysis				X				
4.6	39	Provider reported change in treatment plans due to HRA	Changes in treatment places	Original items	In-depth interview	Qualitative analysis				X				
4.7	40	Provider reported barriers to using HRA information	Barriers reported	Original items	In-depth interview	Qualitative analysis				X				

							Research Question							
Hypo. Number	Measure number	Name	Measure description	Source	Data type	Analyses	1	2	3	4	5	6	7	8
5.1	41	Compare PMPM costs for those who have and have not completed the healthy behaviors in the Iowa Health and Wellness Plan and those in the Medicaid State Plan	Per Member Per Month (PMPM) costs calculated for all costs and for emergency room care	Original items	Administrative data	ICER for MPC, WP, and 3 comparison groups before and after implementation as well as HBI participants versus non-participants after implementation; RDD comparing MPC and WP members at the threshold; DID for MPC, WP members, and four comparison geoups before and after implementation as well as HBI participants versus non-participants after implementation					X			
6.1	42	Disenrolled member reported understanding of disenrollment process	Disenrolled member reported understanding of disenrollment process	Original items	Disenrollment in-depth interviews	Qualitative analysis						X		

Hypo. Number	Measure number	Name	Measure description	Source	Data type	Analyses	Research Question							
							1	2	3	4	5	6	7	8
6.2	43	Disenrolled member reported understanding of premiums	Disenrolled member reported understanding of premiums	Original items	Disenrollment in-depth interviews	Qualitative analysis						X		
6.3	44	Disenrolled members reported understanding of HBI program	Disenrolled members reported understanding of HBI program	Original items	Disenrollment in-depth interviews	Qualitative analysis						X		
6.4	45	Disenrolled member ability to meet health needs	Disenrolled member ability to meet health needs	Original items	Disenrollment in-depth interviews	Qualitative analysis						X		
6.5	46	Disenrolled member reported challenges related to re-enrollment	Disenrolled member reported challenges related to re-enrollment	Original items	Disenrollment in-depth interviews	Qualitative analysis						X		
7.1	47	Member assessment of the value of the program to them	Members asked to assign value to program and behaviors	Original items	Member survey	Process measures							X	
7.2	48A	Member assessment of the costs, barriers, and benefits to program participation	Members indicate cost	Original items	Member survey	Multivariate analysis predicting intention to complete							X	
7.2	48B	Member assessment of the costs, barriers, and benefits to program participation	Members indicate barriers	Original items	Member survey	Multivariate analysis predicting intention to complete							X	
7.2	48C	Member assessment of the costs, barriers, and benefits to program participation	Members indicate benefits	Original items	Member survey	Multivariate analysis predicting intention to complete							X	
7.3	49	Member's perceived locus of control	locus of control	Validated measure	Member survey	Bivariate analysis							X	
7.4	50	Members' knowledge of requirements of program	Knowledge of requirements	Original	In-depth interview Member survey	Qualitative Analysis Process measures							X	

Hypo. Number	Measure number	Name	Measure description	Source	Data type	Analyses	Research Question							
							1	2	3	4	5	6	7	8
7.4	51	Member's knowledge of payment process	Payment process	Original	In-depth interview Member survey	Qualitative Analysis Process measures							X	
7.5	52	Members' knowledge of purpose of program	Knowledge of purpose	Original	In-depth interview Member survey	Qualitative Analysis Process measures							X	
7.5	53	Members' understanding of how program influences behavior	How program influences behavior	Original	In-depth interview Member survey	Qualitative Analysis Process measures							X	
7.6	54	Members' experience with premium payment	Premium payment experiences	Original	In-depth interview Member survey	Qualitative Analysis Process measures							X	
8.1	55	Type and number of barriers to reaching targets for wellness exams and HRA	Type and number of barriers to reaching targets for wellness exams and HRA	Original items	ACO in-depth interviews	Qualitative analysis								X
8.2	56	Type and level of HBI promotion	Type and level of HBI promotion	Original items	ACO in-depth interviews	Qualitative analysis								X
8.3	57	Advantages and successes of HBI program	Advantages and successes of HBI program	Original items	ACO in-depth interviews	Qualitative analysis								X

Appendix C

NCQA HEDIS Specifications

RQ1 H1.1 M1 Adults'access to preventive health services

Description

Proportion of members completing a preventive exam.

Denominator

Members age 19-64 who were enrolled for at least 11 months during the measurement year

Numerator

Members in the denominator who complete a preventive exam.

RQ3 H3.1 M15 Adults'access to preventive/ambulatory health services

Description

- Percent of members who had an ambulatory care visit
- Whether a member had an ambulatory or preventive care visit

Denominator

Members age 19-64 who were enrolled for at least 11 months during the measurement year

Numerator

Members in the denominator who completed a preventive or ambulatory care visit.

RQ3 H3.1 M20 Comprehensive diabetes care: Hemoglobin A1c

Description

The percent of members 19–64 years of age with diabetes (type 1 and type 2) who received at least one Hemoglobin A1c test during the measurement year.

Denominator Members age 19-64 who were enrolled for at least 11 months during the measurement year and had type 1 or type 2 diabetes

Numerator Members in the denominator with at least one Hemoglobin A1c test during the measurement year

Modification

The HEDIS measures include members with diabetes age 65-74. This rate is limited to adults 19-64.

RQ3 H3.1 M21 **Comprehensive diabetes care: LDL-C screening**

The percent of members 18–64 years of age with diabetes (type 1 and type 2) who received at least one LDL-C screen during the measurement year.

- Denominator** Members age 19-64 who were enrolled for at least 11 months during the measurement year and had type 1 or type 2 diabetes
- Numerator** Members in the denominator with at least one Hemoglobin A1c test during the measurement year

Modification

The HEDIS measures include members with diabetes age 65-74. IHAWP is limited to adults 19-64.

RQ3 H3.1 M23 **Ambulatory care**

Description

This measure summarizes utilization of outpatient visits and emergency department visits as a rate per 1,000 member months for members age 19-64 years enrolled for at least 1 month during the measurement year.

- Denominator** Rates 1 and 2: Total months of enrollment for all members age 19-44 years during the measurement year divided by 1000
Rates 3 and 4: Total months of enrollment for all members age 45-64 years during the measurement year divided by 1000
- Numerator** Rate 1: Number of outpatient visits for all members age 19-44 years
Rate 2: Number of emergency department visits for all members age 19-44 years
Rate 3: Number of outpatient visits for all members age 45-64 years
Rate 4: Number of emergency department visits for all members age 45-64 years

Modification

The HEDIS measure includes all age groups breaking adults into 20-44 and 45-64. This rate includes members age 19 in the first age category.

RQ3 H3.2 M30 **Inpatient utilization—general hospital/acute care**

Description

This measure summarizes utilization of acute inpatient care and services in the following categories: total inpatient, surgery and medicine using number of discharges per 1000 member months, number of days stay per 1000 member months and average length of stay for all members who were enrolled for at least 1 month during the measurement year.

- Denominator** Rates 1-6: Total months of enrollment for all members age 19-44 years during the measurement year divided by 1000
Rates 7-12: Total months of enrollment for all members age 45-64 years during the measurement year divided by 1000
Rate 13: Total inpatient days for all members age 19-44 years
Rate 14: Inpatient days for medical stays for all members age 19-44 years
Rate 15: Inpatient days for surgical stays for all members age 19-44 years

Rate 16: Total inpatient days for all members age 45-64 years
 Rate 17: Inpatient days for medical stays for all members age 45-64 years
 Rate 18: Inpatient days for surgical stays for all members age 45-64 years

Numerator

Rate 1: Total discharges for all members age 19-44 years
 Rate 2: Discharges for medical stays for all members age 19-44 years
 Rate 3: Discharges for surgical stays for all members age 19-44 years
 Rate 4: Total inpatient days for all members age 19-44 years
 Rate 5: Inpatient days for medical stays for all members age 19-44 years
 Rate 6: Inpatient days for surgical stays for all members age 19-44 years
 Rate 7: Total discharges for all members age 45-64 years
 Rate 8: Discharges for medical stays for all members age 45-64 years
 Rate 9: Discharges for surgical stays for all members age 45-64 years
 Rate 10: Total inpatient days for all members age 45-64 years
 Rate 11: Inpatient days for medical stays for all members age 45-64 years
 Rate 12: Inpatient days for surgical stays for all members age 45-64 years
 Rate 13: Total discharges for all members age 19-44 years
 Rate 14: Discharges for medical stays for all members age 19-44 years
 Rate 15: Discharges for surgical stays for all members age 19-44 years
 Rate 16: Total discharges for all members age 45-64 years
 Rate 17: Discharges for medical stays for all members age 45-64 years
 Rate 18: Discharges for surgical stays for all members age 45-64 years

Modification

The HEDIS measure includes all age groups breaking adults into 20-44 and 45-64. This rate includes members age 19 in the first age category. The HEDIS measure also includes inpatient utilization for maternity care which is not a relevant measure for this population.

RQ3 H3.2 M31

Plan “all cause” hospital readmissions

For members age 19-64 years who were enrolled for at least one month during the measurement year, the number of acute inpatient stays during the measurement year that were followed by an acute readmission for any diagnosis within 30 days and the predicted probability of an acute readmission.

Denominator Number of Index Hospital Stays, first hospital stays occurring in the first 11 months of the measurement year

Numerator Number of 30-Day Readmissions

Additional Metric Average Adjusted Probability of Readmission

Appendix D

Adult Core Measure Specification

RQ3 H3.2 M28 Diabetes short-term complications admission rate

Description

The number of discharges for diabetes short-term complications per 100,000 Medicaid members 19-64 enrolled for at least 1 month during the measurement year.

Denominator Medicaid members age 19-64 years

Numerator Discharges for short-term complications of diabetes including ketoacidosis, hyperosmolarity, and coma

Modification

The adult core measure includes members age 18. This rate is limited to adults 19-64.

RQ3 H3.2 M29 Asthma admission rate

Description

The number of discharges for asthma per 100,000 Medicaid members 19-64 enrolled for at least 1 month during the measurement year.

Denominator Medicaid members age 19-64 years

Numerator Discharges for asthma

Modification

The HEDIS measure includes all age groups breaking adults into 20-44 and 45-64. This rate includes members age 19 in the first age category.

RQ3 H3.2 M31 Plan all-cause readmission rate

Description

For members age 19-64 years who were enrolled for at least on month during the measurement year, the number of acute inpatient stays during the measurement year that were followed by an acute readmission for any diagnosis within 30 days and the predicted probability of an acute readmission.

Denominator Medicaid members age 19-64 years

Numerator Number of acute inpatient stays that were followed by an acute readmission for any diagnosis within 30 days and the predicted probability of an acute readmission

Modification

The HEDIS measure includes all age groups breaking adults into 20-44 and 45-64. This rate includes members age 19 in the first age category.

Appendix E

Member Survey Specifications

Health Plan Member Survey

Eligible Population for Survey

Language	English
Ages	19 – 64 years old
Continuous Enrollment	The six months prior to the survey sample
Current Enrollment	Currently enrolled at the time the survey is completed

Each measure (**M**) will refer to a research question (**RQ**) and hypothesis (**H**) from the evaluation plan and will include a source indicator (CAHPS or other survey). The recall time period for each question is the six months prior to the survey.

Overview of Research Questions and Measures

RQ1. Which activities do enrollees complete?

H1.4

M4. Member perception of ease of obtaining a yearly physical exam

H1.5

M5. Completion of healthy behavior by perceived sustained effort

H1.6

M6. Completion of healthy behavior by value of behavior

M7. Completion of healthy behavior by value of incentive

RQ2. What personal characteristics are predictive of completing at least one behavior incentive, and the number (or extent) of behavior incentives completed?

H2.1

M8. Reported completion of healthy behavior by source of information

RQ3. Is engaging in behavior incentives associated with health outcomes?

H3.1

M16. Access to and unmet need for urgent care

M17. Access to and unmet need for routine care

M18. Getting timely appointments, care, and information

M19. Prescription medication

M22. Preventive care

M24. Regular source of care—personal doctor

H3.2

M32. Rate of 30 day hospital readmissions

RQ4. What are the effects of the program on health care providers?

H4.2

M35A. Enrollees report providers encouraging them to participate

M35B. Percent of enrollees who reported participation

RQ7. What are members' perceptions/knowledge of a healthy behaviors incentive program?

H7.1

M47. Members' assessment of the value of the program to them

H7.2

M48A. Members' assessment of the costs to program participation.

M48B. Members' assessment of the barriers to program participation

M48C. Members' assessment of the benefits to program participation

H7.3

M49. Members' perceived locus of control

H7.4

M50. Members' knowledge of program requirement

M51. Members' knowledge of payment process

H7.5

M52. Members' knowledge of purpose of program

M53. Members' understanding programs influence on behavior

H7.6

M54. Members' experience with payment mechanism

RQ1. H1.4. M4**Member perception of ease of
obtaining a yearly physical****Description**

Respondent report of how easy it is for them to obtain a yearly exam.

Source Original item

Questions

Modification

RQ1 H1.5 M5**Completion of healthy behavior by
perceived sustained effort****Description**

WP/MPC member report on perceived effort.

Source Original item

Questions

Modification

RQ1 H1.6 M6**Completion of healthy behavior by
value of behavior****Description**

WP/MPC member report on perceived value of behavior

Source Original item

Questions

RQ1 H1.6 M7**Completion of healthy behavior by value of incentive****Description**

WP/MPC member report on perceived value of incentive

Source Original item

Questions

Modification

RQ2 H2.1 M8**Reported completion of healthy behavior by source of information****Description**

WP/MPC member reporting on source of information

Source Original item

Questions

Modification

RQ3 H3.1 M16**Access to and unmet need for urgent care****Description**

Composite of two questions: 1) rating of timely access to urgent care, and 2) needed urgent care but could not get it for any reason.

Source (1) CAHPS Adult Medicaid Survey 5.0
(2) National Health Interview Survey (NHIS)

Questions

Modification

The two measures are calculated only for those who responded that they had an illness, injury, or condition that needed care right away in a clinic, emergency room, or doctor's office in the last 6 months.

RQ3 H3.1 M22**Preventive care****Description**

Access to and unmet need for preventive care.

Source (1) Original item
(2) National Health Interview Survey (NHIS)

Questions .

RQ3 H3.1 M24**Regular source of care—personal doctor****Description**

The percent who respond that they currently have a personal doctor.

Source CAHPS Adult Medicaid Survey 5.0

Question

Modification

RQ3 H3.2 M32**Rate of 30 day hospital readmissions****Description**

Number of 30 day readmissions reported in the last 6 months.

Source Original item

Questions

RQ4 H4.2 M35**Enrollees report providers encouraging them to participate****Description**

Members report on provider encouragement to participate

Source Original item

Questions

Modification

RQ7 H7.1 M47**Members' assessment of the value of the program to them****Description**

Members asked to assign value to program and behaviors.

Source Original item

Questions

Modification

RQ7 H7.2 M48A**Members' assessment of the costs, barriers and benefits to program participation****Description**

Members asked to indicate costs to program participation.

Source Original items

Questions

Modification

RQ7 H7.2 M48B**Members' assessment of the costs, barriers and benefits to program participation****Description**

Members asked to indicate barriers to program participation.

Source Original items

Questions

Modification

RQ7 H7.2 M48C**Members' assessment of the costs, barriers and benefits to program participation****Description**

Members asked to indicate benefits to program participation.

Source Original items

Questions

Modification

RQ7 H7.3 M49**Members' perceived locus of control****Description**

Members' perceived locus of control.

Source Validated measure

Questions

Modification

RQ7 H7.4 M50**Members' knowledge of requirements****Description**

Knowledge of program requirements

Source Original

Questions

Modification

RQ7 H7.4 M51**Members' knowledge of payment process****Description**

Knowledge of payment process

Source Original

Questions

Modification

RQ7 H7.5 M52

Members' knowledge of purpose of HBI program

Description

Members' knowledge of program

Source Original

Questions

Modification

RQ7 H7.5 M53

Members' understanding of how program influences behavior

Description

Understanding of how program influences behavior

Source Original

Questions

Modification

RQ7 H7.6 M54

Members' experience with premium payment mechanism

Description

Experience with premium payment mechanism

Source Original

Questions

Modification

Appendix F
Medicaid Managed Care summary



Iowa Medicaid Managed Health Care Program

Background

Iowa Medicaid piloted its first managed health care program in 1990. The program began in seven counties, and was named the Medicaid Patient Access to Services System (MediPASS).

The goal of the managed health care program was to help address rising costs for inappropriate use of the emergency room. Members of a managed care program choose, or are assigned a primary care provider (PCP). The PCP is responsible for coordinating the member's care.

By establishing a primary care provider, the MediPASS pilot found that members began to seek care in the correct setting. The program was expanded statewide in 1993, targeting specific Medicaid populations. The program primarily serves the Temporary Assistance for Needy Families (TANF) population, and includes many families and children.

Today, the MediPASS program is available in 93 of the 99 counties, and has around 220,000 members monthly.

Key Points of Managed Care:

1. Focused on primary care and establishing a primary care provider for each member.
2. Members are able to choose a primary care provider, or are assigned one if no choice is made.
3. Managed care has been used in Medicaid with some existing populations since 1990.
4. Expanded to the Iowa Wellness Plan in 2014.

Primary Care Provider Enrollment

Provider Enrollment

The MediPASS program permits certain provider types to serve as a PCP, including: family practice, general practice, internal medicine, pediatrics, OB/GYN, ARNPs and certified nurse midwives. Providers determine how many Medicaid patients the practice is willing to accept, up to a maximum of 1,500 patients. The provider may choose to restrict patients accepted by age, gender, or require that the member be a current patient.

Additionally, the provider selects the counties from which the practice will accept patients. After the selection, the provider signs a patient manager agreement, and is paid an additional \$2 per member per month for care coordination.

County Assignments

Each county must meet provider access standards prior to launching the MediPASS program. There must be a sufficient number of provider slots available, which is generally 1.5 times the number of potential enrollees. Once access standards are met, managed care may begin in the county.

Iowa Medicaid Managed Care Fact Sheet



Member Choice

The managed care program must always include choice for the member. Members who live in a county where managed care is available are assigned a PCP. The member may make an alternative selection instead of accepting the default PCP, and is provided with a list of available PCPs in the county. The initial PCP default assignment is performed systematically, and based on:

- History of enrollment with a provider (previously enrolled with the provider)
- Provider closest to home
- Appropriate provider (ex. Pediatrician for a child, if possible)

Health Maintenance Organization

The Iowa Medicaid managed care program allows certain health maintenance organizations (HMO) to participate. The HMO must be certified by the Iowa Insurance Division, have a provider panel that meets potential member enrollment, accept contract requirements and rates, and must be a county where MediPASS is currently available. Iowa Medicaid contracts with one HMO, Meridian Health Plan. Meridian began its contract in March 2012.

The HMO is currently available in 23 counties, and has approximately 41,000 members. The HMO is included in the tentative assignment process, receiving 50 percent of the tentative assignments in the county, per federal requirements. Members are still able to select another PCP, if desired.

Iowa Medicaid HMO History

Various HMOs have been partnering with Iowa Medicaid since the managed care program began in 1990. HMOs involved with Iowa Medicaid prior to Meridian include:

- John Deere: 1990- June 2004
 - Average Monthly Enrollment: 27,600
- Care Choices: 1995- June 1999
 - Average Monthly Enrollment: 5,000
- SHARE: 1998-December 2001
 - Average Monthly Enrollment: 2,100
- Coventry: 1998-January 2009
 - Average Monthly Enrollment: 3,400
- Iowa Health Solutions: October 1997- January 2005
 - Average Monthly Enrollment: 20,000
- Meridian Health Plan: March 2012- Current
 - Average Monthly Enrollment: 41,000

Iowa Medicaid Managed Care Fact Sheet



Iowa Wellness Plan

The Iowa Wellness Plan uses a managed care program, based on the program requirements for MediPASS. The Iowa Wellness Plan has a unique network, meaning that providers must agree to the Iowa Wellness Plan agreement, and become Iowa Wellness Plan patient managers. MediPASS providers did not automatically become Iowa Wellness Plan providers, though many serve both populations. The Iowa Wellness Plan pays a \$4 per member per month care coordination fee.

The Iowa Wellness Plan managed care program is available to members in 74 counties as of January 2014. An additional nine counties will be available beginning in March 2014.

Members follow a similar tentative assignment process as the MediPASS program, and are able to choose another PCP, if desired. The HMO is also available to Iowa Wellness Plan members in 23 counties. The Iowa Wellness Plan managed care program will continue to grow in coming months.

Iowa Wellness Plan Managed Care: As of January 2014



- Counties in light blue are Iowa Wellness Plan Managed Care
- Counties in dark blue can have Iowa Wellness Plan Managed Care or HMO
- Counties in white are non-managed care for January 2014 (Fee-for-service)

Appendix G

Candidate Metrics Matrix

				Multivariate modelling			
Hypotheses	Process measures	Means tests	Logistic Regression	RDD	DID	Incremental cost effectiveness	Qualitative
RQ1. Which activities do enrollees complete?							
1. The proportion of Iowa Wellness Plan (WP) members and Marketplace Choice (MPC) members who complete a wellness exam is greater than the proportion of Medicaid State Plan (MSP) or IowaCare members who complete an exam.		1					
2. The proportion of WP/MPC members who complete a Health Risk Assessment is greater than 50%.	2						
3. The proportion of WP/MPC members who are eligible to participate complete at least one behavior incentive is greater than 50%.	3						
4. Members (WP/MPC) are most likely to complete the behaviors that require the least amount of effort.		4					
5. Members (WP/MPC) will be least likely to complete incentivized behaviors requiring sustained participation.		5					
6. Members (WP/MPC) will be most likely to complete incentivized behaviors with the largest real or perceived value.		6,7					

				Multivariate modelling			
Hypotheses	Process measures	Means tests	Logistic Regression	RDD	DID	Incremental cost effectiveness	Qualitative
RQ2. What personal characteristics are predictive of completing at least one behavior incentive, and the number (or extent) of behavior incentives completed?							
1. Members (WP/MPC) who have heard of program from their health care provider are more likely to complete at least 1 behavior.			8				
2. Members (WP/MPC) who are young, white, female, in metro areas are more likely to complete at least 1 behavior.			9				
3. Members (WP/MPC) with poorer health status are less likely to complete behaviors compared to members with better health status.			10				
4. Members who do not pay a contribution (WP members less than 50% FPL) are least likely to complete behaviors compared to those who pay a contribution.	13	11,12					
5. Members (WP/MPC) receiving care at federally qualified health centers, rural health clinics, and public hospitals will be more likely to participate in the incentive programs than enrollees receiving care in other settings.			14				

				Multivariate modelling			
Hypotheses	Process measures	Means tests	Logistic Regression	RDD	DID	Incremental cost effectiveness	Qualitative
RQ3. Is engaging in behavior incentives associated with improved access to care and health outcomes?							
1. The program will improve WP/MPC members' access to health care.		15A, 16, 17, 18, 19, 20A, 21A, 22, 23, 24		15B, 20B, 21B	15B, 20B, 21B		
2. The health outcomes of WP/MPC members will be positively impacted by completing the healthy behaviors.		25A, 26A, 27, 28A, 29A, 30, 31, 32		25B	25B, 26B, 28B, 29B		
RQ4. What are the effects of the program on health care providers?							
1. Providers use the information from the Health Risk Assessment.	33A, 33B						33A, 33B
2. Providers are encouraging patients to participate in behavior incentive programs.		35A, 35B					34
3. Providers are receiving their additional reimbursement.	36						
4. Providers are more likely to use the HRA with Iowa Wellness Plan members compared to Iowa Marketplace Choice Plan members	37A						37B
5. The HRA changes communication between the provider and patient.							38

				Multivariate modelling			
Hypotheses	Process measures	Means tests	Logistic Regression	RDD	DID	Incremental cost effectiveness	Qualitative
6. The HRA changes provider treatment plans.							39
7. There are barriers to providers using the HRA information.							40

RQ5. How does the program perform in a break-even analysis?							
1. The costs of the program do not exceed the savings.						41	
RQ6. What are the implications of disenrollment?							
1. Disenrolled members do not understand the disenrollment process.							42
2. Disenrolled members do not understand premiums.							43
3. Disenrolled members do not understand the HBI program.							44
4. Disenrolled members find it difficult to meet their health needs.							45
5. Disenrolled members are unable to re-enroll due to administration issues.							46
RQ7. What are members' perceptions/knowledge of a healthy behaviors incentive program?							

Candidate Metrics Matrix

Spring 2015

1. Members (WP/MPC) will value incentives offered to complete healthy behaviors.	47						
2. Members (WP/MPC) will be most willing to complete behaviors that have lower costs/barriers compared to those with higher benefits and relevance.			48A, 48B, 48C				
3. Members (WP/MPC) with a greater sense of locus of control will be more willing to participate.	49						
4. Members (WP/MPC) understand the logistics (for example- payment, payment options, requirements of the program, ...) of the HBI program.	50, 51						
5. Members (WP/MPC) understand the purpose of HBI and how it is supposed to influence their behavior.	52, 53						
6. Members (WP/MPC) do not report difficulties paying premiums related to payment form accepted by IME.	54						
RQ8. What are the experiences of ACOs related to the Healthy Behaviors Incentives program?							
1. ACOs experience barriers to reaching targets for wellness exams and HRA.							55
2. ACOs promote the HBO program.							56
3. ACOs experience advantages and successes reported from the HBI program.							57