

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-01-16
Baltimore, Maryland 21244-1850



Children and Adults Health Programs Group

JUN 04 2014

Jennifer Vermeer
Director
State of Iowa
Department of Human Services
100 Army Post Road
Des Moines, IA 50315

Dear Ms. Vermeer:

The Centers for Medicare & Medicaid Services (CMS) is approving Iowa's proposed evaluation designs for the Section 1115 Demonstrations titled Iowa Wellness Plan (Project Number 11-W-00289/5) and Iowa Marketplace Choice (Project Number 11-W-00288/5) received on April 30, 2014. As a condition of this approval, the State is required to provide the following evaluation design components as provided for following the schedule below:

- First draft of the dental evaluation design addendum including specific provider and enrollee incentives and quality measures: July 31, 2014
- Final dental evaluation design: September 30, 2014
- First draft of the healthy behaviors evaluation design addendum including specific provider and enrollee incentives once the RFP process is complete: October 31, 2014
- Final healthy behaviors evaluation design addendum: December 31, 2014

You may now post the approved evaluation designs on the state Medicaid website pursuant to 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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Center for Medicaid and CHIP Services
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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:

Centers for Medicare & Medicaid Services
Richard Bolling Federal Building
601 East 12th Street
Room 355
Kansas City, MO 64106-2808
Telephone: (816) 426-6417

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, appearing to read "Diane T. Gerrits", with a long horizontal flourish extending to the right.

Diane T. Gerrits
Director
Division of State Demonstrations and Waivers

cc:

Cindy Mann, CMCS
Eliot Fishman, CMCS
James Scott, ARA, Region VII
Vanessa Sammy, CMCS
Andrea Casart, CMCS

Iowa Wellness Plan Evaluation Design

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 Iowa Marketplace Choice and The Iowa Wellness Plan:

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

The **Marketplace Choice Plan** provides coverage for adults 19-64 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 are two statewide commercial health plans offered to Marketplace Choice Plan members: CoOpportunity Health and Coventry.

IHAWP replaces the IowaCare program with more covered services and a broader provider network as well as expands coverage to other low income adults in Iowa who were not previously enrolled in IowaCare. [Appendix A](#) provides a detailed map comparing benefits, provider networks, and healthy behavior incentives for the three plans: IowaCare, Wellness Plan, Marketplace Choice Plan, and Medicaid State Plan.

Program comparisons

The Wellness Plan and Marketplace Choice Plans are being evaluated separately, however, they are part of one expansion effort. Overlapping outcomes and analyses are intentionally included in the two evaluations to allow for understanding the Iowa Health and Wellness Plan as a singular expansion at the same time that the two mechanisms are explored. The final report will include discussions of the expansion and results of the expansion as a combination of the two mechanisms including the interplay between the two.

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-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 members with the comparison groups within the Medicaid State Plan. Second, simple rate comparisons will be computed for the population-based outcomes. 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 Wellness Plan.

The use of the measures, both survey and claims based will vary over time based on the implementation of the plan components and the lagged effects of healthy behaviors and changes in access to care. For some of the measures, such as the premium incentive and impact of the non-emergent ED incentive, there will be a differential impact in year one from subsequent years as a result of the implementation of these policies over time. Please see examples of some changes in the wording of survey questions in year one vs. subsequent years in [Appendix E](#).

In-depth interviews with enrollees will supplement the survey and claims data. Stakeholders will be engaged through a concept mapping process, followed up by interviews and focus groups at the end of year 1 and in year 3.

Questions and hypotheses

Below are the research questions and associated hypotheses for the evaluation of the Wellness Plan. Detailed tables of the specifications for each measure to be used in the study for each hypothesis are provided in [Appendices B-E, G](#).

Question 1 What are the effects of the Wellness Plan on member access to care?

Hypothesis 1.1

Wellness Plan members will have equal or greater access to primary care and specialty services.

Hypothesis 1.2

Wellness Plan members will have equal or greater access to preventive care services.

Hypothesis 1.3

Wellness Plan members will have equal or greater access to mental and behavioral health services.

Hypothesis 1.4

Wellness Plan members will have equal or greater access to care, resulting in equal or lower use of emergency department services for non-emergent care.

Hypothesis 1.5

Wellness Plan members without a non-emergency transportation benefit will have equal or lower barriers to care resulting from lack of transportation.

Hypothesis 1.6

Wellness Plan members ages 19-20 years will have equal or greater access to EPSDT services.

Question 2 What are the effects of the Wellness plan on member insurance coverage gaps and insurance service when their eligibility status changes (churning)?

Hypothesis 2.1

Wellness Plan members will experience equal or less churning.

Hypothesis 2.2

Wellness Plan members will maintain continuous access to a regular source of care when their eligibility status changes.

Question 3 What are the effects of the Wellness Plan on member quality of care?

Hypothesis 3.1

Wellness Plan members will have equal or better quality of care.

Hypothesis 3.2

Wellness Plan members will have equal or lower rates of hospital admissions.

Hypothesis 3.3

Wellness Plan members will report equal or greater satisfaction with the care provided.

Question 4 What are the effects of the Wellness Plan on the costs of providing care?

Hypothesis 4.1

The cost for covering Wellness Plan members will be comparable to the predicted costs for covering the same expansion group in the Medicaid State Plan.

Question 5 What are the effects of the premium incentive and copayment disincentive programs on Wellness Plan enrollees?

Hypothesis 5.1

The premium incentive for the Wellness Plan enrollees will not impact the ability to receive health care.

Hypothesis 5.2

The copayment for inappropriate emergency department (ED) use for the Wellness Plan enrollees will not pose an access to care barrier.

Hypothesis 5.3

In year two and beyond, the utilization of an annual exam will be higher than in the first year of the program.

Hypothesis 5.4

In year two and beyond, the utilization of smoking cessation services will be higher than in the first year of the program.

Question 6 What is the adequacy of the provider network for Wellness Plan enrollees as compared to those in the Iowa Medicaid State Plan?

Hypothesis 6.1

Iowa Wellness Plan members will have the same access to an adequate provider network as members in the Medicaid State Plan.

Study populations and comparison groups

While Iowa is very fortunate to have more comparable data and comparison populations over time than many other states, there are still limitations to the comparability due to income, categorical eligibility, and health status. We include all the comparison groups 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. The data from these groups will be utilized throughout the evaluation as comparison groups where appropriate.

The study and comparison groups may have more than one option from which members may choose. For example, in Wellness Plan members may reside in county with managed care options allowing them to choose a primary care provider or HMO or they may reside in a Fee-for-service county. The evaluation will take advantage of these differences in payment mechanism through subgroup analyses. We do control for the options within the multivariate analyses which provides us with estimates of option effects. We may wish to add post hoc testing to investigate specific findings related to the options further. We believe that the analyses will guide this work.

It has been suggested that the evaluation would benefit from additional exchange data for those from 134-200% FPL. Though this would be beneficial we have been unable to determine that this data is available at the level of detail required to inform the evaluation. We will continue to talk with the State about this option.

Study Population: Wellness Plan

The Wellness Plan members are the population of interest for this evaluation. 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 options

Wellness Plan members will have the following options available depending on their county of residence.

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 other options available in their county. Meridian began

operating in Iowa in March 2012 and now has approximately 41,000 members.

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 \$8 per member per month to manage specialty and emergency 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.

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

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.

Comparison Group 1A: Non-working adult parents of children eligible for Medicaid provide a comparison subgroup specifically for the RDD analyses. Non-working parents of children in Medicaid in families with incomes less than 33% FPL are eligible for Medicaid coverage. To assess the effects of Wellness Plan we will compare members of this group with Wellness Plan members at the 33% FPL threshold.

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 members (disability determination)

Comparison Group 3 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 who will have at least one month of data in the study period. The only payment structure for these members is fee-for-service. They are not eligible for the HMO or PCCM components. Enrollees who may be or become dually enrolled in Medicaid and Medicare will be removed from these analyses.

Comparison Group 3: IowaCare

IowaCare was a limited provider/limited benefit program that operated from 2005-2013. The provider network included one public hospital in Des Moines, the largest teaching hospital in the state 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) People with incomes 101-133% FPL were enrolled into Marketplace Choice
- 2) People with incomes 0-100% FPL were enrolled in Wellness Plan
- 3) People 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 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 member study group

Study Population: Wellness 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

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

implementation data only.

The IowaCare program ended December 31, 2014. The vast majority of these enrollees were auto-enrolled into the Marketplace and 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	
	HMO	PCP	FFS	CoOpportunity Health	Coventry
IowaCare	21,000	21,000	3,000	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
Comparison Group 1: 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 2: 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 3: Medicaid State Plan members enrolled due to disability determination			
FFS	25,000	500	2,000
Total	25,000	500	2,000
Comparison Group 4: 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 payment structures. 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. 95% 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. The PPC staff also has extensive experience with these files as well as extensive experience with CMS adult core measures HEDIS measures. In addition, the database allows members to be followed for long periods of time over both consecutive enrollment months and periods before and after gaps in coverage. When the enrollment database was started in 1965 Iowa made a commitment to retain a member number for at least 3 years and to never reuse the same Medicaid ID number. This allows long-term linkage of member information including enrollment, cost and utilization even if they change plans.

The collection and assimilation of health care encounters for HMO members coupled with Medicaid fee schedules provides more unique opportunities to estimate differences in cost. This will be a valuable comparison versus using HMO premiums and much more timely for 1st year estimates of cost differences.

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.

Consumer surveys

The PPC has worked with the developers of the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) survey and utilized CAHPS survey measures for over 10 years to conduct enrollee surveys for the Iowa Medicaid Enterprise (IME). This background will provide us with access to CAHPS enrollee survey results for both IowaCare enrollees and Medicaid enrollees for several years prior to their enrollment in the Wellness Plan. Thus, we can compare enrollee self-reported utilization and perceptions of care before and after enrollment into the Wellness Plan.

After enrollment, members in each of the health plans will be surveyed annually using an instrument that includes questions from the CAHPS 5.0 survey and some supplemental items appropriate for the programmatic design of the Iowa Wellness Plan. We can then compare enrollee perceptions across payment structures within the Wellness Plan (HMO, PCP, FFS) and between the Wellness Plan and comparison groups 1 and 2. [Appendix E](#) provides a summary of the measures from the survey, the source of the items, and a draft of the survey instrument.

Most recently the PPC conducted a survey, including CAHPS and supplemental items, with Iowa Medicaid members as part of the 1915b managed care waiver evaluation in the spring 2013. We used a mail-back survey methodology with an opportunity to complete the questionnaire online. Questionnaires were mailed to a plan-stratified random sample of Medicaid enrollees who had been in their current plan for at least the last six months. Random samples of community-dwelling adult enrollees were drawn from Medicaid enrollment data current as of April 2013 and included four Medicaid enrollment types (SSI/SSDI, HMO, MediPASS, and FFS). Only one person was selected per household to reduce the relatedness of the responses and respondent burden. The sample was comprised of 3,200 individuals (800 from each enrollment type).

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

Iowa's Medicaid survey response rates mirrors 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. This will allow robust testing of response bias, including comparisons of primary care utilization, emergency room visits and the presence or chronic health conditions such as asthma, diabetes and depression.

In all, survey responses were obtained for 688 adults, for an unadjusted 22% response (Table 3). After adjusting for enrollees who were not eligible for the study (e.g., moved out of the state, invalid address), the response rate was 23%. Based on these response rates, the current study protocol will increase the sampling frame to the recommended 1,350 adults per plan. Non-response bias tests will be conducted to determine if the characteristics of respondents differ significantly from non-respondents.

Table 3. Sampling and response rates

Plan	Number Sampled	Number of Respondents	Response Rate
SSI/SSDI	800	243	35%*
HMO	800	149	22%*
FFS	800	149	22%*
MediPASS	800	147	21%*
Total	3,200	688	22%
Adjusted Total*	2,962	688	23%*

*Adjusted for ineligibles

The survey instrument to evaluate these adult Medicaid enrollees was based on the most recent version of the Consumer Assessment of Healthcare Providers and Systems (CAHPS) 4.1 survey. The CAHPS 5.0 version will be used for this evaluation.

In addition to the CAHPS 5.0 items, we will include questions to tap enrollees' perceptions of unmet need for various health care services. These unmet need items are from the National Health Interview Survey (NHIS). We also will include several items from the CAHPS Patient-Centered Medical Home (PCMH) item set to be able to tap enrollee experiences with 1) access to care, 2) comprehensiveness of care (relative to mental/emotional health), 3) self-management support, 4) shared decision making (relative to prescription medications), 5) coordination of care, and 6) information about care. And, we include several demographic and self-reported health items to be used as adjustment variables in the analyses.

Provider assessments

The primary purpose of the provider assessments will be to understand how the provider incentives built into the Wellness Plan influence provider behavior toward members as well as their perceptions of the clinical and administrative ease/burden of participating in the program.

Several approaches are being considered for the provider assessment portion of the evaluation.

- Written surveys with physicians participating in the Wellness Plan
- Qualitative focus groups/cognitive interviews
- Case studies of participating practices/ACOs

A synopsis of data types and sources is provided below.

- i. Medicaid encounter and claims data
Housed within the PPC Medicaid data repository with monthly updates
- ii. Enrollment data
Housed within the PPC Medicaid data repository with monthly updates
- iii. Provider Network data
Housed within the PPC Medicaid data repository with monthly updates
- iv. Consumer and provider surveys
Data and results from previous surveys are housed at the PPC. Evaluation surveys will be fielded annually
- v. Stakeholder input
Stakeholders will be engaged in order to provide a more complete examination of implementation and to inform other states of potential challenges and strategies for overcoming the challenges. Stakeholders will participate in an online concept mapping process to collect, rate and categorize challenges. The strategies attempted to overcome the challenges will be explored in interviews and focus groups.

Data analyses

The five major analytical strategies within the evaluation. The five are described in more detail below. Each

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

Process measures

Process measures include qualitative assessments of plan documents and provider panels. Process measures are designed to describe the state of the program or some aspect of the program, but do not lend themselves to testing.

Means testing

Many of the outcome measures are population based, making it impossible to model the outcomes and their predictors. The maximum number of groups we will have in any population based outcome analysis is 8, which includes members of MPC, Wellness Plan and the other Medicaid State Plan comparison groups. For these population measures, means testing for the groups before and after implementation will provide us with an understanding of the programmatic effects.

Multivariate modelling

Measures from the Medicaid Adult Core Set, NCQA HEDIS, and annual CAHPS survey will be modelled using 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 modelling, 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 with a skewed distribution). When appropriate, person, program or area fixed effects will be used to control for time-invariant individual (or program or area) effects and year effects. Each method has strengths and weaknesses but combined should offer a robust analysis of program effects on costs and outcomes.

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, enrolled in Medicaid State Plan due to income level, or enrolled in Medicaid State Plan due to disability determination. Sensitivity analyses will include varying the groups included in the analyses, varying the time component and Discontinuity Regression around the income threshold. In addition, costs for members in the HMO will be calculated both with the actual costs (capitation, additional services) and with service fees attached to the services provided as identified through the encounter data.

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

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 or under the FFS payment structure will be calculated using the cost of all services plus any care coordination fees. For members in the HMO, PMPM will be calculated using two methods. First, the analyses will be completed with PMPM costs calculated as the capitation rates plus costs for services that may be provided under Medicaid outside the HMO such as for specific waivers. Second, HMO PMPM costs will be calculated as though the member had not been enrolled in the HMO by applying the Medicaid fee schedule to HMO encounter data in an effort to estimate what the actual costs to Medicaid would have been without this managed care 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 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 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 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 Wellness Plan and those not in Wellness Plan times the number of enrollee months in Wellness Plan 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 Wellness Plan for Years 2 and 3 should provide future savings estimates. All cost savings will adjust 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 lag time 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. We anticipate utilizing the outcome measures and composites identified for further analyses above as the effect measure for the ICER. 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 MPC versus Wellness Plan (WP) and MPC versus Medicaid State Plan (MSP). The formulas below group MSP and WP together to reduce redundancy, however the ratios will be provided separately for each comparison groups in the reports.

Measure 1A Adult access to preventive/ambulatory health services

$$\frac{\text{Total Cost}_{(MPC)} - \text{Total Cost}_{(MSP/WP)}}{\text{Adult Access}_{(MPC)} - \text{Adult Access}_{(MSP/WP)}}$$

$$\frac{\text{Primary Care Cost}_{(MPC)} - \text{Primary Care Cost}_{(MSP/WP)}}{\text{Adult Access}_{(MPC)} - \text{Adult Access}_{(MSP/WP)}}$$

$$\frac{\text{Inpatient Cost}_{(MPC)} - \text{Inpatient Cost}_{(MSP/WP)}}{\text{Adult Access}_{(MPC)} - \text{Adult Access}_{(MSP/WP)}}$$

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 in 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 11A Flu vaccinations for adults ages 19-64

$$\frac{\text{Total Cost}_{(MPC)} - \text{Total Cost}_{(MSP/WP)}}{\text{Flu Vaccinations}_{(MPC)} - \text{Flu Vaccinations}_{(MSP/WP)}}$$

$$\frac{\text{ED Cost}_{(MPC)} - \text{ED Cost}_{(MSP/WP)}}{\text{Flu Vaccinations}_{(MPC)} - \text{Flu Vaccinations}_{(MSP/WP)}}$$

This outcome measure will be utilized as the denominator for 2 ratios with numerators for total cost and ED cost. We would anticipate that flu shots would reduce total costs and should also reduce the ED costs by reducing the use of emergency rooms for non-emergent problems related to flu and flu symptoms.

Measure 18A Mental health utilization

$$\frac{\text{Total Cost}_{(MPC)} - \text{Total Cost}_{(MSP/WP)}}{\text{Mental Health Utilization}_{(MPC)} - \text{Mental Health Utilization}_{(MSP/WP)}}$$

Primary Care Cost_(MPC)-Primary Care Cost_(MSP/WP)
Mental Health Utilization_(MPC)-Mental Health Utilization_(MSP/WP)

This outcome measure will be utilized as the denominator for 2 ratios with numerators for total cost and primary care cost. We would anticipate higher utilization of mental health services would result in better management of acute and chronic mental health conditions. Though this increased utilization will increase primary care costs, total costs should be reduced. We do not test the area where costs are reduced because we anticipate the effects to be across the system of care and not resident in one or two areas such as inpatient or ED cost.

Measure 20A Non-emergent ED use

Total Cost_(MPC)-Total Cost_(MSP/WP)
Non-emergent ED Use_(MPC)-Non-Emergent ED Use_(MSP/WP)

Primary Care Cost_(MPC)-Primary Care Cost_(MSP/WP)
Non-emergent ED Use_(MPC)-Non-Emergent ED Use_(MSP/WP)

ED Cost_(MPC)-ED Cost_(MSP/WP)
Non-emergent ED Use_(MPC)-Non-Emergent ED Use_(MSP/WP)

Specialist Cost_(MPC)-Specialist Cost_(MSP/WP)
Non-emergent ED Use_(MPC)-Non-Emergent ED Use_(MSP/WP)

This outcome measure will be utilized as the denominator for 4 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 24A EPSDT utilization

Total Cost_(MPC)-Total Cost_(MSP/WP)
EPSDT Utilization_(MPC)-EPSDT Utilization_(MSP/WP)

Primary Care Cost_(MPC)-Primary Care Cost_(MSP/WP)
EPSDT Utilization_(MPC)-EPSDT Utilization_(MSP/WP)

This outcome measure will be utilized as the denominator for 2 ratios with numerators for total cost and primary care cost. Access to EPSDT services should result in increased cost for primary care and lower total costs.

Measure 38 Admission rate for COPD, diabetes short-term complications, CHF and asthma

Total Cost_(MPC)-Total Cost_(MSP/WP)
Admission Rate_(MPC)-Admission Rate_(MSP/WP)

Inpatient Cost_(MPC)-Inpatient Cost_(MSP/WP)
Admission Rate_(MPC)-Admission Rate_(MSP/WP)

This outcome measure will be utilized as the denominator for 2 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.

Measure 44 Plan all-cause hospital readmissions

Total Cost_(MPC)-Total Cost_(MSP/WP)
 Readmission Rate_(MPC)-Readmission Rate_(MSP/WP)

Inpatient Cost_(MPC)-Inpatient Cost_(MSP/WP)
 Readmission Rate_(MPC)-Readmission Rate_(MSP/WP)

Primary Care Cost_(MPC)-Primary Care Cost_(MSP/WP)
 Non-emergent ED Use_(MPC)-Non-Emergent ED Use_(MSP/WP)

Specialist Cost_(MPC)-Specialist Cost_(MSP/WP)
 Non-emergent ED Use_(MPC)-Non-Emergent ED Use_(MSP/WP)

This outcome measure will be utilized as the denominator for 4 ratios with numerators for total cost, inpatient cost, primary care cost, and specialist cost. Access to comprehensive care should result in reduced readmissions as primary care providers and specialists manage conditions post-hospitalization. While primary care cost and specialist cost may increase, total cost and inpatient cost should decline.

GIS

The provider network for the Wellness Plan is anticipated to be different than that for the Medicaid State Plan. To establish that Wellness Plan members have equal access to providers as Medicaid State Plan members, small area analytic methods, which have been developed and refined in previous hospital utilization and primary medical care studies (most notably by the Dartmouth Atlas of Healthcare), will be used to delineate service areas that approximate local market areas better than counties. Service areas are created by assigning patient origin ZIP codes to provider locations based on where a plurality of patients received care. Service areas will be adjusted based on requirements for minimum population size and geographic contiguity. ZIP codes are linked with zip code tabulation area (ZCTA) data from the U.S. Census and provider information from the Medicaid and HMO provider files.

Maps will be generated to examine geographic variation in provider availability. Service areas will be categorized into quartiles of increasing provider availability and described using counts, means, and proportions of service area-level characteristics. Three types of providers will be separately mapped: primary care, mental health, and hospital.

Primary Care-Physicians, physician assistants, and nurse practitioners with the following specialties: general practice, family practice, internal medicine (no subspecialty), and pediatrics are include in primary care, as are Rural Health Clinics (RHC) and Federally Qualified Health Centers (FQHC).

Mental Health-Psychiatrists, psychologists, licensed social workers, and any other providers credentialed through Magellan Behavioral Health are included in mental health.

Hospital-All hospitals including critical access hospitals will be included in this category.

GIS analyses are routinely limited to providers within Iowa. Counties that border other states may have enrollees/members who receive the preponderance of their care outside the state. These enrollees who receive more than 50% of their care from providers outside Iowa will be removed from the analyses.

Qualitative analyses

Concept mapping-The online software, Concept Systems, Inc. will be used to manage the concept mapping data and conduct the analysis. The analysis will consist of rankings and differences in rankings by stakeholder type. Differences in pile sorting categorization and the relationships between identified challenges will be explored. Concept mapping uses similarity matrices, multidimensional scaling, hierarchical cluster analysis and anchoring/bridging analysis to provide a window into how concepts are related.

Interviews and focus groups-Qualitative data will be digitally recorded and transcribed. The transcripts will be coded using Grounded Theory as a framework. Nvivo 10 will be used for coding and analysis. Three trained coders will code the transcripts. The analysis will focus on identifying salient themes and the relationships between the themes.

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 reflect the service provided accurately.

There may be a propensity for enrollees who have the most to gain from insurance coverage to have accessed services earlier through the IowaCare program than those with less to gain. This has the potential to bias all the estimates of program effects on quality measures and costs. Essentially, those who are sicker may use services earlier and the reduction in costs accounted for these enrollees by the Wellness Plan may be greater than for later enrollees. Risk adjustments attempt to correct for this potential bias. Some methods, such as RDD, may result in estimates that are more valid but only pertain to a segment of the population (e.g., the beneficiaries around the income threshold between programs).

Though we propose specific analytical tools within this evaluation document and even go so far as to link analytical strategies to hypotheses, we may find that additional analytical strategies will have to be employed. Propensity scoring, instrumental variables analyses and survival analyses are all techniques that we will retain in our list of possible techniques. As we become more familiar with the distribution of the outcomes and the data we will be using, we need to be comfortable modelling and testing each outcome with the strategy that will provide us with the most accurate and useful results.

Operationalization of questions and hypotheses

Hypothesis 1.1

Wellness Plan members will have equal or greater access to primary care and specialty services.

Measure 1 Adults access to primary care

1A Percent of members who had an ambulatory care visit

Protocol-NCQA HEDIS AAP

Data source-Administrative

Analyses-Means tests between Wellness Plan members and three comparison groups before and after implementation

1B Whether a member had an ambulatory or preventive care visit

Protocol-NCQA HEDIS AAP adapted as individuals

Data source-Administrative

Analyses-RDD comparing Wellness Plan members and MPC members at the threshold

DID for Wellness Plan members and three comparison groups before and after implementation

Measure 2 Follow-up after hospitalization for mental illness

2A Percent of discharges for members with a mental illness diagnosis that were followed by a visit with a mental health provider

Protocol-NCQA HEDIS FUH; Adult core measure #3

Data source-Administrative

Analyses-Means tests between Wellness Plan members and three comparison groups before and after implementation

2B Whether a member discharged with a mental illness diagnosis had a follow-up visit with a mental health provider

Protocol-NCQA HEDIS AAP; Adult core measure #3 adapted as individuals

Data source-Administrative

Analyses-RDD between Wellness Plan members and MPC members at the threshold.

DID for Wellness Plan members and three comparison groups before and after implementation

Measure 3 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 Wellness Plan members and three comparison groups after implementation

Measure 4 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 Wellness Plan members and three comparison groups after implementation

Measure 5 Getting Timely Appointments, Care, and Information

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

Protocol-CAHPS 5.0

Data source-Member Survey

Analyses-RDD between Wellness Plan members and Medicaid State Plan adults at the threshold

Measure 6 After-hours care

Member experience with knowing what to do to obtain care after regular office hours

Protocol-CAHPS 5.0

Data source-Member Survey

Analyses-RDD between Wellness Plan members and Medicaid State Plan adults at the threshold

Measure 7 Specialist care

Access to and unmet need for care from a specialist

Protocol-CAHPS 4.0; NHIS

Data source-Member Survey

Analyses-RDD between Wellness Plan members and Medicaid State Plan adults at the threshold

Measure 8 Prescription medication

Access to and unmet need for prescription medication

Protocol-CAHPS 4.0; NHIS

Data source-Member Survey

Analyses-RDD between Wellness Plan members and Medicaid State Plan adults at the threshold

Hypothesis 1.2

Wellness Plan members will have equal or greater access to preventive care services.

Measure 9 Breast cancer screening

9A Percent of women 50-64 who had a mammogram to screen for breast cancer

Protocol-NCQA HEDIS BCS; NQF 0031; Adult core measure #3

Data source-Administrative

Analyses-Means testing between Wellness Plan members and three comparison groups before and after implementation

- 9B Whether a women 50-64 had a mammogram to screen for breast cancer
Protocol-NCQA HEDIS BCS; NQF 0031; Adult core measure #3 adapted for individuals
Data source-Administrative
Analyses-DID using MPC and the 4 comparison groups before and after implementation

Measure 10 Cervical cancer screening

- 10A Percent of women 21-64 who were screened for cervical cancer
Protocol-NCQA HEDIS CCS; NQF 0032; Adult core measure #4
Data source-Administrative
Analyses-Means testing between Wellness Plan members and three comparison groups before and after implementation
- 10B Whether a women 21-64 was screened for cervical cancer
Protocol-NCQA HEDIS CCS; NQF 0032; Adult core measure #4 adapted for individuals
Data source-Administrative
Analyses-DID using MPC and the 4 comparison groups before and after implementation

Measure 11 Flu shots in past year

- 11A Percent of members 21-64 who received an influenza vaccination
Protocol-CAHPS; NQF 0039
Data source-Member Survey; Administrative
Analyses-Means testing between Wellness Plan members and the three comparison groups before and after implementation
- 11B Whether a member 21-64 received an influenza vaccination
Protocol-CAHPS; NQF 0039adapted for individuals
Data source-Member Survey; Administrative
Analyses-RDD using survey data between Wellness Plan members and Medicaid State Plan adults at the threshold
DID using MPC and the 4 comparison groups before and after implementation

Measure 12 Chlamydia screening in past year

Percent of women 18-24 years of age who were identified as sexually active and had at least one test for Chlamydia
Protocol-NCQA HEDIS CHL; NQF 0033
Data source-Administrative
Analyses-Means testing between Wellness Plan members and the three comparison groups before and after implementation

Measure 13 Comprehensive diabetes care: Hemoglobin A1c

- 13A 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 Wellness Plan members and the three comparison groups before and after implementation
- 13B 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 Wellness Plan members and Medicaid State Plan adults at the threshold
DID for Wellness Plan members and three comparison groups before and after implementation
- Measure 14 Comprehensive diabetes care: LDL-C screening
- 14A 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 Wellness Plan members and the three comparison groups before and after implementation
- 14B 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 Wellness Plan members and Medicaid State Plan adults at the threshold
DID for Wellness Plan members and three comparison groups before and after implementation
- Measure 15 Annual monitoring for patients on persistent medication
Percent of members on a persistent medication (ACE/ARB,digoxin, diuretic, anticonvulsant) who were monitored
Protocol-NCQA HEDIS MPM; Adult core measure #22
Data source-Administrative
Analyses-Means testing between Wellness Plan members and the three comparison groups before and after implementation
- Measure 16 Preventive care
Access to and unmet need for preventive care
Protocol-Original item; NHIS
Data source-Member Survey
Analyses-RDD comparing Wellness Plan members and Medicaid State Plan adults at the threshold

Hypothesis 1.3

Wellness Plan members will have equal or greater access to mental and behavioral health services.

Measure 17 Anti-depressant medication management

17A Percent of members with major depressive disorder who remained on antidepressant medication

Protocol-NCQA HEDIS AMM; NQF 0105, Adult core measure #20

Data source-Administrative

Analyses-Means testing between Wellness Plan members and the three comparison groups before and after implementation

17B Whether a member with major depressive disorder remained on antidepressant medication

Protocol-NCQA HEDIS AMM; NQF 0105, Adult core measure #20 adapted for individuals

Data source-Administrative

Analyses-RDD comparing Wellness Plan members and Medicaid State Plan adults at the threshold

DID for Wellness Plan members and three comparison groups before and after implementation

Measure 18 Mental health utilization

18A Number and percent of members receiving any mental health services

Protocol-NCQA HEDIS MPT

Data source-Administrative

Analyses-Means testing between Wellness Plan members and the three comparison groups before and after implementation

18B Number of mental health services a member received

Protocol-NCQA HEDIS MPT adapted for individuals

Data source-Administrative

Analyses-RDD comparing Wellness Plan members and Medicaid State Plan adults at the threshold

DID for Wellness Plan members and three comparison groups before and after implementation

Measure 19 Behavioral/emotional care

Access to and unmet need for preventive care

Protocol-CAHPS 4.0; NHIS

Data source-Member Survey

Analyses-DID for Wellness Plan members and three comparison groups before and after implementation

Hypothesis 1.4

Wellness Plan members will have equal or greater access to care, resulting in equal or lower use of emergency department services for non-emergent care.

Measure 20 Non-emergent ED use

20A Number of non-emergent ED visits per 1,000 member months

Protocol-Original measure

Data source-Administrative

Analyses-Means testing between Wellness Plan members and the three comparison groups before and after implementation

20B Whether member had a non-emergent ED visit

Protocol-Original measure

Data source-Administrative

Analyses-RDD comparing Wellness Plan members and Medicaid State Plan adults at the threshold

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

Measure 21 Follow-up ED visits

21A Percent of members with ED visit within the first 30days after index ED visit

Protocol-Original measure

Data source-Administrative

Analyses-Means testing between Wellness Plan members and the three comparison groups before and after implementation

21B 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 22 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 Wellness Plan members and the three comparison groups before and after implementation

Hypothesis 1.5

Wellness Plan members without a non-emergency transportation benefit will have equal or lower barriers to care resulting from lack of transportation.

Measure 23 Barriers to care due to transportation

Member experiences with transportation issues to and from health care visits

Protocol-Original items

Data source-Member Survey

Analyses-RDD comparing Wellness Plan members and Medicaid State Plan adults at the threshold

Hypothesis 1.6

Wellness Plan members ages 19-20 years will have equal or greater access to EPSDT services.

Measure 24 EPSDT utilization

24A Percent of members age 19-20 with at least one EPSDT-related visit as defined by EPSDT procedure code modifiers

Protocol-Original measure

Data source-Administrative

Analyses-Means testing between Wellness Plan members and the three comparison groups before and after implementation

24B Whether member had an EPSDT visit

Protocol-Original measure

Data source-Administrative

Analyses-RDD comparing Wellness Plan members and Medicaid State Plan adults at the threshold

Question 2 What are the effects of the Wellness plan on member insurance coverage gaps and insurance service when their eligibility status changes (churning)?

Hypothesis 2.1

Wellness Plan members will experience equal or less churning.

Measure 25 Gaps in coverage in past 12 months

Number of months in the previous year when the respondent did not have health insurance coverage

Protocol-Original item

Data source-Member Survey

Analyses-RDD comparing Wellness Plan members and Medicaid State Plan adults at the threshold

Measure 26 Consecutive months covered by an insurance plan

Percent of members with 6 months continuous eligibility and 12 months continuous eligibility

Protocol-Measures from literature

Data source-Administrative

Analyses-RDD comparing Wellness Plan members and Medicaid State Plan adults at the threshold

Measure 27 Number of times member changes plans and/or loses eligibility during the year

Whether member did not change plans or lose eligibility, changed plans or lost eligibility once, changed plans or lost eligibility 2-3times or changed plans or lost eligibility 4 or more times

Protocol-Original measure

Data source-Administrative

Analyses-RDD comparing Wellness Plan members and the three comparison groups before and after implementation

Hypothesis 2.2

Wellness Plan members will maintain continuous access to a regular source of care when their eligibility status changes.

Measure 28 Proportion who had to change primary care physician when joining the Wellness Plan Plan

Percent of members who switched who switched primary care physicians at entry to plan

Protocol-Original measure

Data source-Administrative

Analyses-Means testing between Wellness Plan members and the three comparison groups before and after implementation

Measure 29 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 Wellness Plan members and the three comparison groups before and after implementation

Measure 30 Continuity of care and satisfaction if they need to change to a new primary care physician when enrolled with a new plan

Member experiences with changing personal doctor/primary care provider

Protocol-Original items

Data source-Member Survey

Analyses-RDD comparing Wellness Plan members and the three comparison groups before and after implementation

Question 3 What are the effects of the Wellness Plan on member quality of care?

Hypothesis 3.1

Wellness Plan members will have equal or better quality of care.

Measure 31 Avoidance of antibiotic treatment in adults with acute bronchitis

The percent of members 19–64 years of age who were enrolled for at least 11 months during the measurement year with a diagnosis of acute bronchitis who were not dispensed an antibiotic prescription

Protocol-NCQA HEDIS AAB; NQF 0058

Data source-Administrative

Analyses- Means tests between Wellness Plan members and three comparison groups before and after implementation

Measure 32 Use of appropriate medications for people with asthma

The percent of members who were identified as having persistent asthma and who were appropriately prescribed medication during the measurement year

Protocol-NCQA HEDIS ASM; NQF 0036

Data source-Administrative

Analyses-Means tests between Wellness Plan members and three comparison groups before and after implementation

Measure 33 Medication management for people with asthma

The percent of members identified as having persistent asthma who were dispensed appropriate medications that they remained on during the treatment period

Protocol-NCQA HEDIS MMA; NQF 1799

Data source-Administrative

Analyses-Means tests between Wellness Plan members and three comparison groups before and after implementation

Measure 34 Pharmacotherapy management of COPD exacerbation

34A The percent of COPD exacerbations for members age 40-64 years of age who had an acute inpatient discharge or emergency department visit during the first 11 months of the measurement year and who were enrolled for at least 30 days following the inpatient stay or emergency department visit and who were dispensed appropriate medications

Protocol-NCQA HEDIS PCE

Data source-Administrative

Analyses-Means tests between Wellness Plan members and three comparison groups before and after implementation

34B Whether member meeting above protocol experienced at least one COPD exacerbation

Protocol-NCQA HEDIS PCE adapted for individual

Data source-Administrative

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

Measure 35 Cholesterol management for patients with cardiovascular conditions

35A Percent of members who were discharged alive for AMI, coronary artery bypass graft (CABG) or percutaneous coronary interventions (PCI) in the year prior to the measurement year, or who had a diagnosis of ischemic vascular disease (IVD) during the measurement year and the year prior to the measurement year, who had LDL-C screening during the measurement year

Protocol-NCQA HEDIS CMC

Data source-Administrative

Analyses-Means tests between Wellness Plan members and three comparison groups before and after implementation

35B Whether member meeting above protocol had LDL-C screening

Protocol-NCQA HEDIS CMC adapted for individual

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

Measure 36 Self-reported receipt of flu shot

Percent of respondents who reported having a flu shot

Protocol-CMS Health Care Quality Measures for Adults, 2013

Data source-Member Survey

Analyses-Means tests between Wellness Plan members and three comparison groups before and after implementation

Measure 37 Emergency department use

Percent of respondents who reported that the care they received at their most recent visit to the emergency room could have been provided in a doctor's office if one was available at the time

Protocol-Original items

Data source-Member Survey

Analyses-Means tests between Wellness Plan members and three comparison groups before and after implementation

Hypothesis 3.2

Wellness Plan members will have equal or lower rates of hospital admissions.

Measure 38 Admission rate for COPD, diabetes short-term complications, CHF, and asthma

The number of discharges for COPD, CHF, short-term complications from diabetes or asthma per 100,000 Medicaid members

Protocol-Original measure

Data source-Administrative

Analyses-Means tests between Wellness Plan members and three comparison groups before and after implementation

Measure 39 Admission rate for COPD

39A Number of discharges for COPD per 100,000 Medicaid members

Protocol-Adult Core Measures #9, PQI 05

Data source-Administrative

Analyses-Means tests between Wellness Plan members and three comparison groups before and after implementation

39B Whether member had an admission for COPD

Protocol-Adult Core Measures #9, PQI 05 adapted for individual

Data source-Administrative

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

Measure 40 Admission rate for diabetes short-term complications

40A 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 Wellness Plan members and three comparison groups before and after implementation

40B 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 41 Admission rate for CHF

41A Number of discharges for CHF per 100,000 Medicaid members

Protocol-Adult Core Measures #10, PQI 08

Data source-Administrative

Analyses-Means tests between Wellness Plan members and three comparison groups before and after implementation

41B Whether member had an admission for CHF

Protocol-Adult Core Measures #10, PQI 08 adapted for individual

Data source-Administrative

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

Measure 42 Admission rate for asthma

42A Number of discharges for asthma per 100,000 Medicaid members

Protocol-Adult Core Measures #11, PQI 15

Data source-Administrative

Analyses-Means tests between Wellness Plan members and three comparison groups before and after implementation

42B 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 43 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 Wellness Plan members and three comparison groups before and after implementation

Measure 44 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 Wellness Plan members and three comparison groups before and after implementation

Measure 45 Rate of hospital admissions in past 6 months

Hospitalization reported in the previous 6 months

Protocol-Original items

Data source-Member Survey

Analyses-RDD comparing Wellness Plan members and Medicaid State Plan adults at the threshold

DID for Wellness Plan members and three comparison groups before and after implementation

Measure 46 Rate of 30 day hospital readmissions

30 day readmissions reported in last 6 months

Protocol-Original items

Data source-Member Survey

Analyses-RDD comparing Wellness Plan members and Medicaid State Plan adults at the threshold

Hypothesis 3.3

Wellness Plan members will report equal or greater satisfaction with the care provided.

Measure 47 Provider communication

This is a CAHPS composite measure designed to assess respondent perception of how well their personal doctor communicated with them during office visits.

Protocol-CAHPS 5.0

Data source-Member Survey

Analyses-Means tests between Wellness Plan members and three comparison groups before and after implementation

Measure 48 Self-management support

This is a CAHPS Patient-Centered Medical Home (PCMH) composite measure designed to assess respondent perception of how well their provider supported them in taking care of their own health.

Protocol-CAHPS PCMH supplemental items

Data source-Member Survey

Analyses-Means tests between Wellness Plan members and three comparison groups before and after implementation

Measure 49 Attention to mental/emotional health

This is a CAHPS Patient-Centered Medical Home (PCMH) composite measure designed to assess respondent perception of how well their provider paid attention to their mental or emotional health which is the CAHPS way to assess the comprehensive care component of the PCMH.

Protocol-CAHPS PCMH supplemental items

Data source-Member Survey

Analyses-RDD comparing Wellness Plan members and Medicaid State Plan adults at the threshold

DID for Wellness Plan members and three comparison groups before and after implementation

Measure 50 Shared decision-making regarding medications

This is a CAHPS Patient-Centered Medical Home (PCMH) composite measure designed to assess respondent perception of how well their provider talked with them about their prescription medications which is the CAHPS way to assess the shared decision making component of the PCMH.

Protocol-CAHPS PCMH supplemental items

Data source-Member Survey

Analyses-RDD comparing Wellness Plan members and Medicaid State Plan adults at the threshold

DID for Wellness Plan members and three comparison groups before and after implementation

Measure 51 Care coordination

There are three individual items from the CAHPS Patient-Centered Medical Home (PCMH) items designed to assess respondent perception of their provider's attention to the care they received from other providers. This is the CAHPS way to assess the care coordination component of the PCMH.

Protocol-CAHPS PCMH supplemental items

Data source-Member Survey

Analyses-RDD comparing Wellness Plan members and Medicaid State Plan adults at the threshold

DID for Wellness Plan members and three comparison groups before and after implementation

Measure 52 Rating of personal doctor

Rating of personal doctor on 0-10 scale

Protocol-CAHPS 5.0

Data source-Member Survey

Analyses-Means tests between Wellness Plan members and three comparison groups before and after implementation

Measure 53 Rating of all care received

Rating of all care received on 0-10 scale

Protocol-CAHPS 5.0

Data source-Member Survey

Analyses-Means tests between Wellness Plan members and three comparison groups before and after implementation

Measure 54 Rating of health care plan

Rating of health care plan on 0-10 scale

Protocol-CAHPS 5.0

Data source-Member Survey

Analyses-Means tests between Wellness Plan members and three comparison groups before and after implementation

Question 4 What are the effects of the Wellness Plan on the costs of providing care?Hypothesis 4.1

The cost for covering Wellness Plan members will be comparable to the predicted costs for covering the same expansion group in the Medicaid State Plan.

Measure 55 Compare Wellness Plan PMPM costs to those in the Medicaid State Plan and the Wellness Plan

Per Member Per Month (PMPM) costs calculated for all care and specific cost categories such as inpatient, emergency room, specialist, behavioral/emotional, and prescription medications

Protocol-Original measure

Data source-Administrative

Analyses-ICER utilizing MPC and 4 comparison groups before and after implementation

RDD comparing Wellness Plan members and Medicaid State Plan adults at the threshold

DID for Wellness Plan members and three comparison groups before and after implementation

Question 5 What are the effects of the premium incentive and copayment disincentive programs on Wellness Plan enrollees?Hypothesis 5.1

The premium incentive for the Wellness Plan enrollees will not impact the ability to receive health care.

Measure 56 Member awareness of premium incentive

The percent of respondents who are aware of the premiums

Protocol-Original items

Data source-Member Survey

Analyses-Means tests between Wellness Plan members and three comparison groups before and after implementation

Measure 57 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

Protocol-Original items

Data source-Member Survey

Analyses-RDD comparing Wellness Plan members and Medicaid State Plan adults at the threshold

DID for Wellness Plan members and three comparison groups before and after implementation

Measure 58 Member perception of hardship of premium levels

The percent who report that they would be 'somewhat' or 'a great deal' worried if they had to pay a \$5 or \$10/month premium

Protocol-Original items

Data source-Member Survey

Analyses-Means tests between Wellness Plan members and three comparison groups before and after implementation

Hypothesis 5.2

The copayment for inappropriate emergency department (ED) use for the Wellness Plan enrollees will not pose an access to care barrier.

Measure 59 Member awareness of the copayment

The percent of respondents who are aware of the \$8 copayment for inappropriate ER use

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 measure

Data source-Administrative

Analyses-Process measures for Wellness Plan

Measure 60 Member understanding of a non-emergent condition

The percent of respondents who report that it will be 'somewhat' or 'very' easy for them to determine when their health condition would be considered an emergent

Protocol-Original items

Data source-Member Survey

Analyses-Means tests between Wellness Plan members and three comparison groups before and after implementation

Measure 61 Perception of effectiveness of copayment on reducing non-emergent use of the ED

The percent who report that an \$8 per visit copayment would keep them from going to the emergency room for a health condition that could be treated in their doctor's office instead

Protocol-Original items
Data source-Member Survey
Analyses-Means tests between Wellness Plan members and three comparison groups before and after implementation

Hypothesis 5.3

In year two and beyond, the utilization of an annual exam will be higher than in the first year of the program.

Measure 62 Well adult visit

62A Percent of members with a well adult visit

Protocol-Original measure
Data source-Administrative
Analyses-Means tests between Wellness Plan members and three comparison groups before and after implementation

62B Whether member had well adult visit

Protocol-Original measure
Data source-Administrative
Analyses-RDD comparing Wellness Plan members and Medicaid State Plan adults at the threshold
DID for Wellness Plan members and three comparison groups before and after implementation

Hypothesis 5.4

In year two and beyond, the utilization of smoking cessation services will be higher than in the first year of the program.

Measure 63 Medical assistance with smoking and tobacco use

The percent of members that were current smokers or tobacco users and who received medical assistance from a health care provider during the measurement year in the following three ways: 1) Advised Smokers and Tobacco Users to Quit, 2) Discussed Cessation Medications, and 3) Discussed Cessation Strategies.

Protocol-CMS Health Care Quality Measures for Adults, 2013
Data source-Member Survey
Analyses-Means tests between Wellness Plan members and three comparison groups before and after implementation

Question 6 What is the adequacy of the provider network for Wellness Plan enrollees as compared to those in the Iowa Medicaid State Plan?

Hypothesis 6.1

Iowa Wellness Plan members will have the same access to an adequate provider network as members the Medicaid State Plan.

Measure 64 Geographic distance and time spent travelling to primary care provider

Average travel distance and average time to access primary care provider in local

service delivery area

Protocol-Original measure
Data source-Administrative
Analyses-GIS analyses

Measure 65 Analysis of rules and procedures for determining the adequacy of the provider network

Subjective assessment of the rules and policies surrounding network adequacy

Protocol-Original measure
Data source-Plan documents
Analyses- Process measures for Wellness Plan

Measure 66 Provider willingness to accept new patients

Percent of primary care providers indicating they will take new patients who are members of the plan

Protocol-Original items
Data source-Provider Survey
Analyses-RDD comparing Wellness Plan members and Medicaid State Plan adults at the threshold
DID for Wellness Plan members and three comparison groups before and after implementation

Measure 67 Provider satisfaction with plan key components such as fee schedules and documentation

Qualitative assessment of provider opinions on aspects of the plan

Protocol-Original items
Data source-Provider Survey
Analyses-RDD comparing Wellness Plan members and Medicaid State Plan adults at the threshold
DID for Wellness Plan members and three comparison groups before and after implementation

Areas of emphasis

To clarify the areas of the evaluation designed to determine the effects of specific program aspects, particularly those that may be unique to Iowa or private exchanges we have provided an additional section pulling together the research questions and hypotheses that relate to each area of emphasis.

Copayment for non-emergency use of the emergency department

Iowa's STC that has been approved by CMS indicates that:

"...the state may impose a copayment for non-emergency use of the emergency room consistent with its approved state plan and with all federal requirements that are set forth in statute, regulation and policies, including exemptions from cost-sharing set forth in 42 CFR § 447.56.

In the current evaluation plan, the impact of these incentives is embedded in Research Question 1, hypothesis 1.4 and Research Question 5, hypothesis 5.3.

Question 1 What are the effects of the Wellness Plan on member access to care?

Hypothesis 1.4

Wellness Plan members will have equal or greater access to care, resulting in equal or lower use of emergency department services for non-emergent care.

Measure 20 Non-emergent ED use

20A Number of non-emergent ED visits per 1,000 member months

Protocol-Original measure

Data source-Administrative

Analyses-Means testing between Wellness Plan members and the three comparison groups before and after implementation

20B Whether member had a non-emergent ED visit

Protocol-Original measure

Data source-Administrative

Analyses-RDD comparing Wellness Plan members and Medicaid State Plan adults at the threshold

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

Measure 21 Follow-up ED visits

21A Percent of members with ED visit within the first 30days after index ED visit

Protocol-Original measure

Data source-Administrative

Analyses-Means testing between Wellness Plan members and the three comparison groups before and after implementation

20B Whether member had an ED visit within the first 30days after index ED visit

Protocol-Original measure

Data source-Administrative

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

Measure 22 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 Wellness Plan members and the three comparison groups before and after implementation

Question 5 What are the effects of the premium incentive and copayment disincentive programs on

Wellness Plan enrollees?

Hypothesis 5.2

The copayment for inappropriate emergency department (ED) use for the Wellness Plan enrollees will not pose an access to care barrier.

Measure 59 Member awareness of the copayment

The percent of respondents who are aware of the \$8 copayment for inappropriate ER use

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 measure

Data source-Administrative

Analyses-Process measures for Wellness Plan

Measure 60 Member understanding of a non-emergent condition

The percent of respondents who report that it will be 'somewhat' or 'very' easy for them to determine when their health condition would be considered an emergent

Protocol-Original items

Data source-Member Survey

Analyses-Means tests between Wellness Plan members and three comparison groups before and after implementation

Measure 61 Perception of effectiveness of copayment on reducing non-emergent use of the ED

The percent who report that an \$8 per visit copayment would keep them from going to the emergency room for a health condition that could be treated in their doctor's office instead

Protocol-Original items

Data source-Member Survey

Analyses-Means tests between Wellness Plan members and three comparison groups before and after implementation

Non-Emergency Medical Transportation (NEMT)

Iowa's STC that has been approved by CMS also indicates that:

"The state is not required to assure NEMT to and from providers for the Wellness Plan Population. This waiver authority will sunset after one year, to allow for reevaluation of this authority to allow for the state and CMS to consider the impact on access to care."

In the current evaluation plan, the impact of not providing NEMT as a covered service is embedded in Research Question 1, hypothesis 1.5. We continue discussions with the University of Iowa Institutional Review Board regarding the possibility of linking claims data to survey results. This linkage would allow us to determine whether those who indicated lack of NEMT was a problem were also less likely to get care. Should this approach be infeasible, we will attempt to derive a weighted region based measure of lack of NEMT as a barrier to care and link this to region based measures of

access. This approach is driven largely by the data we obtain through the surveys.

Question 1 What are the effects of the Wellness Plan on member access to care?

Hypothesis 1.5

Wellness Plan members without a non-emergency transportation benefit will have equal or lower barriers to care resulting from lack of transportation.

Measure 23 Barriers to care due to transportation

Member experiences with transportation issues to and from health care visits

Protocol-Original items

Data source-Member Survey

Analyses-RDD comparing Wellness Plan members and Medicaid State Plan adults at the threshold

Behavioral/emotional health services

Though there is no specific language in the STCs that addresses this issue, the State has made it clear that there are behavioral/emotional care that will be limited within the QHPs. In particular, behavioral health intervention services, assertive community treatment, intensive psychiatric rehab, community support service, peer support, residential substance abuse treatment and a host of other services are not required as part of the QHP benefit package.

In the current evaluation plan, the impact of less mental health coverage is embedded in Research Question 1, hypothesis 1.1, measure 2; hypothesis 1.3, measures 17-19; Research question 3, hypothesis 3.3, measure 49:

Question 1 What are the effects of the Wellness Plan on member access to care?

Hypothesis 1.1

Wellness Plan members will have equal or greater access to primary care and specialty services.

Measure 2 Follow-up after hospitalization for mental illness

- 2A Percent of discharges for members with a mental illness diagnosis that were followed by a visit with a mental health provider

Protocol-NCQA HEDIS FUH; Adult core measure #3

Data source-Administrative

Analyses-Means tests between Wellness Plan members and three comparison groups before and after implementation

- 2B Whether a member discharged with a mental illness diagnosis had a follow-up visit with a mental health provider

Protocol-NCQA HEDIS AAP; Adult core measure #3 adapted as individuals

Data source-Administrative

Analyses-RDD between Wellness Plan members and Medicaid State Plan adults at the threshold.

DID for Wellness Plan members and three comparison groups before and after

implementation

Hypothesis 1.3

Wellness Plan members will have greater or equal access to mental and behavioral health services.

Measure 17 Anti-depressant medication management

17A Percent of members with major depressive disorder who remained on antidepressant medication

Protocol-NCQA HEDIS AMM; NQF 0105, Adult core measure #20

Data source-Administrative

Analyses-Means testing between Wellness Plan members and the three comparison groups before and after implementation

17B Whether a member with major depressive disorder remained on antidepressant medication

Protocol-NCQA HEDIS AMM; NQF 0105, Adult core measure #20 adapted for individuals

Data source-Administrative

Analyses-RDD comparing Wellness Plan members and Medicaid State Plan adults at the threshold

DID for Wellness Plan members and three comparison groups before and after implementation

Measure 18 Mental health utilization

18A Number and percent of members receiving any mental health services

Protocol-NCQA HEDIS MPT

Data source-Administrative

Analyses-Means testing between Wellness Plan members and the three comparison groups before and after implementation

18B Number of mental health services a member received

Protocol-NCQA HEDIS MPT adapted for individuals

Data source-Administrative

Analyses-RDD comparing Wellness Plan members and Medicaid State Plan adults at the threshold

DID for Wellness Plan members and three comparison groups before and after implementation

Measure 19 Behavioral/emotional care

Access to and unmet need for preventive care

Protocol-CAHPS 4.0; NHIS

Data source-Member Survey

Analyses-DID for Wellness Plan members and three comparison groups before and after implementation

Question 3 What are the effects of the Wellness Plan on member quality of care?

Hypothesis 3.3

Wellness Plan members will report equal or greater satisfaction with the care provided.

Measure 49 Attention to mental/emotional health

This is a CAHPS Patient-Centered Medical Home (PCMH) composite measure designed to assess respondent perception of how well their provider paid attention to their mental or emotional health which is the CAHPS way to assess the comprehensive care component of the PCMH.

Protocol-CAHPS PCMH supplemental items

Data source-Member Survey

Analyses-RDD comparing Wellness Plan members and Medicaid State Plan adults at the threshold

DID for Wellness Plan members and three comparison groups before and after implementation

Churning

Churning, the process whereby people move between Medicaid programs and QHPs as their eligibility changes has been identified as a major area of concern. Generally, the movement from one coverage option to another may bring with it changes in access to care through differing provider networks, benefit structures, and service provider locations. Researchers estimating the amount of churn within Medicaid indicate that up to 50% of members may move across plans. The evaluation will focus on whether and to what extent members move between programs and on how that movement affects their access to care.

Question 2 What are the effects of the Wellness Plan on member insurance coverage gaps and insurance service when their eligibility status changes (churning)?

Hypothesis 2.1

Wellness Plan members will experience equal or less churning.

Measure 25 Gaps in coverage in past 12 months

Number of months in the previous year when the respondent did not have health insurance coverage

Protocol-Original item

Data source-Member Survey

Analyses-RDD comparing Wellness Plan members and Medicaid State Plan adults at the threshold

Measure 26 Consecutive months covered by an insurance plan

Percent of members with 6 months continuous eligibility and 12 months continuous eligibility

Protocol-Measures from literature

Data source-Administrative

Analyses-RDD comparing Wellness Plan members and Medicaid State Plan adults at the threshold

- Measure 27 Number of times member changes plans and/or loses eligibility during the year
- Whether member did not change plans or lose eligibility, changed plans or lost eligibility once, changed plans or lost eligibility 2-3times or changed plans or lost eligibility 4 or more times
- Protocol-Original measure
Data source-Administrative
Analyses-RDD comparing Wellness Plan members and the three comparison groups before and after implementation

Hypothesis 2.2

Wellness Plan members will maintain continuous access to a regular source of care when their eligibility status changes.

- Measure 28 Proportion who had to change primary care physician when joining the Wellness Plan
- Percent of members who switched who switched primary care physicians at entry to plan
- Protocol-Original measure
Data source-Administrative
Analyses-Means testing between Wellness Plan members and the three comparison groups before and after implementation
- Measure 29 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 Wellness Plan members and the three comparison groups before and after implementation
- Measure 30 Continuity of care and satisfaction if they need to change to a new primary care physician when enrolled with a new plan
- Member experiences with changing personal doctor/primary care provider
- Protocol-Original items
Data source-Member Survey
Analyses-RDD comparing Wellness Plan members and the three comparison groups before and after implementation

Healthy Behavior incentives

As allowed in Iowa's STC Iowa is going to be implementing a "healthy behaviors" component to the Iowa Health and Wellness Plan to encourage more preventive behavior. Enrollees will be asked to complete these healthy behaviors, defined as an annual physical exam and a clinical risk assessment, each year.

The evaluation will consider the impact of the ways that the IHAWP will be incentivizing the completion of these healthy behaviors from both the provider and enrollee perspective. In particular, the program will be providing both positive and negative encouragement as described below.

1) Enrollee incentives

- a. Positive incentive-Enrollees will be provided with a reward to be determined if they complete certain healthy behaviors beginning in year two. A request for proposals (RFP) will be let soon by the Iowa Medicaid Enterprise for a vendor who will provide a reward system for enrollees who complete an annual physical exam, a health risk assessment and/or some other healthy behaviors that might want to be incentivized such as completing a smoking cessation program (exact protocols are still being developed). Examples might be a gift card, cash reward or the ability to select from a variety of rewards. The exact nature of the incentive will be determined between the IME and the vendor following the completion of the RFP process. It is possible that a randomized trial could be implemented to evaluate which among several incentives was most effective with enrollees.
- b. Negative incentive-While all enrollees will be “required” to complete the healthy behaviors annually, those in the Wellness Plan will face paying a \$10 monthly premium if they do not complete the healthy behaviors annually (the premiums would begin in year two after an initial year to comply). The person can be disenrolled for failure to pay the premium for three straight months.

In the current evaluation plan, the impact of these incentives is embedded in Research Question 5 and the following hypotheses:

Question 5 What are the effects of the premium incentive and copayment disincentive programs on Wellness Plan enrollees?

Hypothesis 5.1

The premium incentive for the Wellness Plan enrollees will not impact the ability to receive health care.

Measure 56 Member awareness of premium incentive

The percent of respondents who are aware of the premiums

Protocol-Original items

Data source-Member Survey

Analyses-Means tests between Wellness Plan members and three comparison groups before and after implementation

Measure 57 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

Protocol-Original items

Data source-Member Survey

Analyses-RDD comparing Wellness Plan members and Medicaid State Plan adults at the threshold

DID for Wellness Plan members and three comparison groups before and after implementation

Measure 58 Member perception of hardship of premium levels

The percent who report that they would be ‘somewhat’ or ‘a great deal’ worried if

they had to pay a \$5 or \$10/month premium

Protocol-Original items

Data source-Member Survey

Analyses-Means tests between Wellness Plan members and three comparison groups before and after implementation

Hypothesis 5.3

In year two and beyond, the utilization of an annual exam will be higher than in the first year of the program.

Measure 62 Well adult visit

62A Percent of members with a well adult visit

Protocol-Original measure

Data source-Administrative

Analyses-Means tests between Wellness Plan members and three comparison groups before and after implementation

62B Whether member had well adult visit

Protocol-Original measure

Data source-Administrative

Analyses-RDD comparing Wellness Plan members and Medicaid State Plan adults at the threshold

DID for Wellness Plan members and three comparison groups before and after implementation

Currently there is no evaluation of the impact of the provider incentive.

A more robust evaluation plan of the specific provider and enrollee incentives will be completed once the RFP process is complete, and the actual enrollee incentives are known. This evaluation will be submitted by the IME to CMS for review and approval prior to implementation.

Dental Wellness Plan

The new “Dental Wellness Plan” is being implemented beginning May 1, 2014 for adults in both the Wellness Plan and Wellness Plan Plan. In the first year, this plan will be operated by Delta Dental of Iowa and will include an earned benefits model to encourage healthy preventive care seeking behaviors.

Provider incentives

Delta Dental of Iowa will set aside \$1 million that will be distributed at the end of year one among all participating dentists based on the number of annual dental exams and clinical risk assessments that they complete.

Enrollee incentives

Positive incentive-Enrollees who complete an annual dental exam and clinical risk assessment can earn the ability to receive more services. Initially all enrollees will be eligible for a “Core” set of

benefits that includes diagnostic and preventive services, emergency services, stabilization services (e.g., large cavities), root canals if emergent, and dentures if patients are edentulous. If they return for an exam in 6-12 months, they can “Enhanced” services such as routine fillings, root canals, non-surgical gum treatment, and non-emergent tooth extractions. After receiving a third exam in 6-12 from the second one, they can receive “Enhanced Plus” services such as tooth replacements, crowns and gum surgeries.

Negative incentive-If enrollees do not complete an exam every 6-12 months, they will lose the ability to receive the Enhanced or Enhanced Plus services.

In the current evaluation plan, the impact of these incentives is included in Research Question 7 and hypotheses 7.1 and 7.2.

Hypothesis 7.1

Dental Wellness Plan members will have greater access to dental care than adults in the Medicaid State Plan.

Measure 74 Dental care access

74A Percent of members who receive any dental care

Protocol-NCQA HEDIS ADV; NQF 1388 adapted for adults

Data source-Administrative

Analyses-Means tests between Wellness Plan members and three comparison groups before and after implementation

74B Whether member received any dental care

Protocol-NCQA HEDIS ADV; NQF 1388 adapted for adults and individuals

Data source-Administrative

Analyses- RDD comparing Wellness Plan members and MPC members at the threshold

DID for Wellness Plan members and three comparison groups before and after implementation

Hypothesis 7.2

Dental Wellness Plan members will be more likely to receive preventive dental care than adults in the Medicaid State Plan.

Measure 75 First preventive dental visit

75A Percent of members who have a dental check-up within their first 6-12 months in the program

Protocol-Original measure

Data source-Administrative

Analyses-Means tests between Wellness Plan members and three comparison groups before and after implementation

75B Whether member received a dental check-up within their first 6-12 months in the program

Protocol-Original measure

Data source-Administrative

Analyses- RDD comparing Wellness Plan members and MPC members at the threshold

DID for Wellness Plan members and three comparison groups before and after implementation

Measure 76 Second preventive dental visit

76A Percent of members who have a dental check-up within 6-12 months of their first dental check-up

Protocol-Original measure

Data source-Administrative

Analyses-Means tests between Wellness Plan members and three comparison groups before and after implementation

76B Whether member received a dental check-up within 6-12 months of their first dental check-up

Protocol-Original measure

Data source-Administrative

Analyses- RDD comparing Wellness Plan members and MPC members at the threshold

DID for Wellness Plan members and three comparison groups before and after implementation

Measure 77 Any preventive dental care

Percent of members who receive any preventive dental care

Protocol-Original measure

Data source-Administrative

Analyses-Means tests between Wellness Plan members and three comparison groups before and after implementation

A more robust evaluation plan for the Dental Wellness Plan and the specific provider and enrollee incentives will be developed once the specifics of the program are approved and operational. This evaluation plan will be submitted by the IME to CMS for review and approval prior to implementation.

Medically Exempt members

Enrollees who meet the income requirements for Marketplace Choice or Wellness Plan with '*disabling mental disorders (including adults with serious mental illness), individuals with chronic substance use disorders, individuals with serious and complex medical conditions, individuals with a physical, intellectual or developmental disability that significantly impairs their ability to perform 1 or more activities of daily living, or individuals with a disability determination based on Social Security criteria*' may apply for and be deemed Medically Exempt. Enrollees who qualify to as Medically Exempt are enrolled in Medicaid State Plan to allow for a broader set of services.

Currently, approximately 3,200 members of Marketplace Choice been given medical exemption and transferred to Wellness Plan or Medicaid State Plan. Those in Wellness Plan are provided a less expansive set of mental health and substance abuse options than those transferred to Medicaid State Plan. Though this member group does not serve as a comparison group, they are a group of interest.

The evaluation will detail the services provided to Medically Exempt (ME) members that would not have been provided under the Marketplace Choice Plan. We will include the following hypotheses and metrics for this group.

Question 1 What are the effects of the Marketplace Choice Plan on ME members' access to care?

Hypothesis 1.1

ME members will have equal or greater access to primary care and specialty services.

Measure 1 Adults access to primary care

1A Percent of members who had an ambulatory care visit

Protocol-NCQA HEDIS AAP

Data source-Administrative

Analyses-Means tests between ME members and Marketplace Choice before and after implementation

Measure 2 Follow-up after hospitalization for mental illness

2A Percent of discharges for members with a mental illness diagnosis that were followed by a visit with a mental health provider

Protocol-NCQA HEDIS FUH; Adult core measure #3

Data source-Administrative

Analyses-Means tests between ME members and Marketplace Choice before and after implementation

Measure 11 Flu shots in past year

11A Percent of members 21-64 who received an influenza vaccination

Protocol-CAHPS; NQF 0039

Data source-Member Survey; Administrative

Analyses-Means tests between ME members and Marketplace Choice before and after implementation

Hypothesis 1.3

ME members will have greater or equal access to mental and behavioral health services.

Measure 18 Mental health utilization

18A Number and percent of members receiving any mental health services

Protocol-NCQA HEDIS MPT

Data source-Administrative

Analyses-Means tests between ME members and Marketplace Choice before and after implementation

Hypothesis 1.4

ME members will have equal or greater access to care, resulting in equal or lower use of emergency department services for non-emergent care.

Measure 20 Non-emergent ED use

20A Number of non-emergent ED visits per 1,000 member months

Protocol-Original measure

Data source-Administrative

Analyses-Means tests between ME members and Marketplace Choice before and after implementation

Measure 21 Follow-up ED visits

21A Percent of members with ED visit within the first 30days after index ED visit

Protocol-Original measure

Data source-Administrative

Analyses-Means tests between ME members and Marketplace Choice before and after implementation

Budget

PERSONNEL	7/1/2014- 12/31/2014	1/1/2015- 12/31/2015	1/1/2016- 12/31/2016	1/1/2017- 12/31/2017
Betsy Momany, PI	(6 mos)	(12 mos)	(12 mos)	(12 mos)
30%, 44 months	\$ 14,967	\$ 30,383	\$ 31,295	\$ 32,234
Fringe benefits	\$ 5,343	\$ 10,847	\$ 11,172	\$ 11,507
Pete Damiano, Co-PI				
15%, 44 months	\$ 15,234	\$ 30,924	\$ 32,323	\$ 32,808
Fringe benefits	\$ 3,412	\$ 6,927	\$ 7,135	\$ 7,349
Suzanne Bentler, Investigator				
30%, 44 months	\$ 10,830	\$ 22,582	\$ 23,259	\$ 23,957
Fringe benefits	\$ 3,866	\$ 8,062	\$ 8,304	\$ 8,553
Dan Shane, Investigator				
10%, 44 months	\$ 4,596	\$ 9,331	\$ 9,611	\$ 9,899
Fringe benefits	\$ 1,342	\$ 2,725	\$ 2,806	\$ 2,890
Susan McKernan, Investigator				
10%, 44 months	\$ 4,897	\$ 9,942	\$ 10,240	\$ 10,547
Fringe benefits	\$ 1,097	\$ 2,227	\$ 2,294	\$ 2,363
Natoshia Askelson, Investigator				
15%, 44 months	\$ 6,026	\$ 12,232	\$ 12,599	\$ 12,977
Fringe benefits	\$ 2,151	\$ 4,367	\$ 4,498	\$ 4,633
Survey Administrator/Analyst, (TBA)				
50%, 44 months	\$ 14,163	\$ 28,750	\$ 29,612	\$ 30,501
Fringe benefits	\$ 5,056	\$ 10,264	\$ 10,572	\$ 10,889
Claims Data Analyst, (TBA)				
100%, 44 months	\$ 28,325	\$ 57,500	\$ 59,225	\$ 61,001
Fringe benefits	\$ 13,275	\$ 20,527	\$ 21,143	\$ 21,778
Database Administrator, (TBA)				
50%, 44 months	\$ 16,738	\$ 28,750	\$ 29,612	\$ 30,501
Fringe benefits	\$ 5,975	\$ 10,264	\$ 10,572	\$ 10,889
Graduate Research Assistant, (TBA)				
100%, 44 months	\$ 22,252	\$ 45,172	\$ 46,527	\$ 47,923
Fringe benefits	\$ 2,782	\$ 5,646	\$ 5,816	\$ 5,990
TOTAL PERSONNEL	\$ 179,165	\$ 363,705	\$ 375,087	\$ 385,854
OTHER DIRECT COSTS				
Survey costs				
Provider (1500*\$20)	\$ 30,000		\$ 30,000	
Member (1350*3*\$25)	\$ 97,200	\$ 97,200	\$ 97,200	
Disenrollment Survey (100*\$100)		\$	\$ 10,000	
Office supplies, telephone copying	\$ 300	\$ 300	\$ 300	\$ 300
Travel & Meeting Costs	\$ 1,400	\$ 1,450	\$ 1,450	\$ 2,500
Graduate Tuition (no F&A)	\$ 16,212	\$ 16,698	\$ 17,199	\$ 17,715
Total Direct Costs	\$ 324,277	\$ 479,353	\$ 531,236	\$ 406,370
Facilities & Administration (8.0%)	\$ 25,942	\$ 38,348	\$ 42,499	\$ 32,510
Yearly Project Budget	\$ 350,219	\$ 517,701	\$ 573,739	\$ 438,879
Total Budget 44 months	\$1,864,308			

Budget Justification

Elizabeth T. Momany, PhD will provide 30% of her time as Principal Investigator. She will be responsible for directing the project, including all aspects of the research design implementation, data management, data analysis, project organization, writing and liaison with CMS, national evaluators and the State of Iowa. Her specific responsibilities include to assist in the ongoing conceptualization of the data analysis plan, to organize, develop and manage the claims, encounter, enrollment, and program data, and assist in data analysis. She will also assist in writing papers and reports. Following the completion of data analysis she will dedicate her time to assisting in the development and writing of the final report. 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 15% of his effort to supervise staff, liaise with state and federal policymakers, liaise with external and internal constituencies such as CMS and University personnel, and develop and write research reports and papers. 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 30% of her time to focus on the development and analyses of the outcomes data with a particular emphasis on the facility based outcomes such as readmission rates. She will also be instrumental in developing the member surveys.

Dan Shane, PhD will provide 10% of his time to the development, refinement and testing of the cost effects models and sensitivity analyses. His special knowledge regarding the effects of a system that automatically enrolls eligible members and how to model these effects will be critical to the successful evaluation of cost savings.

Susan McKernan, DDS, PhD will provide 10% of her time to direct geo mapping and analyses required to determine the provider network adequacy. Her previous work in developing and comparing service areas for dental care in Iowa adds needed skill and knowledge to the research team. In addition, Dr. McKernan brings experience in provider survey development and implementation.

Natoshia Askelson, PhD will provide 15% of her time to development and direct the disenrollment surveys. Working with DHS staff and stakeholders she will develop a telephone-based interview to determine the effects of disenrollment on members.

Survey Administrator/Analyst (TBA) at 50% will manage the day-to-day activities of the surveys, including developing and finalizing the instruments, overseeing the printing, mailing, and data collection, organizing and assimilating the data, and documenting procedures and protocols. The Survey administrator/analyst will be responsible for analyzing survey data under the direction of the investigators.

Claims Data Analyst (TBA) at 100% will provide support to investigators preparing datasets for analyses, independently performing simple data analyses and providing descriptive statistics to the investigators, performing complex data analyses under the direction of the investigators, documenting data protocols and archiving data following completion of analyses. The data analyst will be responsible for aiding in the cost, outcomes, and cost effectiveness analytics.

Database Administrator (TBA) at 50% time will continue the development and maintenance of the Medicaid data repository housing the claims, enrollment, encounter, and provider data for the study

period. The data analyst/database administrator will provide support to investigators preparing datasets for analyses, documenting data protocols and archiving data following completion of analyses. In addition, the data analyst/database administrator will liaise with all entities providing data to the project including the Department of Human Services and health plans.

Graduate Research Assistant (TBA) at 100% 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.

Member Surveys

The project budget includes \$291,600 to complete 4,050 surveys: 1,350 baseline surveys for members of the Wellness Plan, Medicaid State Plan due to low income, and Medicaid State Plan due to disability determination ($1,350 \times 3 = 4,050$) and two post-implementation follow-up surveys for these groups one year and two years after the beginning of the Iowa Health and Wellness Plan ($1,350 \times 3 \times 3 = 12,150$). The cost for each survey is budgeted at \$24. This estimate is based on the current Health Home evaluation for Iowa Medicaid.

Provider Surveys

Two waves of provider surveys are budgeted to determine provider experience and satisfaction with IHAWP. We anticipate mailed surveys to 1,500 providers at an estimated cost of \$20 per provider.

Disenrollment Surveys

Disenrollment surveys will begin on July 1, 2015 and continue through June 30, 2017 collecting 100 responses. Each survey will consist of a telephone interview developed by PPC personnel in consultation with DHS. The costs per interview is estimated at \$100 to include efforts to locate members and validate addresses and phone numbers, mailings to related to the interview and the telephone interview.

Materials and Supplies

Funds in the amount of \$1,200 across the four years are requested for supplies such as copy paper, pens, binders, secure files for data storage, etc.

Travel

We have budgeted \$6,800 for travel across the 3 years of the grant. This includes approximately \$250 per year for travel to meet with State program staff and \$1,450 per year to present the data at National meetings or meet with CMS and evaluators from other states.

Graduate Tuition

\$16,212 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

	2014			2015				2016				2017			
	Q2	Q3	Q4	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															
Enrollment outcomes															
Data Collection/Assimilation															
Demographics and Churning															
Claims-based outcomes															
Data Collection/Assimilation															
Protocol development															
Outcome rates															
Multivariate models															
Survey-based outcomes															
Survey development															
Survey data collection															
Analyses															
Network adequacy															
Provider survey development															
Provider survey data coll.															
Geomapping															
Cost Outcomes															
Model design															
PMPM models															
Incremental cost effectiveness															

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%
		<i>NOTE: Medically Exempt individuals will be enrolled in the Medicaid State Plan benefit with the option to Opt-out</i>	<i>NOTE: Medically Exempt individuals will be enrolled in the Medicaid State Plan benefit with the option to Opt-out</i>
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	<p>Mental Health and Substance Abuse services covered through the Iowa Plan, 1915(b) managed care plan (Magellan) – all populations except Medically Needy</p> <p>Iowa Plan benefits are the benefits described above</p>	<p>Mental Health and Substance Abuse services covered through the Iowa Plan</p> <p>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</p>	<p>Per QHP plan contracts if applicable</p> <p>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</p>
Integrated Health Home	<p>Eligibility based on specified mental health diagnosis</p> <p>IHH provides health home services, including peer support, care coordination, etc. through IHH providers</p>	<p>Only covered under the Medicaid State Plan <u>after</u> a Medically Frail/Exempt determination; person is moved into regular Medicaid</p>	<p>Only covered under the Medicaid State Plan <u>after</u> a Medically Frail/Exempt determination; person is moved into regular Medicaid</p>
Provider Network	<p>Magellan contracted provider network; Medicaid and Magellan reimbursement rates and policies</p>	<p>Magellan contracted provider network; Medicaid and Magellan reimbursement rates and policies</p>	<p>QHP contracted provider network; QHP reimbursement methods and contracts</p>

Appendix B

Measures summary

Measure number	Name	Measure description	Source	Data type	Comparisons	Analyses	Research Question							
							Access	Continuity	Quality	Costs	Incentive/disincentive	Network adequacy	Premium Monitoring	
1A	Adults' access to preventive/ambulatory health services	Percent of members who had an ambulatory or preventive care visit	NCQA HEDIS AAP	Administrative data	Pre-Post WP and 3 comp. groups	Means test	X		X	X				
1B	Adults' access to preventive/ambulatory health services	Whether the member had an ambulatory or preventive care visit	Above protocol modified for the individual	Administrative data	Pre-Post WP and 3 comp. groups	RDD & DID	X		X	X				
2A	Follow-up after hospitalization for mental illness	Percent of discharges for members with a mental illness diagnosis that were followed by a visit with a mental health provider	NCQA HEDIS FUH Adult core measure #13	Administrative data	Pre-Post WP and 3 comp. groups	Means test	X		X					
2B	Follow-up after hospitalization for mental illness	Whether a member discharged with a mental illness diagnosis had a follow-up visit with a mental health provider	Above protocol modified for the individual	Administrative data	Pre-Post WP and 3 comp. groups	RDD & DID	X		X					
3	Access to and unmet need for urgent care	1) Rating of timely access to urgent care 2) Needed urgent care but could not get it for any reason	1) CAHPS 5.0, 2) NHIS	Member Survey	Post WP and 3 comp. groups	Means test	X		X					
4	Access to and unmet need for routine care	1) Rating of timely access to routine care 2) Needed routine care but could not get it for any reason	1) CAHPS 5.0, 2) NHIS	Member Survey	Post WP and 3 comp. groups	Means test	X		X					X
5	Timely Appointments, Care, & Information	Member experience with getting appointments for care in a timely manner, time spent waiting for their appointment, and receiving timely answers to their questions	CAHPS 5.0	Member Survey	Post WP and 3 comp. groups	RDD	X		X					
6	After-hours care	Member experience with knowing what to do to obtain care after regular office hours	CAHPS 5.0	Member Survey	Post WP and 3 comp. groups	RDD	X		X					

Measure number	Name	Measure description	Source	Data type	Comparisons	Analyses	Research Question							
							Access	Continuity	Quality	Costs	Incentive/ disincentive	Network adequacy	Premium Monitoring	
7	Specialist Care	Access to and unmet need for care from a specialist	1) CAHPS 5.0, 2) NHIS	Member Survey	Post WP and 3 comp. groups	RDD	X		X					
8	Prescription medications	Access to and unmet need for prescription medications	1) CAHPS 4.0, 2) NHIS	Member Survey	Post WP and 3 comp. groups	RDD	X		X					
9A	Breast cancer screening	Percent of women 50-64 who had a mammogram to screen for breast cancer	NCQA HEDIS BCS, NQF 0031, Adult core measure #3	Administrative data	Pre-Post WP and 3 comp. groups	Means test	X		X					
9B	Breast cancer screening	Whether a women 50-64 had a mammogram to screen for breast cancer	Above protocol modified for the individual	Administrative data	Pre-Post WP and 3 comp. groups	DID	X		X					
10A	Cervical cancer screening	Percent of women 21-64 who were screened for cervical cancer	NCQA HEDIS CCS, NQF 0032, Adult core measure #4	Administrative data	Pre-Post WP and 3 comp. groups	Means test	X		X					
10B	Cervical cancer screening	Whether a woman 21-64 was screened for cervical cancer	Above protocol modified for the individual	Administrative data	Pre-Post WP and 3 comp. groups	DID	X		X					
11A	Flu vaccinations for adults ages 19-64	Percent of members 19-64 who received an influenza vaccination	CAHPS, NQF 0039	CAHPS survey, administrative data	Pre-Post WP and 3 comp. groups	Means test	X		X	X				
11B	Flu vaccinations for adults ages 19-64	Whether a member 19-64 received an influenza vaccination	Above protocol modified for the individual	CAHPS survey, administrative data	Pre-Post WP and 3 comp. groups	RDD & DID	X		X	X				
12	Chlamydia screening in women	Percent of women 18-24 years of age who were identified as sexually active and had at least one test for Chlamydia	NCQA HEDIS CHL, NQF 0033	Administrative data	Pre-Post WP and 3 comp. groups	Means test	X		X					
13A	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	Pre-Post WP and 3 comp. groups	Means test	X		X	X				

Measure number	Name	Measure description	Source	Data type	Comparisons	Analyses	Research Question						
							Access	Continuity	Quality	Costs	Incentive/ disincentive	Network adequacy	Premium Monitoring
13B	Comprehensive diabetes care: Hemoglobin A1c	Whether a member with type 1 or type 2 diabetes had Hemoglobin A1c testing	Above protocol modified for the individual	Administrative data	Pre-Post WP and 3 comp. groups	RDD & DID	X		X	X			
14A	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	Pre-Post WP and 3 comp. groups	Means test	X		X	X			
14B	Comprehensive diabetes care: LDL-C screening	Whether a member with type 1 or type 2 diabetes had LDL-C screening	Above protocol modified for the individual	Administrative data	Pre-Post WP and 3 comp. groups	RDD & DID	X		X	X			
15	Annual monitoring for patients on persistent medication	Percent of members on a persistent medication (ACE/ARB, digoxin, diuretic, anticonvulsant) who were monitored	NCQA HEDIS MPM, Adult core measure #22	Administrative data	Pre-Post WP and 3 comp. groups	Means test	X		X				
16	Preventive care	Access to and unmet need for preventive care	1) Original item, 2) NHIS	Member Survey	Post WP and 3 comp. groups	RDD	X		X				
17A	Anti-depressant medication management	Members with major depressive disorder who remained on antidepressant medication	NCQA HEDIS AMM, NQF 0105, Adult core measure #20	Administrative data	Pre-Post WP and 3 comp. groups	Means test	X		X				
17B	Anti-depressant medication management	Whether a member with major depressive disorder is prescribed an antidepressant and length of time on antidepressant	Above protocol modified for the individual	Administrative data	Pre-Post WP and 3 comp. groups	RDD & DID	X		X				
18A	Mental health utilization	Number and percent of members receiving any mental health service	NCQA HEDIS MPT	Administrative data	Pre-Post WP and 3 comp. groups	Means test	X						
18B	Mental health utilization	Number of mental health services received	Above protocol modified for the individual	Administrative data	Pre-Post WP and 3 comp. groups	RDD & DID	X						
19	Mental/Emotional Care	Access to and unmet need for mental/emotional care	1) CAHPS 4.0, 2) NHIS	Member Survey	Post WP and 3 comp. groups	DID	X		X				

							Research Question						
Measure number	Name	Measure description	Source	Data type	Comparisons	Analyses	Access	Continuity	Quality	Costs	Incentive/ disincentive	Network adequacy	Premium Monitoring
20A	Non-emergent ED use	Number of non-emergent ED visits per 1,000 member months	Original measure	Administrative data	Pre-Post WP and 3 comp. groups	Means test	X			X	X		X
20B	Non-emergent ED use	Whether member had a non-emergent ED visit	Original measure	Administrative data	Pre-Post WP and 3 comp. groups	RDD and DID	X			X	X		X
21A	Follow-up ED visits	Percent of members with ED visit within the first 30days after index ED visit	Original measure	Administrative data	Post WP and 3 comp. groups	Means test	X		X		X		
21B	Follow-up ED visits	Days until second ED visit following index ED visit	Original measure	Administrative data	Pre-Post WP and 3 comp. groups	DID	X		X		X		
22	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	Pre-Post WP and 3 comp. groups	Means test	X		X				X
23	Barriers to care due to transportation	Member experiences with transportation issues to and from health care visits	Original items	Member Survey	Post WP and 3 comp. groups	RDD	X					X	
24A	EPSDT utilization	Percent of members age 19-20 with at least one EPSDT-related visit as defined by EPSDT procedure code modifiers	Original measure	Administrative data	Pre-Post WP and 3 comp. groups	Means test	X		X				
24B	EPSDT utilization	Whether member age 19-20 had at least one EPSDT-related visit as defined by EPSDT procedure code modifiers	Original measure	Administrative data	Pre-Post WP and 3 comp. groups	RDD	X		X				

Measure number	Name	Measure description	Source	Data type	Comparisons	Analyses	Research Question							
							Access	Continuity	Quality	Costs	Incentive/ disincentive	Network adequacy	Premium Monitoring	
25	Gaps in coverage in past 12 months	# of months in the previous year when the respondent did not have health insurance coverage	Original items	Member Survey	Pre-Post WP and 3 comp. groups	RDD		X						
26	6 months continuous eligibility and 12 months continuous eligibility	Percent of members with 6 months continuous eligibility and 12 months continuous eligibility	Previous literature	Administrative data	Pre-Post WP and 3 comp. groups	RDD		X						
27	Number of times member changes plans and/or loses eligibility	Percent of members each of 4 categories: did not change or lose, changed or lost 1 time, 2-3 times and 4 or more times	Original measure	Administrative data	Pre-Post WP and 3 comp. groups	RDD		X						
28	Proportion who had to change primary care physician	Percent of members who switched primary care physicians at entry to plan	Original measure	Administrative data	Post WP and 3 comp. groups	Means test		X	X					
29	Regular source of care	The percent who respond that they currently have a personal doctor	CAHPS 5.0	Member Survey	Pre-Post WP and 3 comp. groups	Means test	X	X	X					
30	Continuity of care	Member experiences with changing personal doctor/primary care provider	Original items	Member Survey	Post WP and 3 comp. groups	RDD		X	X					
31	Avoidance of antibiotic treatment in adults with acute bronchitis	The percent of members 19–64 years of age who were enrolled for at least 11 months during the measurement year with a diagnosis of acute bronchitis who were not dispensed an antibiotic prescription	NCQA HEDIS AAB, NQF 0058	Administrative data	Pre-Post WP and 3 comp. groups	RDD & DID			X					

Measure number	Name	Measure description	Source	Data type	Comparisons	Analyses	Research Question							
							Access	Continuity	Quality	Costs	Incentive/ disincentive	Network adequacy	Premium Monitoring	
32	Use of appropriate medications for people with asthma	The percent of members who were identified as having persistent asthma and who were appropriately prescribed medication during the measurement year	NCQA HEDIS ASM, NQF 0036	Administrative data	Pre-Post WP and 3 comp. groups	Means test			X					
33	Medication management for people with asthma	The percent of members identified as having persistent asthma who were dispensed appropriate medications that they remained on during the treatment period	NCQA HEDIS MMA, NQF 1799	Administrative data	Pre-Post WP and 3 comp. groups	Means test			X					
34A	Pharmacotherapy management of COPD exacerbation	The percent of COPD exacerbations for members age 40-64 years of age who had an acute inpatient discharge or emergency department visit during the first 11 months of the measurement year and who were enrolled for at least 30 days following the inpatient stay or emergency department visit and who were dispensed appropriate medications	NCQA HEDIS PCE			Means test			X					
34B	Pharmacotherapy management of COPD exacerbation	Whether member meeting above protocol experienced at least one COPD exacerbation	NCQA HEDIS PCE	Administrative data	Pre-Post WP and 3 comp. groups	DID								

Measure number	Name	Measure description	Source	Data type	Comparisons	Analyses	Research Question							
							Access	Continuity	Quality	Costs	Incentive/ disincentive	Network adequacy	Premium Monitoring	
35A	Cholesterol management for patients with cardiovascular conditions	The percent of members who were discharged alive for AMI, coronary artery bypass graft (CABG) or percutaneous coronary interventions (PCI) in the year prior to the measurement year, or who had a diagnosis of ischemic vascular disease (IVD) during the measurement year and the year prior to the measurement year, who had LDL-C screening during the measurement year	NCQA HEDIS CMC	Administrative data	Pre-Post WP and 3 comp. groups	Means test			X					
35B	Cholesterol management for patients with cardiovascular conditions	Whether member meeting above protocol had LDL-C screening during the measurement year	NCQA HEDIS CMC	Administrative data	Pre-Post WP and 3 comp. groups	DID			X					
36	Self-reported flu shot	Percent of respondents who reported having a flu shot	CMS Health Care Quality Measures for Adults, 2013	Member Survey	Post WP and 3 comp. groups	Means test			X					
37	Emergency Department Use	Percent of respondents who reported that the care they received at their most recent visit to the emergency room could have been provided in a doctor's office if one was available at the time	Original items	Member Survey	Post WP and 3 comp. groups	Means test			X					
38	Admission rate for COPD, diabetes short-term complications, CHF and asthma	The number of discharges for COPD, CHF, short-term complications from diabetes or asthma per 100,000 Medicaid members	Original measure	Administrative data	Pre-Post WP and 3 comp. groups	Means test			X	X				

Measure number	Name	Measure description	Source	Data type	Comparisons	Analyses	Research Question							
							Access	Continuity	Quality	Costs	Incentive/ disincentive	Network adequacy	Premium Monitoring	
39A	Admission rate for COPD	The number of discharges for COPD per 100,000 Medicaid members	Adult core #9, PQI 05	Administrative data	Pre-Post WP and 3 comp. groups	Means test			X					
39B	COPD admission	Whether or not member had admission for COPD	Above protocol modified for the individual	Administrative data	Pre-Post WP and 3 comp. groups	DID			X					
40A	Admission rate for diabetes short-term complications	The number of discharges for short-term complications of diabetes per 100,000 Medicaid members	Adult core #8, PQI 01	Administrative data	Pre-Post WP and 3 comp. groups	Means test			X					
40B	Diabetes short-term complication admission	Whether or not member had admission for short-term complications of diabetes	Above protocol modified for the individual	Administrative data	Pre-Post WP and 3 comp. groups	DID			X					
41A	Admission rate for CHF	The number of discharges for CHF per 100,000 Medicaid members	Adult core #10, PQI 08	Administrative data	Pre-Post WP and 3 comp. groups	Means test			X					
41B	CHF admission	Whether or not member had admission for CHF	Above protocol modified for the individual	Administrative data	Pre-Post WP and 3 comp. groups	DID			X					
42A	Admission rate for asthma	The number of discharges for asthma per 100,000 Medicaid members	Adult core #11, PQI 15	Administrative data	Pre-Post WP and 3 comp. groups	Means test			X					
42B	Asthma admission	Whether or not member had admission for asthma	Above protocol modified for the individual	Administrative data	Pre-Post WP and 3 comp. groups	DID			X					

Measure number	Name	Measure description	Source	Data type	Comparisons	Analyses	Research Question							
							Access	Continuity	Quality	Costs	Incentive/disincentive	Network adequacy	Premium Monitoring	
43	Inpatient utilization for 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	Pre-Post WP and 3 comp. groups	Means test			X	X				
44	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 measure #7	Administrative data	Pre-Post WP and 3 comp. groups	Means test			X					
45	Hospital Admissions	Hospitalization reported in the previous 6 months	Original items	Member Survey	Post WP and 3 comp. groups	RDD & DID	X		X					X
46	Hospital Readmission	Reported 30 day hospital readmissions	Original items	Member Survey	Post WP and 3 comp. groups	RDD			X					
47	Provider communication	This is a CAHPS composite measure designed to assess respondent perception of how well their personal doctor communicated with them during office visits.	CAHPS 5.0	Member Survey	Post	Means test			X					

Measure number	Name	Measure description	Source	Data type	Comparisons	Analyses	Research Question							
							Access	Continuity	Quality	Costs	Incentive/ disincentive	Network adequacy	Premium Monitoring	
48	Self-management support	This is a CAHPS Patient-Centered Medical Home (PCMH) composite measure designed to assess respondent perception of how well their provider supported them in taking care of their own health.	CAHPS PCMH Supplemental Items	Member Survey	Post	Means test			X					
49	Attention to mental/emotional health	This is a CAHPS Patient-Centered Medical Home (PCMH) composite measure designed to assess respondent perception of how well their provider paid attention to their mental or emotional health which is the CAHPS way to assess the comprehensive care component of the PCMH.	CAHPS PCMH Supplemental Items	Member Survey	Post	RDD & DID			X					
50	Shared-decision making	This is a CAHPS Patient-Centered Medical Home (PCMH) composite measure designed to assess respondent perception of how well their provider talked with them about their prescription medications which is the CAHPS way to assess the shared decision making component of the PCMH.	CAHPS PCMH Supplemental Items	Member Survey	Post	RDD & DID			X					

Measure number	Name	Measure description	Source	Data type	Comparisons	Analyses	Research Question							
							Access	Continuity	Quality	Costs	Incentive/disincentive	Network adequacy	Premium Monitoring	
51	Care coordination	There are three individual items from the CAHPS Patient-Centered Medical Home (PCMH) items designed to assess respondent perception of their provider's attention to the care they received from other providers. This is the CAHPS way to assess the care coordination component of the PCMH.	CAHPS PCMH Supplemental Items	Member Survey	Post	RDD & DID			X					
52	Rating of personal doctor	0-10 scale	CAHPS 5.0	Member Survey	Post	Means test			X					
53	Rating of overall health care	0-10 scale	CAHPS 5.0	Member Survey	Post	Means test			X					
54	Rating of health plan	0-10 scale	CAHPS 5.0	Member Survey	Post	Means test			X					
55	PMPM cost comparisons	Monthly total cost	Original measure	Administrative data	Pre-Post WP and 3 comp. groups	RDD & DID				X				
56	Member awareness of premium incentive	The percent of respondents who are aware of the premiums	Original item	Member Survey	Post	Means test					X			
57	Member perception of meeting premium waiver requirement	Respondent report of how easy it is for them to obtain a yearly physical exam	Original item	Member Survey	Post	RDD & DID					X			
58	Member perception of hardship of premium levels	The percent who report that they would be 'somewhat' or 'a great deal' worried if they had to pay a \$5 or \$10/month premium	Original items	Member Survey	Post	Means test					X			
59	Member awareness of copayment	The percent of respondents who are aware of the \$8 copayment for inappropriate ER use	Original item	Member Survey	Post	Descriptives					X			X

Measure number	Name	Measure description	Source	Data type	Comparisons	Analyses	Research Question										
							Access	Continuity	Quality	Costs	Incentive/disincentive	Network adequacy	Premium Monitoring				
60	Member understanding of non-emergent condition	The percent of respondents who report that it will be 'somewhat' or 'very' easy for them to determine when their health condition would be considered an emergent	Original item	Member Survey	Post	Means test						X			X		
61	Member perception of effectiveness of copayment	The percent who report that an \$8 per visit copayment would keep them from going to the emergency room for a health condition that could be treated in their doctor's office instead	Original item	Member Survey	Post	Means test						X			X		
62A	Well adult visit	Percent of members with a well adult visit (yearly physical exam)	Original measure	Administrative data	Pre-Post WP and 3 comp. groups	Means test	X		X	X		X			X		
62B	Well adult visit	Whether member had a well adult visit	Original measure	Administrative data	Pre-Post WP and 3 comp. groups	RDD & DID	X		X	X		X			X		
63	Medical assistance with smoking and tobacco use	The percent of members that were current smokers or tobacco users and who received medical assistance from a health care provider during the measurement year in the following three ways: 1) Advised Smokers and Tobacco Users to Quit, 2) Discussed Cessation Medications, and 3) Discussed Cessation Strategies.	CMS Health Care Quality Measures for Adults, 2013	Member Survey	Pre-Post WP and 3 comp. groups	Means test						x			x		X
64	Geographic distance and time spent travelling to primary care provider	Average travel distance and average time to access primary care provider in local service delivery area	Original measure	Administrative data	Pre-Post WP and 3 comp. groups	GIS analyses	X							X			

Measure number	Name	Measure description	Source	Data type	Comparisons	Analyses	Research Question							
							Access	Continuity	Quality	Costs	Incentive/ disincentive	Network adequacy	Premium Monitoring	
65	Analysis of rules and procedures for determining the adequacy of provider network	Subjective assessment of the rules and policies surrounding network adequacy	Original measure	Plan documents	Post	Process	X						X	
66	Provider willingness to accept new patients	Percent of primary care providers indicating they will take new patients who are members of the plan	Original measure	Provider survey	Post	RDD & DID	X						X	
67	Provider satisfaction with plan key components such as fee schedules and documentation	Qualitative assessment of provider opinions on aspects of the plan	Original measure	Provider survey	Post	RDD & DID			X				X	

Appendix C

NCQA HEDIS Specifications

RQ1 H1.1 M1 Adults' Access to Preventive/Ambulatory Health Services

Description

The percent of members age 20-64 years who were enrolled for at least 11 months during the measurement year and had an ambulatory or preventive care visit.

Denominator	Members age 20- 64 years who were enrolled for at least 11 months during the measurement year
Numerator	Members in the denominator who had one or more ambulatory or preventive care visits during the measurement year

RQ1 H1.4 M22 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.

RQ7 H7.1 M74 Annual Dental Visit

Description

The percent of members who were enrolled for at least 11 months during the measurement year and received at least one dental visit with a dental practitioner during the measurement year.

Denominator	Members who were enrolled for at least 11 months during the measurement year
Numerator	Members in the denominator who received at least one dental visit with a dental practitioner during the measurement year

Modification

The HEDIS measure includes members 2-21. IHAWP is limited to adults 19-64.

RQ1 H1.2 M15 Annual Monitoring for Patients on Persistent Medications

Description

The percent of members age 19-64 who are enrolled for at least 11 months during the measurement year and who received at least 180 treatment days of ambulatory medication therapy for a select therapeutic agent during the measurement year and at least one therapeutic monitoring event for the therapeutic agent in the measurement year.

Denominator	Rate 1:Members 19-64 who are enrolled for at least 11 months during the measurement year and who were on ACE/ARB Rate 2:Members 19-64 who are enrolled for at least 11 months during the measurement year and who were on digoxin Rate 3:Members 19-64 who are enrolled for at least 11 months during the measurement year and who were on diuretics Rate 4:Members 19-64 who are enrolled for at least 11 months during the measurement year and who were on anticonvulsants Rate 5:Members 19-64 who are enrolled for at least 11 months during the measurement year and who were on any of the following: ACE/ARB, digoxin, diuretics, or anticonvulsants
Numerator	Number of members in the denominator who received medication monitoring during the measurement year

Modification

The HEDIS measure includes members age 18. IHAWP is limited to adults 19-64.

RQ1 H1.3 M17 Antidepressant Medication Management

Description

The percent of members age 19-64 years with a diagnosis of major depression who were treated with antidepressant medication, and who remained on an antidepressant medication treatment. Two rates are reported: the percent of members who remained on an antidepressant medication for at least 84 days and the percent of members who remained on an antidepressant medication for at least 180 days.

Denominator	Members age 19-64 years with a diagnosis of major depression who were treated with antidepressant medication
Numerator	Number of members in the denominator who have at least 84 days of continuous treatment with antidepressant medication during the 114-day period following the index prescription start date

RQ3 H3.1 M31 Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis

Description

The percent of members 19–64 years of age who were enrolled for at least 11 months during the measurement year with a diagnosis of acute bronchitis who were not dispensed an antibiotic prescription.

Denominator Members 19-64 years of age who were enrolled for at least 11 months during the measurement year with a diagnosis of acute bronchitis

Numerator Inverse of the number of members in the denominator dispensed prescription for antibiotic medication on or three days after the index episode start date

Modification

The HEDIS measure includes members age 18. IHAWP is limited to adults 19-64.

RQ1 H1.2 M9 Breast Cancer Screening

Description

The percent of women age 50–64 years who were enrolled for at least 11 months in each of the two years prior to the measurement year and during the measurement year and who had a mammogram to screen for breast cancer.

Denominator Women 50-64 years of age who were enrolled for at least 11 months in each of the two years prior to the measurement year and during the measurement year

Numerator Number of women in the denominator with one or more mammograms any time during the three year period from two years prior to the measurement year through the measurement year

Modification

The HEDIS measure reported nationally includes women 65-74. IHAWP is limited to adults 19-64.

RQ1 H1.2 M10 Cervical Cancer Screening

Description:

The percent of women 21–64 years of age who were screened for cervical cancer using cervical cytology performed every 3 years.

Denominator Women age 21-64 who were enrolled for at least 11 months in each of the two years prior to the measurement year and during the measurement year

Numerator The number of women in the denominator who had cervical cytology during the measurement year or the two years prior to the measurement year

Modification

The HEDIS measure include a second method for determining cervical cancer screening that requires 4 years of data prior to the measurement year. We have eliminated the second method.

RQ1 H1.2 M12 Chlamydia Screening in Women

Description

The percent of women 16–24 years of age who were identified as sexually active and who had at least one test for chlamydia during the measurement year.

Denominator Women 16-24 identified a sexually active and enrolled for at least 11 months during the measurement year

Numerator Women in the denominator with at least one chlamydia test during the measurement year

RQ3 H3.1 M35 Cholesterol Management for Patients with Cardiovascular Conditions: LDL-C Screening

Description

The percent of members age 19-64 years who were enrolled for at least 11 months during the measurement year and 11 month during the year prior to the measurement year who were discharged alive for AMI, coronary artery bypass graft (CABG) or percutaneous coronary interventions (PCI) in the year prior to the measurement year, *or* who had a diagnosis of ischemic vascular disease (IVD) during the measurement year and the year prior to the measurement year, who had LDL-C screening during the measurement year.

Denominator Members age 19-64 years who were enrolled for at least 11 months during the measurement year and 11 month during the year prior to the measurement year who were discharged alive for AMI, coronary artery bypass graft (CABG) or percutaneous coronary interventions (PCI) in the year prior to the measurement year, *or* who had a diagnosis of ischemic vascular disease (IVD) during the measurement year and the year prior to the measurement year

Numerator Number of members in the denominator who had an LDL-C test performed during the measurement year

Modification

The HEDIS measures include members with cardiovascular conditions age 18-75. IHAWP is limited to adults 19-64.

RQ1 H1.2 M13 Comprehensive Diabetes Care: Hemoglobin A1c

Description

The percent of members 18–64 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 18-64 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.

RQ1 H1.2 M14 **Comprehensive Diabetes Care: LDL-C Screening**

Description

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 18-64 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.

RQ1 H1.1 M2 **Follow-Up after Hospitalization for Mental Illness**

Description

The percent of discharges for members age 19-64 years who were hospitalized for treatment of selected mental illness diagnoses and who had an outpatient visit, an intensive outpatient encounter or partial hospitalization with a mental health practitioner. Two rates are reported: the percent of discharges for which the member received follow-up within 30 days of discharge and the percent of discharges for which the member received follow-up within 7 days of discharge.

Denominator	Members age 19-64 years who were hospitalized for treatment of selected mental illness diagnoses
Numerator	Rate 1: Number of members in the denominator who had an outpatient visit, intensive outpatient visit or partial hospitalization with a mental health practitioner within 30 days after discharge Rate 2: Number of members in the denominator who had an outpatient visit, intensive outpatient visit or partial hospitalization with a mental health practitioner within 7 days after discharge

Modification

The HEDIS measure includes members 6 and older. IHAWP is limited to adults 19-64.

RQ3 H3.2 M43 **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
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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 H3.1 M33 Medication Management for People with Asthma

Description

The percent of members age 19–64 years who were enrolled for at least 11 months during the measurement year and 11 months during the year prior to the measurement year were identified as having persistent asthma and were dispensed appropriate medications that they remained on during the treatment period. Two rates are reported: the percent of members who remained on an asthma controller medication for at least 50% of their treatment period and the percent of members who remained on an asthma controller medication for at least 75% of their treatment period.

Denominator

Members age 19–64 years who were enrolled for at least 11 months during the measurement year and 11 months during the year prior to the measurement year were identified as having persistent asthma

Numerator

Rate 1: The number of members in the denominator who achieved a proportion of days covered of at least 50% for their asthma controller medications during the measurement year

Rate 2: The number of members in the denominator who achieved a PDC of at least 75% for their asthma controller medications during the measurement year

RQ1 H1.3 M18 Mental Health Utilization

Description

The number and percent of members age 19-64 years who were enrolled for at least one month during the measurement year receiving any mental health service, inpatient mental health service, intensive outpatient or partial hospitalization for mental health, or outpatient/emergency department visit with mental health service component during the measurement year. All rates are calculated for women and men separately then combine for a total.

Denominator Number of members age 19-64 years who were enrolled for at least 1 month during the measurement year

Numerator Rate 1: Total number of mental health services
Rate 2: Number of inpatient stays for mental health service
Rate 3: Number of intensive outpatient or partial hospitalization for mental health services
Rate 4: Number of outpatient or emergency department visits for mental health services

Modification

The HEDIS measure includes members age 18 years in the rate. IHAWP is limited to adults 19-64.

RQ3 H3.1 M34 Pharmacotherapy Management of COPD Exacerbation

Description

The percent of COPD exacerbations for members age 40-64 years of age who had an acute inpatient discharge or emergency department visit during the first 11 months of the measurement year and who were enrolled for at least 30 days following the inpatient stay or emergency department visit and who were dispensed appropriate medications. Two rates are reported: Dispensed a systemic corticosteroid within 14 days of the event and dispensed a bronchodilator within 30 days of the event.

Denominator Number of inpatient discharges and emergency department visits with a principal diagnosis of COPD

Numerator Rate 1: Number of occurrences in the denominator that were followed by the dispensing of a systemic corticosteroid within 14 days
Rate 2: Number of occurrences in the denominator that were followed by the dispensing of a bronchodilator within 30 days

RQ3 H3.2 M44 Plan All-Cause Readmissions

Description

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

RQ3 H3.1 M32 Use of Appropriate Medications for People with Asthma

Description

The percent of members age 19–64 years who were enrolled for at least 11 months during the measurement year and for at least 11 months during the year prior to the measurement year who were identified as having persistent asthma and who were appropriately prescribed medication during the measurement year.

Denominator Members age 19-64 years who were enrolled for at least 11 months during the measurement year and for at least 11 months during the year prior to the measurement year and were identified as having persistent asthma

Numerator Members in the denominator who were dispensed at least one prescription for an asthma controller medication during the measurement year

Modification

The HEDIS measure includes members 5-18. IHAWP is limited to adults 19-64.

Appendix D

Adult Core Measure Specifications

RQ3 H3.2 M38 Combined Admission Rate for COPD, CHF, Short-term Complications from Diabetes, and Asthma

Description

The number of discharges for COPD, CHF, short-term complications from diabetes or 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 COPD

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 M39 COPD Admission Rate

Description

The number of discharges for COPD 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 COPD

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 M40 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. IHWP is limited to adults 19-64.

RQ3 H3.2 M41 CHF Admission Rate

Description

The number of discharges for CHF 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 CHF

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 M42 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.

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. Access to Care

H1.1

- M3. Urgent Care
- M4. Routine Care
- M5. Getting Timely Appointments, Care, and Information (composite)
- M6. After-hours Care
- M7. Specialist Care
- M8. Prescription Medication

H1.2

- M16. Preventive Care

H1.3

- M19. Behavioral/Emotional Health Care

H1.5

- M22. Barriers to care due to Transportation

RQ2. Continuity

H2.1

- M25. Gaps in Insurance Coverage

H2.2

M29. Regular Source of Care (Personal Doctor)

M30. Provider Continuity

RQ3. Quality of Care**H3.1**

M36. Flu shot

M37. Emergency Department Use

H3.2

M45. Hospitalization in past 6 months

M46. Hospital readmission within 30 days

H3.3

M47. How well doctors communicate with patients (composite)

M48. Providers support you in taking care of your own health (PCMH composite)

M49. Providers pay attention to your mental/emotional health (PCMH composite)

M50. Providers discuss medication decisions (PCMH composite)

M51. Attention to care from other providers

M52. Rating of Personal Doctor

M53. Rating of Health Care Received (overall)

M54. Rating of Health Care Plan

RQ5. Premium Incentive & Copayment**H5.1**

M56. Awareness or premium incentive

M57. Ability to comply

M58. Hardship of premiums

H5.2

M59. Awareness of the copayment for non-emergent emergency room use

M60. Ability to comply

M61. Effectiveness of copayment

H5.4

M63. Medical assistance with smoking and tobacco use cessation

RQ1. H1.1. M3. Access – Urgent Care

Description

There are two measures to this concept: 1) Access to urgent care = the percentage who responded that they ‘Usually’ or ‘Always’ got care as soon as they needed when they needed care right away, and 2) Unmet need for urgent care = the percentage who responded that there was a time when they needed care right away but could not get it for any reason.

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

Questions Q3, Q4, Q5

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.

RQ1. H1.1. M4. Access – Routine Care

Description

There are two measures to this concept: 1) Access to routine care = the percentage who responded that they ‘Usually’ or ‘Always’ got an appointment for a check-up or routine care at a doctor’s office as soon as they needed, and 2) Unmet need for routine care = the percentage who responded that there was a time when they needed a check-up or routine care but could not get it for any reason.

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

Questions Q6, Q7, Q8

Modification

The two measures are calculated only for those who responded that they made at least one appointment for a check-up or routine care at a doctor’s office in the last 6 months.

RQ1. H1.1. M5. Access – Timely Appointments, Care, Information

Description

This is a CAHPS composite measure designed to assess respondent experience with getting appointments for care as soon as they needed, the time they spend at the office waiting for their appointment, and receiving timely answers to questions when they call the doctor's office. Composite measures combine results for closely-related items that have been grouped together. Five survey items are combined for this composite measure: got appointment for urgent care as soon as needed, got appointment for routine care as soon as needed, got answer to medical question the same day s/he phoned the doctor's office, got answer to medical question as soon as needed when phoned doctor's office after hours, and saw provider within 15 minutes of appointment time.

Source (1) CAHPS Adult Medicaid Survey 5.0

Questions Q4, Q7, Q13, Q15, Q44

RQ1. H1.1. M6. Access – After Hours Care

Description

There are three measures to this concept: 1) Access to information about what to do for care on evenings, weekends, or holidays = the percentage who responded that their doctor's office gave them information about what to do if they needed care during evenings, weekends, or holidays, 2) Access to care after hours = the percentage who responded that they 'usually' or 'always' got the care they needed from a doctor's office during evenings, weekends or holidays, and 3) Received reminders = the percentage who responded that they received reminders between visits about tests, treatments, or appointments in the last 6 months.

Source (1) CAHPS Adult Medicaid Survey 5.0

Questions Q9, Q11, Q16

Modification

Measure 2) is calculated only for those who responded that they needed care during evenings, weekends, or holidays in the last 6 months (Q10).

RQ1. H1.1. M7.**Access – Specialist Care****Description**

There are two measures to this concept: 1) Access to specialist care = the percentage who responded that they received an appointment to see a specialist as soon as they needed in the last 6 months, and 2) Unmet need for specialist care = the percentage who responded that there was a time when they needed care from a specialist but could not get it for any reason.

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

Questions Q23, Q25

Modification

The first measure is only calculated for those who responded that they made at least one appointment to see a specialist in the last 6 months (Q22).

RQ1. H1.1. M8.**Access – Medications****Description**

There are two measures to this concept: 1) Access to prescription medication = the percentage who responded that they 'usually' or 'always' got the prescription medication they needed in the last 6 months, and 2) Unmet need for prescription medication = the percentage who responded that there was a time when they needed prescription medicine but could not get it for any reason.

Source (1) CAHPS Adult Medicaid Survey 4.0 – Supplemental Items
(2) National Health Interview Survey (NHIS)

Questions Q30, Q31

Modification

These measures are only calculated for those who responded that there was at least one time during the last 6 months when they or a health professional thought they needed prescription medicine for any reason (Q29).

RQ1. H1.2. M16.**Access – Preventive Care****Description**

There are two measures to this concept: 1) Access to preventive care = the percentage who responded that they received any preventive care (such as a check-up, physical exam, mammogram, or Pap smear test) from a doctor's office in the last 6 months, and 2) Unmet need for preventive care = the percentage who responded that there was a time when they needed preventive care but could not get it for any reason.

Source	(1) Original item (2) National Health Interview Survey (NHIS)
Questions	Q17, Q18

RQ1. H1.3. M19**Access – Mental/Emotional Health Care****Description**

There are two measures to this concept: 1) Access to treatment or counseling for a mental or emotional health problem = the percentage who responded that they 'usually' or 'always' got treatment or counseling for a mental or emotional health problem as soon as they needed in the last 6 months, and 2) Unmet need for mental/emotional health care = the percentage who responded that there was a time when they needed treatment or counseling for a mental or emotional health problem but could not get it for any reason.

Source	(1) CAHPS Adult Medicaid Survey 4.0 – Supplemental Items (2) National Health Interview Survey (NHIS)
Questions	Q27, Q28

Modification

These measures are only calculated for those who responded that they needed any treatment or counseling for a mental or emotional health problem in the last 6 months (Q26).

RQ1. H1.5 M23**Access – Transportation****Description**

There are several access to transportation (related to health care visits) concepts: 1) Type of transportation used most often (descriptive assessment), 2) Need for transportation assistance from others to get to health care visits = percentage who report 'usually' or 'always', 3) Unmet need for transportation services = the percentage who responded that there was a time when they needed transportation to or from a health care visit but could not get it for any reason (in the last 6 months), and 4) Worry about cost of transportation = the percentage who respond that they worry 'a great deal' about their ability to pay for the cost of transportation to or from a health care visit.

Source Original items

Questions Q36, Q37, Q38, Q40

RQ2. H2.1 M25**Continuity – Gaps in Insurance****Description**

One survey item will be used to assess gaps in insurance coverage during the past 12 months. Time without insurance = # of months during the prior year when the respondent did not have health insurance coverage.

Source Original item

Questions Q2

RQ2. H2.2 M29**Continuity – Regular Source of Care****Description**

Regular source of care = the percentage who respond that they currently have a personal doctor. A personal doctor is defined as the person they would see if they need a check-up, want advice about a health problem, or get sick or hurt.

Source CAHPS Adult Medicaid Survey 5.0

Question Q57

RQ2. H2.2 M30 Continuity – Provider Continuity

Description

Continuity of care will be measured by assessing whether or not the respondent changed personal doctor after enrolling in their new health plan and ease in changing primary care provider if they chose to do so. 1) Continuity in personal doctor = Percentage who respond that their currently identified personal doctor is the same person who was their personal doctor before enrolling in the new health plan, 2) Choice to change primary care provider = Percentage who responded that they decided to change primary care providers from the one they were assigned, and 3) Ease of change = Percentage who reported that it was ‘Somewhat easy’ or ‘Very easy’ to change from their assigned primary care provider.

Source Original Items

Question Q58, Q69, Q70

Modification

Measure (1) will only be assessed for those who identify that they currently have someone they consider to be their personal doctor (Q57 = yes). Measure (2) will only be assessed for those who identify that they were automatically assigned a primary care provider (Q68 = yes) and Measure (3) will only be assessed for those who decided to change to a new primary care provider from the one they were assigned (Q69 = yes)

RQ3. H3.1 M36 Quality – Flu Shot

Description

The percentage of respondents who reported having received a flu shot since September 1, YYYY where YYYY = the measurement year for the survey. For example, if the survey is fielded in the year 2014, YYYY = 2013.

Source CMS Health Care Quality Measures for Adults Enrolled in Medicaid, v2013.

Question Q19

Modification

We will calculate this measure for all respondents (age 19-64) as well as for the limited age range (50-64) indicated in the CMS measure.

RQ3. H3.1 M37 Quality – Emergency Department

Description

The percentage of respondents who reported that the care they received at their most recent visit to the emergency room could have been provided in a doctor's office if one was available at the time.

Source Original Item

Question Q20, Q21

Modification

We will calculate this measure for all who respondents who reported that they went to the emergency room at least one time in the last 6 months (Q20).

RQ3. H3.2 M45 Quality – Hospitalization

Description

We will measure any hospitalization in the previous six months. Hospitalization = the percentage of respondents who reported that they spent at least one night in the hospital (for any reason) in the last 6 months.

Source Original Item

Question Q41

RQ3. H3.2 M46 Quality – Hospital Readmission

Description

We will measure self-reported hospital readmission: 30-day readmission = the percentage of those with at least one hospitalization in the last 6 months who reported that they had to go back into the hospital within 30 days of being allowed to go home because they were still sick or had a problem.

Source Original Item

Question Q42

RQ3. H3.3 M47 Quality – Provider/Patient Communication

Description

This is a CAHPS composite measure designed to assess respondent perception of how well their personal doctor communicated with them during office visits. Composite measures combine results for closely-related items that have been grouped together. Six survey items are combined for this composite measure: provider explanations easy to understand, listens carefully, gives easy to understand information, knows important information about medical history, shows respect for what patient has to say, and spends enough time with patient.

Source CAHPS Adult Medicaid Survey 5.0

Questions Q60, Q61, Q63, Q64, Q65, Q66

Modification

This measure is only calculated for respondents who identify that they have a personal doctor (Q57) and report having visited their personal doctor at least one time in the previous six months (Q59).

RQ3. H3.3 M48 Quality – PCMH Self-Management Support

Description

This is a CAHPS Patient-Centered Medical Home (PCMH) composite measure designed to assess respondent perception of how well their provider supported them in taking care of their own health. Composite measures combine results for closely-related items that have been grouped together. Two survey items are combined for this composite measure: provider worked with you to set specific goals for your health and asked you if there were things that make it hard for you to take care of your health.

Source CAHPS Adult Medicaid Survey 5.0 – PCMH Supplemental Items

Questions Q45, Q46

Modification

This measure is only calculated for respondents who report having visited their doctor’s office or clinic to get health care at least one time in the previous six months (Q43).

RQ3. H3.3 M49 Quality – PCMH Comprehensive Care

Description

This is a CAHPS Patient-Centered Medical Home (PCMH) composite measure designed to assess respondent perception of how well their provider paid attention to their mental or emotional health which is the CAHPS way to assess the comprehensive care component of the PCMH. Three survey items are combined for this composite measure: provider talked with you about personal or family problems or alcohol/drug use, talked with you about worry or stress in your life, and talked with you about feeling sad or depressed.

Source CAHPS Adult Medicaid Survey 5.0 – PCMH Supplemental Items

Questions Q47, Q48, Q49

Modification

This measure is only calculated for respondents who report having visited their doctor’s office or clinic to get health care at least one time in the previous six months (Q43).

RQ3. H3.3 M50 Quality – PCMH Shared Decision Making

Description

This is a CAHPS Patient-Centered Medical Home (PCMH) composite measure designed to assess respondent perception of how well their provider talked with them about their prescription medications which is the CAHPS way to assess the shared decision making component of the PCMH. Three survey items are combined for this composite measure: provider talked about reasons to take a medicine, reasons NOT to take a medicine, and asked what the patient thought was best for them regarding medicine.

Source CAHPS Adult Medicaid Survey 5.0 – PCMH Supplemental Items

Questions Q33, Q34, Q35

Modification

This measure is only calculated for respondents who report that their doctor or other health care provider talked to them about starting or stopping a prescription medicine in the previous six months (Q32).

RQ3. H3.3 M51 Quality – PCMH Care Coordination

Description

There are three individual items from the CAHPS Patient-Centered Medical Home (PCMH) items designed to assess respondent perception of their provider’s attention to the care they received from other providers. This measures the care coordination component of the PCMH. Three measures are used for this concept: 1) the percentage of respondents who report that their doctor’s office ‘usually’ or ‘always’ followed-up to give them results of blood tests, x-rays, or other tests, 2) the percentage who report that their doctor’s office ‘usually’ or ‘always’ seemed informed and up-to-date about the care they got from specialists, and 3) the percentage who report that their doctor or other health care provider talked to them about starting or stopping a prescription medicine in the last 6 months.

Source CAHPS Adult Medicaid Survey 5.0 – PCMH Supplemental Items

Questions Q55, Q24, Q32

Modification

Measure 1) is only calculated for respondents who report that their doctor or other health care provider ordered a blood test, x-ray, or other test for them in the last 6 months (Q54). Measure 2) is only calculated for those who report that they made an appointment to see a specialist within the last 6 months (Q22).

RQ3. H3.3 M52 Quality – Rating of Personal Doctor**Description**

Respondents will be asked to rate their personal doctor on a scale from 0 (worst possible) to 10 (best possible).

Source CAHPS Adult Medicaid 5.0

Question Q67

Modification

This measure is only calculated for those who report that they have a personal doctor (Q57).

RQ3. H3.3 M53 Quality – Rating of Overall Health Care**Description**

Respondents will be asked to rate their overall health care on a scale from 0 (worst possible) to 10 (best possible).

Source CAHPS Adult Medicaid 5.0

Question Q56

Modification

This measure is only calculated for respondents who report having visited their doctor's office or clinic to get health care at least one time in the previous six months (Q43).

RQ3. H3.3 M54 Quality – Rating of Health Plan**Description**

Respondents will be asked to rate their new health plan on a scale from 0 (worst possible) to 10 (best possible).

Source CAHPS Adult Medicaid 5.0

Question Q78

RQ5. H5.1 M56-58 Premium Incentive

Description

Several measures will be used to assess the effect of the premium as an incentive for patients to engage in healthy behaviors. 1) Awareness of the premium = the percentage of respondents who are aware of the premiums, 2) Ease of obtaining the yearly physical = the percentage of respondents who report that it will be 'somewhat' or 'very' easy for them to obtain a yearly physical exam, 3) Impact of premium on decision to seek healthy behaviors, 4) Hardship of a \$5/month premium = the percentage who report that they would be 'somewhat' or 'a great deal' worried if they had to pay a \$5/month premium, and 5) 3) Hardship of a \$10/month premium = the percentage who report that they would be 'somewhat' or 'a great deal' worried if they had to pay a \$10/month premium.

Source Original Items

Question Q74 - Q77

RQ5. H5.2 M59-61 Copayment Disincentives

Description

Three measures will be used to assess the effect of the copayment as a disincentive to patients for using the emergency room for non-emergency situations. 1) Awareness of the copayment = the percentage of respondents who are aware of the \$8 copayment for inappropriate ER use, 2) Awareness of a non-emergent condition = the percentage of respondents who report that it will be 'somewhat' or 'very' easy for them to determine when their health condition would be considered an emergent, and 3) Copayment as a disincentive = the percentage who report that an \$8 per visit copayment would keep them from going to the emergency room for a health condition that could be treated in their doctor's office instead.

Source Original Items

Question Q71 - Q73

RQ5. H5.2 M63 Incentives/Disincentives – Medical Assistance with Smoking/Tobacco Use Cessation

Description

The following three components of this measure assess different aspects of providing medical assistance with smoking and tobacco use cessation and will be reported as three separate rolling averages (the percentage of members that were current smokers or tobacco users (Q50) and who received medical assistance during the measurement year): 1) Advising Smokers and Tobacco Users to Quit, 2) Discussing Cessation Medications, and 3) Discussing Cessation Strategies.

Source CMS Health Care Quality Measures for Adults Enrolled in Medicaid, v2013

Question Q51, Q52, Q53

DRAFT Health Plan Member Survey

1. **Our records show that you are now in {INSERT HEALTH PLAN NAME}. Is that right?**

- ¹ Yes
² No → If No, go to Question *
³ Don't Know/Unsure

2. **How many months of the past year did you have health insurance coverage?**

- ⁰ I did not have health insurance at all last year
¹ 1 - 5 months
² 6 - 11 months
³ I had insurance all of last year

YOUR HEALTH CARE IN THE LAST 6 MONTHS

These questions ask about your own health care. Do not include care you got when you stayed overnight in a hospital. Do not include the times you went for dental care visits.

3. **In the last 6 months, did you have an illness, injury or condition that needed care right away in a clinic, emergency room, or doctor's office?**

- ¹ Yes
² No → If No, go to Question 6

4. **In the last 6 months, when you needed care right away, how often did you get care as soon as you needed?**

- ¹ Never
² Sometimes
³ Usually
⁴ Always

5. **In the last 6 months, was there any time when you needed care right away but could not get it for any reason?**

- ¹ Yes
² No

6. In the last 6 months, did you make any appointments for a check-up or routine care at a doctor's office or clinic?
- ¹ Yes
- ² No → If No, go to Question 9
7. In the last 6 months, how often did you get an appointment for a check-up or routine care at a doctor's office or clinic as soon as you needed?
- ¹ Never
- ² Sometimes
- ³ Usually
- ⁴ Always
8. In the last 6 months, was there any time when you needed a check-up or routine care but could not get it for any reason?
- ¹ Yes
- ² No
9. In the last 6 months, did a doctor's office give you information about what to do if you needed care during evenings, weekends, or holidays?
- ¹ Yes
- ² No
10. In the last 6 months, did you need care for yourself during evenings, weekends, or holidays?
- ¹ Yes
- ² No → If No, go to Question 12
11. In the last 6 months, how often were you able to get the care you needed from a doctor's office during evenings, weekends, or holidays?
- ¹ Never
- ² Sometimes
- ³ Usually
- ⁴ Always

12. In the last 6 months, did you phone a doctor's office with a medical question during regular office hours?

- ¹ Yes
² No → If No, go to Question 14

13. In the last 6 months, when you phoned a doctor's office during regular office hours, how often did you get an answer to your medical question that same day?

- ¹ Never
² Sometimes
³ Usually
⁴ Always

14. In the last 6 months, did you phone a doctor's office with a medical question after regular office hours?

- ¹ Yes
² No → If No, go to Question 16

15. In the last 6 months, when you phoned a doctor's office after regular office hours, how often did you get an answer to your medical question as soon as you needed?

- ¹ Never
² Sometimes
³ Usually
⁴ Always

16. Some offices remind patients between visits about tests, treatment or appointments. In the last 6 months, did you get any reminders from a doctor's office between visits?

- ¹ Yes
² No

PREVENTIVE CARE

17. In the last 6 months, did you get any preventive care, such as a check-up, physical exam, mammogram or Pap smear test from a doctor's office?

- ¹ Yes
² No

18. In the last 6 months, was there any time when you needed preventive care but could not get it for any reason?

- ¹ Yes
² No

19. Have you had a flu shot since September 1, {YYYY}?

- ¹ Yes
² No

EMERGENCY ROOM CARE {Renumber this section and rest of survey}

20. In the last 6 months, how many times did you go to an emergency room (ER) to get care for yourself?

- ⁰ 0 times → **Go to Question 22**
¹ 1 time
² 2
³ 3
⁴ 4
⁵ 5 or more times

20a. For the next few questions, please think about the last time you went to an ER. What was the main reason for this visit to the ER?

- ⁰ Trauma/broken bones/stitches
¹ Cold/Flu
² High Fever
³ Trouble breathing (asthma)
⁴ Severe Cough only
⁵ Chest Pains
⁶ Other _____

20b. Did a doctor, nurse, or other health care provider tell you to go to an ER for this care?

- ¹ Yes
² No

21. Do you think the care you received at your most recent visit to the ER could have been provided in a doctor's office if one was available at the time?

¹ Yes

² No

21a. What was the main reason you did not get to a doctor's office or clinic for this care?

¹ The Wellness Plan/Marketplace Choice Plan would not cover the care I needed if I went to a doctor's office or clinic

² I had to wait too long for an appointment with a doctor's office or clinic

³ I had transportation problems getting to a doctor's office or clinic

⁴ A doctor's office or clinic was not open when I needed care

⁵ Other _____

GETTING HEALTH CARE FROM SPECIALISTS

Specialists are doctors like surgeons, heart doctors, allergy doctors, skin doctors, and others who specialize in one area of health care.

22. In the last 6 months, did you make any appointments to see a specialist?

¹ Yes

² No → **If No, go to Question 25**

23. In the last 6 months, how often did you get an appointment to see a specialist as soon as you needed?

- ¹ Never
² Sometimes
³ Usually
⁴ Always

24. In the last 6 months, how often did your personal doctor's office seem informed and up-to-date about the care you got from specialists?

- ¹ Never
² Sometimes
³ Usually
⁴ Always

25. In the last 6 months, was there any time when you needed care from a specialist but could not get it for any reason?

- ¹ Yes
² No

MENTAL OR EMOTIONAL HEALTH CARE

26. In the last 6 months, did you need any treatment or counseling for a mental or emotional health problem?

- ¹ Yes
² No → If No, go to Question 29

27. In the last 6 months, how often did you get treatment or counseling for a mental or emotional health problem as soon as you needed?

- ¹ Never
² Sometimes
³ Usually
⁴ Always

28. In the last 6 months, was there any time when you needed treatment or counseling for a mental or emotional health problem but could not get it for any reason?

- ¹ Yes
² No

PRESCRIPTION MEDICINE

29. During the last 6 months, was there any time when you or a health professional thought you needed prescription medicine for any reason?

- ¹ Yes
² No → If No, go to Question 32

30. In the last 6 months, how often did you get the prescription medicine you needed?

- ¹ Never
² Sometimes
³ Usually
⁴ Always

31. In the last 6 months, was there any time when you needed prescription medicine but could not get it for any reason?

- ¹ Yes
² No

32. In the last 6 months, did you and a doctor or other health care provider talk about starting or stopping a prescription medicine?

- ¹ Yes
² No → If No, go to Question 36

33. When you talked about starting or stopping a prescription medicine, how much did the doctor or other health care provider talk about the reasons you might want to take a medicine?

- ¹ Not at all
² A little
³ Some
⁴ A lot

34. When you talked about starting or stopping a prescription medicine, how much did the doctor or other health care provider talk about the reasons you might not want to take a medicine?

- ¹ Not at all
² A little
³ Some
⁴ A lot

35. When you talked about starting or stopping a prescription medicine, did the doctor or other health care provider ask you what you thought was best for you?

- ¹ Yes
² No

TRANSPORTATION

36. When you need to get health care, what is the type of transportation you use most often to get to your visit?

- ¹ I drive myself, using my own vehicle
² Someone else (such as a friend, neighbor, or family) drives me, using my own vehicle
³ Someone else (such as a friend, neighbor, or family) drives me, using their vehicle
⁴ I take a taxi cab
⁵ I take public transportation (such as a bus or government-provided transit)
⁶ Other: _____

37. How often do you need assistance from other sources (such as friends, family, public transportation, etc.) to get to your health care visit?

- ¹ Never
² Sometimes
³ Usually
⁴ Always

38. In the last 6 months, was there any time when you needed transportation to or from a health care visit but could not get it for any reason?

- ¹ Yes
² No

39. Have you ever used transportation paid for by Medicaid to get to or from a health care visit?

- ¹ Yes
² No

40. In the past 6 months, how much, if at all, have you worried about your ability to pay for the cost of transportation to or from a health care visit?

- ¹ Not at all
² A little
³ Somewhat
⁴ A great deal

HOSPITAL CARE

41. In the last 6 months, how many nights did you spend in the hospital for any reason?

- ⁰ 0 nights → **Go to Question 43**
¹ 1 night
² 2 nights
³ 3 nights
⁴ 4 or more nights

42. In the last 6 months, did you ever have to go back into the hospital within 30 days of being allowed to go home because you were still sick or had a problem?

- ¹ Yes
² No

YOUR EXPERIENCES AT THE DOCTOR'S OFFICE

43. In the last 6 months, not counting the times you went to an emergency room, how many times did you go to a doctor's office or clinic to get health care for yourself?

⁰ None → Go to Question 57

¹ 1 time

² 2

³ 3

⁴ 4

⁵ 5 to 9

⁶ 10 or more times

44. Wait time includes time spent in the waiting room and exam room. In the last 6 months, how often did you see a doctor within 15 minutes of your appointment time?

¹ Never

² Sometimes

³ Usually

⁴ Always

45. In the last 6 months, did anyone in a doctor's office talk with you about specific goals for your health?

¹ Yes

² No

46. In the last 6 months, did anyone in a doctor's office ask you if there are things that make it hard for you to take care of your health?

¹ Yes

² No

47. In the last 6 months, did anyone in a doctor's office ask you if there was a period of time when you felt sad, empty, or depressed?

¹ Yes

² No

48. In the last 6 months, did you and anyone in a doctor's office talk about things in your life that worry you or cause you stress?

¹ Yes

² No

49. In the last 6 months, did you and anyone in a doctor's office talk about a personal problem, family problem, alcohol use, drug use, or a mental or emotional illness?

- ¹ Yes
² No

50. In the last 6 months, did you ever use any tobacco products including cigarettes and/or smokeless tobacco?

- ¹ Yes
² No → If No, go to Question 54

51. In the last 6 months, how often were you advised by a doctor or other health care provider to quit smoking or using tobacco?

- ¹ Never
² Sometimes
³ Usually
⁴ Always

52. In the last 6 months, how often was medication (such as nicotine gum, patch, nasal spray, inhaler, or prescription medicine) recommended or discussed by a doctor or other health care provider to assist you with quitting smoking or using tobacco?

- ¹ Never
² Sometimes
³ Usually
⁴ Always

53. In the last 6 months, how often did your doctor or other health care provider discuss or provide methods and strategies other than medication (such as using a telephone hotline, individual or group counseling, or a cessation program) to assist you with quitting smoking or using tobacco?

- ¹ Never
² Sometimes
³ Usually
⁴ Always

54. In the last 6 months, did anyone in a doctor's office order a blood test, x-ray, or other test for you?

¹ Yes

² No → If No, go to Question 56

55. In the last 6 months, when that doctor's office ordered a blood test, x-ray, or other test for you, how often did someone from that doctor's office follow up to give you those results?

¹ Never

² Sometimes

³ Usually

⁴ Always

56. Using any number from 0 to 10, where 0 is the worst health care possible and 10 is the best health care possible, what number would you use to rate all of your health care in the last 6 months?

⁰⁰ 0 Worst health care possible

⁰¹ 1

⁰² 2

⁰³ 3

⁰⁴ 4

⁰⁵ 5

⁰⁶ 6

⁰⁷ 7

⁰⁸ 8

⁰⁹ 9

¹⁰ 10 Best health care possible

YOUR PERSONAL DOCTOR

57. A personal doctor is the person you would see if you need a check-up, want advice about a health problem, or get sick or hurt. Do you have a personal doctor now?

¹ Yes

² No → If No, go to Question 68

58. Is your personal doctor the same person who was your personal doctor before you enrolled in your new health plan?

- ¹ Yes, I have the same personal doctor as before enrolling in my new health plan
² No, I have a different personal doctor than before enrolling in my new health plan
³ I did not have a personal doctor before enrolling in my new health plan

59. In the last 6 months, how many times did you visit your personal doctor to get health care for yourself?

- ⁰ None → **Go to Question 67**
¹ 1 time
² 2
³ 3
⁴ 4
⁵ 5 to 9
⁶ 10 or more times

60. In the last 6 months, how often did your personal doctor explain things in a way that was easy to understand?

- ¹ Never
² Sometimes
³ Usually
⁴ Always

61. In the last 6 months, how often did your personal doctor listen carefully to you?

- ¹ Never
² Sometimes
³ Usually
⁴ Always

62. In the last 6 months, did you talk with your personal doctor about any health questions or concerns?

- ¹ Yes
² No → **If No, go to Question 64**

63. In the last 6 months, how often did your personal doctor give you easy to understand information about these health questions or concerns?

- 1 Never
- 2 Sometimes
- 3 Usually
- 4 Always

64. In the last 6 months, how often did your personal doctor seem to know the important information about your medical history?

- 1 Never
- 2 Sometimes
- 3 Usually
- 4 Always

65. In the last 6 months, how often did your personal doctor show respect for what you had to say?

- 1 Never
- 2 Sometimes
- 3 Usually
- 4 Always

66. In the last 6 months, how often did your personal doctor spend enough time with you?

- 1 Never
- 2 Sometimes
- 3 Usually
- 4 Always

67. Using any number from 0 to 10, where 0 is the worst doctor possible and 10 is the best doctor possible, what number would you use to rate your personal doctor?

- ⁰⁰ 0 Worst doctor possible
⁰¹ 1
⁰² 2
⁰³ 3
⁰⁴ 4
⁰⁵ 5
⁰⁶ 6
⁰⁷ 7
⁰⁸ 8
⁰⁹ 9
¹⁰ 10 Best doctor possible

YOUR HEALTH PLAN

The next questions ask about your experience with your new health plan.

68. When you enrolled in your new health plan, were you automatically assigned to a primary care provider?

- ¹ Yes
² No → If No, go to Question 71

69. Did you decide to change to a different primary care provider from the one you were assigned?

- ¹ Yes
² No → If No, go to Question 71

70. How easy was it for you to change from your assigned primary care provider to a different primary care provider?

- ¹ Very easy
² Somewhat easy
³ Somewhat hard
⁴ Very hard

As part of your new health plan coverage, you may have to pay \$8.00 each time you use an emergency room for a non-emergent condition. An emergency is considered any condition that could endanger your life or cause permanent disability if not treated immediately. The following questions pertain to this part of your new health plan.

71. Do you know that you will have to pay an \$8.00 fee anytime you use the emergency room when your health conditions is not an emergency?

- ¹ Yes
² No

72. How easy do you think it would be to know when your health condition would be considered an ‘emergency’?

- ¹ Very easy
² Somewhat easy
³ Somewhat hard
⁴ Very hard

72x. Have you ever contacted your health care provider to help you decide when you should go to the emergency room to get care for a particular health condition?

- ¹ Yes
² No

72x. How much would it worry you if you had to pay an \$8 fee to use the emergency room?

- ¹ Not at all
² A little
³ Somewhat
⁴ A great deal

73. Do you think an added \$8 fee would keep you from going to the emergency room when you have a health condition that could be treated in your doctor’s office instead?

- ¹ Yes
² No

73x. Have you been charged this \$8 fee for your own use of an emergency room in a situation that was determined not to be an emergency?

- ¹ Yes
² No → If No, go to Question 74

73x. Did you agree that the medical situation was not an emergency and could have been treated in a doctor's office or clinic?

- ¹ Yes
² No

During the first year of your new health plan coverage, you will not have to pay any monthly premium. Starting in the second year of your new health plan coverage, you may be required to pay a monthly premium of \$5 to \$10 per month (depending on your income). However, if you complete 'specified healthy behaviors' such as a yearly physical exam, your premium payments will be waived (i.e., you will not have to pay any premiums).

74. Did you know about these requirements with regard to monthly premium payments?

- ¹ Yes
² No

75. How easy do you think it will be for you to obtain a yearly physical exam?

- ¹ Very easy
² Somewhat easy
³ Somewhat hard
⁴ Very hard

76. How much would it worry you if you had to pay \$5 per month for your new health plan?

- ¹ Not at all
² A little
³ Somewhat
⁴ A great deal

77. How much would it worry you if you had to pay \$10 per month for your new health plan?

- 1 Not at all
2 A little
3 Somewhat
4 A great deal

77x. Do you think you would obtain a physical exam {or other healthy behaviors to be determined} to avoid paying a monthly payment to your health plan?

- 1 Yes
2 No

78. Using any number from 0 to 10, where 0 is the worst health plan possible and 10 is the best health plan possible, what number would you use to rate your new health plan?

- 00 0 Worst health plan possible
01 1
02 2
03 3
04 4
05 5
06 6
07 7
08 8
09 9
10 10 Best health plan possible

ABOUT YOU

79. In general, how would you rate your overall physical health?

- 1 Excellent
2 Very good
3 Good
4 Fair
5 Poor

80. In general, how would you rate your overall mental or emotional health?

- 1 Excellent
- 2 Very good
- 3 Good
- 4 Fair
- 5 Poor

81. In the past 6 months, did you get health care 3 or more times for the same condition or problem?

- 1 Yes
- 2 No → If No, go to Question 83

82. Is this a condition or problem that has lasted for at least 3 months? Do not include pregnancy or menopause.

- 1 Yes
- 2 No

83. Do you now need or take medicine prescribed by a doctor? Do not include birth control.

- 1 Yes
- 2 No → If No, go to Question 85

84. Is this medicine to treat a condition that has lasted for at least 3 months? Do not include pregnancy or menopause.

- 1 Yes
- 2 No

85. What is your age?

- 1 18 to 24
- 2 25 to 34
- 3 35 to 44
- 4 45 to 54
- 5 55 to 64

86. Are you male or female?

- 1 Male
- 2 Female

87. What is the highest grade or level of school that you have completed?

- ¹ 8th grade or less
² Some high school, but did not graduate
³ High school graduate or GED
⁴ Some college or 2-year degree
⁵ 4-year college graduate
⁶ More than 4-year college degree

88. Are you of Hispanic or Latino origin or descent? (Optional)

- ¹ Yes, Hispanic or Latino
² No, not Hispanic or Latino

89. What is your race? Mark one or more. (Optional)

- ¹ White
² Black or African American
³ Asian
⁴ Native Hawaiian or Other Pacific Islander
⁵ American Indian or Alaska Native
⁶ Other (*write in*) _____

90. Did someone help you complete this survey?

- ¹ Yes
² No → **Go to Comments**

91. How did that person help you? Check all that apply.

- ¹ Read the questions to me
² Wrote down the answers I gave
³ Answered the questions for me
⁴ Translated the questions into my language
⁵ Helped in some other way
(*write in*) _____

Comments:

Please tell us if there is anything else you like or dislike about your new health plan.

THANK YOU!

Please return the completed survey in the postage-paid envelope.

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

Hypotheses	Process measures	Means tests	Multivariate modelling		Incremental cost effectiveness	GIS
			RDD	DID		
1-Access						
1. Wellness Plan members will have access to primary care and specialty services equal to or greater than Medicaid State Plan members.		1A, 2A, 3, 4	1B, 2B, 5-7	1B, 2B		
2. Wellness Plan members will have access to preventive care services equal to or greater than Medicaid State Plan members.		9A, 10A, 11A, 12, 13A, 14A, 15	11B, 13B, 14B, 16	9B, 10B, 11B, 13B, 14B		
3. Wellness Plan members access to mental and behavioral health services will be equal to or greater than Medicaid State Plan members.		17A, 18A	17B, 18B	17B, 18B, 19		
4. Wellness Plan members will access emergency department services for non-emergent care at equal or lower rates than Medicaid State Plan members.		20A, 21A, 22	20B, 21B			
5. Wellness Plan members without a non-emergency transportation benefit will have equal or lower barriers to care resulting from lack of transportation than Medicaid State Plan members.			23			
6. Wellness Plan members will have equal or greater access to EPSDT services than Medicaid State Plan members.		24A	24B			

			Multivariate modelling			
Hypotheses	Process measures	Means tests	RDD	DID	Incremental cost effectiveness	GIS
2-Continuity						
1. Wellness Plan members will experience less churning than Medicaid State Plan members.			25-27			
2. Wellness Plan members will maintain continuous access to a regular source of care when their eligibility status changes.		28-29	30			
3-Quality						
1. Wellness Plan members will have equal or better quality of care than Medicaid State Plan members.		31-33, 34A, 35A, 36, 37		34B, 35B		
2. Wellness Plan members will have equal or lower rates of hospital admissions than those in the Medicaid State Plan.		38, 39A, 40A, 41A, 42A, 43, 44	45, 46	39B, 40B, 41B, 42B, 45		
3. Wellness Plan members will report equal or greater satisfaction with the care provided than Medicaid State Plan members.		47, 48, 52-54	49-51	49-51		
4-Costs						
1. The cost for covering Wellness Plan members will be comparable to the predicted costs for covering the same expansion group in the Medicaid State Plan.			55	55	55	

			Multivariate modelling			
Hypotheses	Process measures	Means tests	RDD	DID	Incremental cost effectiveness	GIS
5-Incentive/disincentive						
1. The monthly premium for the Wellness Plan enrollees will be perceived as a positive incentive by enrollees for receiving preventive services.	59	56, 58	57	57		
2. The copayment for inappropriate emergency department (ED) use for the Wellness Plan enrollees will not pose an access to care barrier.		60, 61				
3. In year two and beyond, the utilization of an annual exam will be higher than in the first year of the program.		62A	62B	62B		
4. In year two and beyond, the utilization of smoking cessation services will be higher than in the first year of the program.		63				
6-Provider Network						
1. Iowa Wellness Plan members will have the same access to an adequate provider network as members the Medicaid State Plan.	65		66, 67	66,67		64
			Multivariate modelling			

Hypotheses	Process measures	Means tests	RDD	DID	Incremental cost effectiveness	GIS
7-Dental Care						
1. Dental Wellness Plan members will have greater access to dental care than adults in the Medicaid State Plan.		74A	74B	74B		
2. Dental Wellness Plan members will be more likely to receive preventive dental care than adults in the Medicaid State Plan.		75A, 76A, 77	75B, 76B	75B, 76B		

*There are no comparisons groups for these measures.