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Iowa Health and Wellness Plan Evaluation Interim Report

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Background

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

Wellness Plan (WP) 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 have access to the Medicaid provider network established for this program.

Marketplace Choice Plan (MPC) 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. Marketplace Choice members could choose from two Qualified Health Plans (QHP):

CoOpportunity Health

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

Coventry Health Care of Iowa

Coventry is a national managed care company that is based in Bethesda, MD. They operate statewide and are available on the Health Insurance Marketplace through the federal portal.

IHAWP replaced the IowaCare program with more covered services and a broader provider network as well as expanded 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, WP, MPC, and Medicaid State Plan.

The program has been modified in significant ways in its first 2 years. First, CoOpportunity Health withdrew from the IHAWP at the end of November 2014.¹ CoOpportunity members were automatically transitioned to Wellness Plan providers on December 1, 2014, however; they retain their designation as Marketplace Choice members. At the time of this change, approximately 9,700 Iowans were enrolled with CoOpportunity.

Second, the state of Iowa has submitted a waiver to the Centers for Medicare and Medicaid Services (CMS) to place all Medicaid members, including those in the IHAWP, into managed care organizations beginning March 1, 2016. At this time, three MCOs are expected to provide services to all but a small portion of the Medicaid population including those eligible for health care services through IHAWP: Amerigroup Iowa, Inc.; AmeriHealth Caritas Iowa, Inc.; and UnitedHealthCare Plan of the River Valley, Inc.. Though the move toward managed care does not directly affect the results for the two years of IHAWP, it will clearly impact future evaluation activities.

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

Program comparisons

Initially, the Wellness Plan and Marketplace Choice Plan were to be evaluated separately. This report, however, provides one source for evaluation of both programs. Overlapping outcomes and analysis are intentionally included to better understand the Iowa Health and Wellness Plan as a singular expansion, while exploring distinct qualities of each component of the program. This interim report includes discussions of the expansion and results of the expansion as a combination of the two mechanisms including the interplay between the two.

Study populations

Within the IHAWP evaluation there are seven distinct groups. Two of these are the study groups, Wellness Plan and Marketplace Choice, as described above. There are five additional comparison groups used for various parts of the evaluation, where such a comparison is appropriate. Analyses involving administrative data utilize adult members in the Family Medical Assistance Program (FMAP) and adult members of IowaCare as comparisons. Analyses involving survey data utilize adult members of the Medicaid State Plan who were eligible due to income (MSP-IE), adult members of the Medicaid State Plan eligible due to disability (MSP-SSI), and IowaCare members when questions from that program's evaluation were comparable. Below is a description of the Medically Exempt/Frail group. While this group is not a study or comparison group at this time, they will be used in a study directed at the experience of individuals who are found to be Medically Exempt/Frail in 2017.

FMAP – Family Medical Assistance Program

The FMAP comparison group is composed of adult parents of children eligible for Medicaid. Non-employed and employed parents of children in Medicaid in families with incomes from 0-77% FPL are eligible for Medicaid coverage. As they earn more they are able to increase the percent FPL allowed for eligibility to encourage employment. They may be covered through a Health Maintenance Organization (HMO), Primary Care Case Management (PCCM), or Fee for Service (FFS) structure.

MSP-IE – Medicaid State Plan income eligible

MSP-IE consists of 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. They may be covered through an HMO, PCCM, or FFS structure.

MSP-SSI – Medicaid State Plan disability eligible

MSP-SSI is composed of Medicaid State Plan members enrolled due to disability determination. The FPL for these members may range from 0 to 200%. Approximately 25,000 adults have at least one month of data in the study period. The only payment structure for these members is FFS. They are not eligible for the HMO or PCCM components.

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 (FQHC). The plan served 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 was from 133-200% or whose income could not be verified were not enrolled in any program

IowaCare did not provide coverage for routine dental coverage or prescription medications. In addition, primary care providers (Medical Homes) were limited to eight sites for outpatient care, six Federally Qualified Health Centers, the University of Iowa Hospitals and Clinics (UIHC), and Broadlawns Medical Center (BMC). Options for emergency or inpatient care were limited to UIHC and BMC.

The map below (Figure 1) shows the provider locations and counties in which IowaCare members were assigned to each Medical Home while in IowaCare. IHAWP only covers uninsured adults up to 133% FPL, but provides prescription drug coverage, dental care and a much broader provider network than was available for members in IowaCare. Appendix A provides a comparison between the coverage provided by IowaCare and IHAWP and the Medicaid State Plan (MSP) and IHAWP. Members who were eligible for IHAWP and enrolled in the IowaCare program as of December 31, 2013 were automatically enrolled into IHAWP as of January 1, 2014 if they met the eligibility criteria. Since IowaCare provided coverage for adults up to 200% FPL and IHAWP provides coverage to only 133% FPL, IowaCare members with incomes between 134% and 200% FPL were not auto-enrolled into IHAWP.

Figure 1 Map of IowaCare Medical Home Regions

IowaCare Provider Network: January 1, 2013

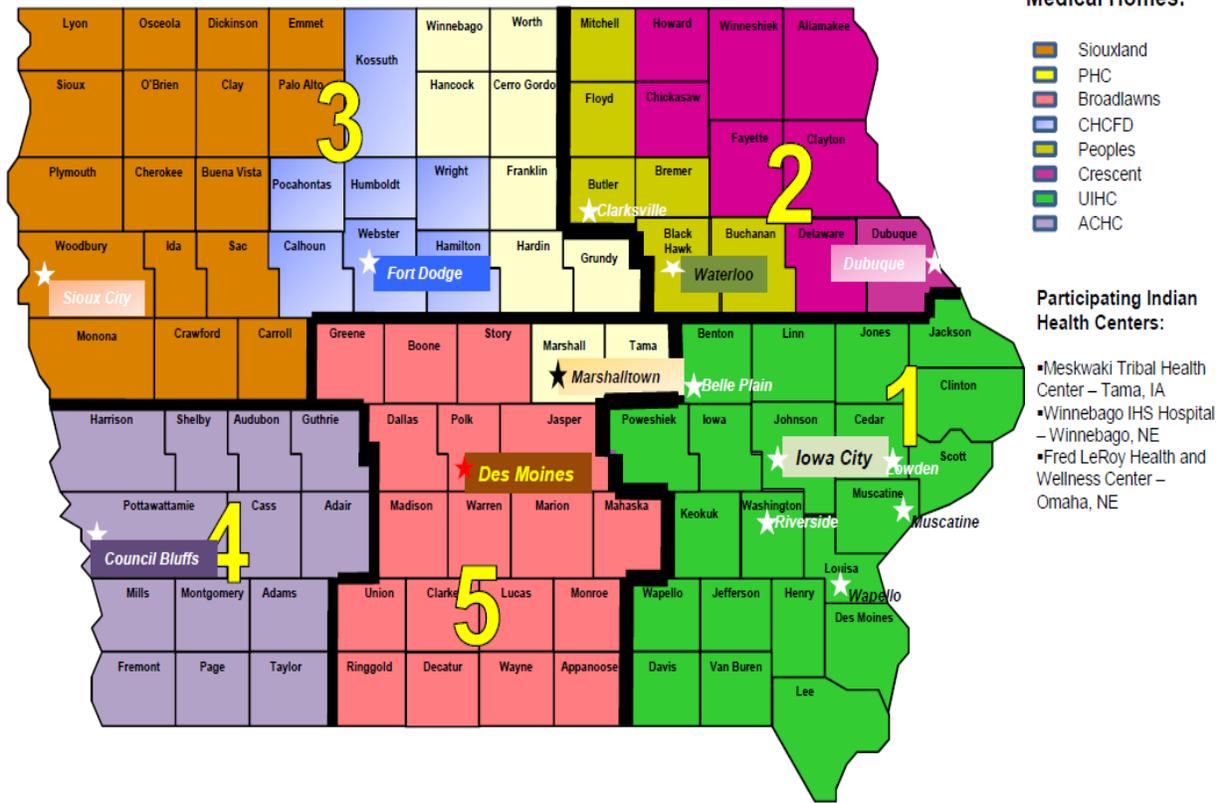


Table 1 compares the demographic characteristics of those who were eligible for IowaCare as of December 31, 2013 and auto-enrolled in IHAWP to those eligible for IowaCare and not auto-enrolled. Men and women were equally likely to be enrolled in WP, while women were more likely to be enrolled in MPC or not be enrolled. There were slight differences by race with whites more likely to be enrolled in WP or MPC. Interestingly, those with undeclared race were much less likely to be enrolled. Additionally, older members were less likely to be enrolled in either program, while residential rurality did not appear to have any effect.

Table 1. Demographic characteristics of IowaCare members by auto-enrollment status, CY 2014

	Enrolled in Wellness Plan N (%)	Enrolled in Marketplace Choice N (%)	Not enrolled N (%)	Percent NOT auto- enrolled
Gender				
Female	20,673 (49%)	5,290 (60%)	5,570 (55%)	18%
Male	21,211 (51%)	3,528 (40%)	4,472 (45%)	15%
Race				
White	21,866 (52%)	4,587 (52%)	4,692 (48%)	15%
Black	3,183 (8%)	465 (5%)	420 (4%)	10%
American Indian	329 (1%)	52 (1%)	34 (<1%)	8%
Asian	553 (1%)	138 (2%)	176 (2%)	20%
Hispanic	788 (2%)	224 (3%)	243 (2%)	19%
Pacific Islander	35 (<1%)	12 (<1%)	8 (<1%)	15%
Multiple-Hispanic	270 (1%)	60 (1%)	65 (1%)	17%
Multiple-Other	116 (<1%)	27 (<1%)	20 (<1%)	12%
Undeclared	14,744 (35%)	3,253 (37%)	4,384 (44%)	20%
Age				
18-21 years	1,355 (3%)	272 (3%)	339 (3%)	17%
22-30 years	9,699 (23%)	1,732 (20%)	1,803 (18%)	14%
31-40 years	8,627 (21%)	1,773 (20%)	1,745 (17%)	14%
41-50 years	10,378 (25%)	1,976 (22%)	2,386 (24%)	16%
51 and over	11,825 (28%)	3,065 (35%)	3,769 (38%)	20%
County rural/urban status				
Metropolitan	26,530 (63%)	5,451 (62%)	6,289 (63%)	16%
Non-metropolitan, urban	1,667 (4%)	420 (5%)	408 (4%)	16%
Non-metropolitan, rural	13,687 (33%)	2,947 (33%)	3,345 (33%)	17%
Total members	41,884	8,818	10,042	17%

Limitations to the study populations

The IowaCare program did not provide prescription drug coverage; however, members may have obtained medications from IowaCare providers. Anecdotal evidence indicates the IowaCare enrollees with University of Iowa Hospitals and Clinics 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 are removed from the analysis, since accurate claims data are not available.

Active enrollment into IHAWP

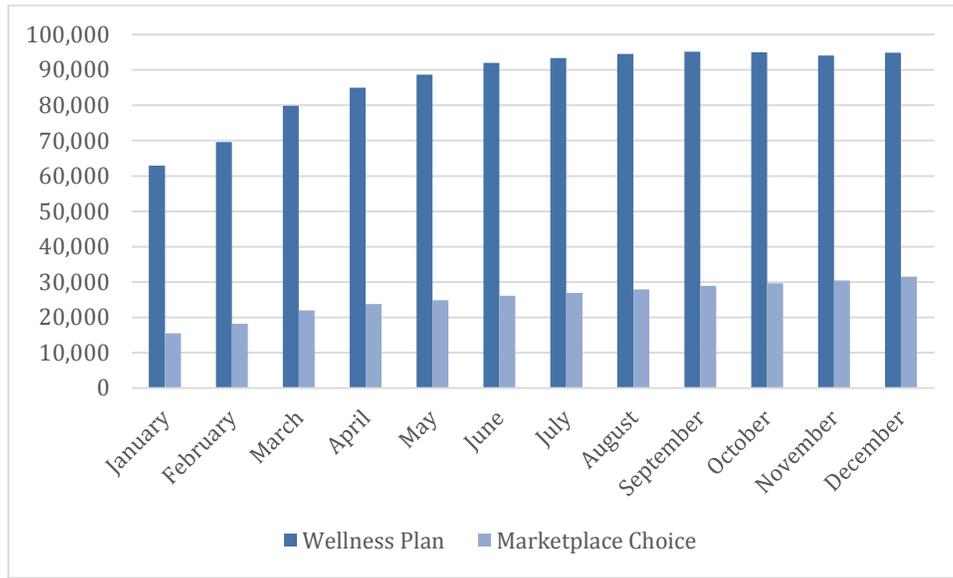
Table 2 provides the demographics of new enrollees in IHAWP, specifically those who were not auto-enrolled from the IowaCare program. These members entered through the Health Care Marketplace or were directed to these plans through Medicaid or a navigator at their local physician office or public health office. People who enrolled in IHAWP were more likely to be female, white, ages 22-40 years and live in a more urban location.

Table 2. Demographic characteristics of IHAWP members not auto-enrolled from IowaCare, CY 2014

	Enrolled in Wellness Plan N (%)	Enrolled in Marketplace Choice N (%)
Gender		
Female	39,860 (52%)	16,539 (62%)
Male	37,586 (48%)	10,241 (38%)
Race		
White	52,386 (68%)	18,399 (69%)
Black	6,310 (8%)	1,529 (6%)
American Indian	1,130 (2%)	272 (1%)
Asian	1,567 (2%)	683 (3%)
Hispanic	2,950 (4%)	1,350 (5%)
Pacific Islander	396 (1%)	293 (1%)
Multiple-Hispanic	739 (1%)	264 (1%)
Multiple-Other	622 (1%)	220 (1%)
Undeclared	11,346 (15%)	3,770 (14%)
Age		
18-21 years	7,314 (9%)	1,781 (7%)
22-30 years	22,228 (29%)	8,305 (31%)
31-40 years	17,624 (23%)	7,310 (27%)
41-50 years	14,018 (18%)	4,592 (17%)
51 and over	16,262 (21%)	4,792 (18%)
County rural/urban status		
Metropolitan	46,293 (60%)	15,466 (58%)
Non-metropolitan, urban	3,448 (5%)	1,408 (5%)
Non-metropolitan, rural	27,705 (36%)	9,906 (37%)
Total	77,446	26,780

The monthly enrollments for WP and MPC are shown in Figure 2. Enrollment rose continuously from January through June and then leveled off with only moderate increases after July 2014. WP grew to over 90,000 members by June, while MPC grew to nearly 30,000.

Figure 2. Monthly enrollment in IHAWP by plan-all enrollees, CY 2014



Methodology

Data Availability and Primary Collection

Data Access

The Public Policy Center (PPC) has worked closely 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 (IRB) and the Iowa Department of Human Services. Additional data agreements will be initiated as needed, though at present none are anticipated.

Data sources

Administrative data

This evaluation provides a unique opportunity to optimize several sources of data to assess the effects of innovative coverage options. The PPC is home to a Medicaid Data Repository encompassing over 100 million claims, encounter and eligibility records for all Iowa Medicaid enrollees for the period January 2000 through the present. Data are assimilated into the repository on a monthly basis. Ninety-five percent of medical and pharmaceutical claims are completely adjudicated within three months of the first date of service, while the 'run out' for institutional claims is six months. The PPC staff has extensive experience with these files as well as extensive experience with CMS adult core measures and Healthcare Effectiveness Data and Information Set (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 member identification numbers for at least three years and to never reuse the same Medicaid ID number. This allows long-term linkage of member information including enrollment, cost, and utilization throughout changes in programs.

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.

Member surveys

This report includes data from surveys of Wellness Plan (WP), Marketplace Choice Plan (MPC), Medicaid State Plan – Income Eligible adults (MSP-IE), Medicaid State Plan – Supplemental Security Income adults (MSP-SSI), and IowaCare members. Surveys with members of the WP, MPC, MSP-IE, and MSP-SSI were fielded post-implementation of the IHAWP (in October of 2014) and the IowaCare survey data included in this report was from 2012 which was pre-IHAWP implementation. Detailed survey methodology, including the survey instruments, responses to each item in the surveys, and summarized results can be found at the following websites for each survey population.

IHAWP: <http://ppc.uiowa.edu/publications/evaluation-iowa-health-and-wellness-plan-member-experiences-first-year>

MSP (IE & SSI): <http://ppc.uiowa.edu/health/study/evaluation-iowa-medicaid-managed-care-programs>

IowaCare 2012: <http://ppc.uiowa.edu/publications/evaluation-iowacare-program-information-about-medical-home-expansion>

General methods used to develop, field, and compile the data from these surveys follow.

Survey Instruments

The survey instruments used with the IHAWP and MSP adult populations were based on the most recent versions of the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) 5.0 Health Plan survey² and the CAHPS Clinician and Group Survey³. A number of items were added to the CAHPS survey to provide information about the following topic areas:

- Need and Unmet Need for Health Care Services (derived from NHIS⁴)
- Quality of Primary Care Delivery (derived from the CAHPS Patient-Centered Medical Home Item Set⁵)
- Continuity of Care with a Primary Care Provider (Original items)
- Emergency Room Care and Hospitalizations (Original items)
- Mental Health and Emotional Health Care (Original Items)
- Non-Emergency Medical Transportation (Original Items)
- Behavior Change Incentives (Original Items for IHAWP only)
- Functional Limitations (derived from the Behavioral Risk Factor Surveillance System (BRFSS)⁶)
- Chronic Physical and Mental Health Conditions (Original Items)
- Smoking Status and Smoking Cessation (Original Items)

The 2012 IowaCare survey instrument included content similar to the topics listed above. Any significant changes between the 2012 IowaCare survey and the 2014 IHAWP and Medicaid surveys will be noted in the results.

Survey Field Methods

The 2014 Survey of IHAWP members was conducted during the fall and winter of 2014/2015 using a mixed-mode mail methodology. Surveys were mailed to a stratified random sample of IHAWP members who had been in their current plan for at least the previous six months. The sample was stratified into five groups: WP FFS, WP HMO, WP PCCM, MPC CoOp, and MPC Coventry.

As part of a separate Medicaid evaluation, a survey of traditional Medicaid State Plan (MSP) members was conducted during this same period of time, using the same methodology. The MSP-IE population is used as a comparison for the WP and MPC groups. The Medicaid sample included adults from three Medicaid-IE

² Agency for Healthcare Research and Quality (AHRQ). CAHPS Surveys and Tools to Advance Patient-Centered Care. CAHPS Health Plan Survey. Available at <https://cahps.ahrq.gov/surveys-guidance/hp/index.html>

³ AHRQ. CAHPS Surveys and Tools to Advance Patient-Centered Care. CAHPS Clinician and Group Survey. Available at <https://cahps.ahrq.gov/surveys-guidance/cg/index.html>

⁴ Centers for Disease Control and Prevention (CDC). National Health Interview Survey. Available at http://www.cdc.gov/nchs/nhis/quest_doc.htm

⁵ AHRQ. CAHPS Patient-Centered Medical Home (PCMH) Item Set. Available at <https://cahps.ahrq.gov/surveys-guidance/item-sets/PCMH/index.html>

⁶ CDC. BRFSS. Available at <http://www.cdc.gov/brfss/questionnaires.htm>

member groups (HMO, MediPASS, FFS) and a Medicaid-SSI group. Data from the MSP-SSI group is presented, but this group is not used in statistical comparisons.

Random samples for each survey were drawn from IHAWP and Medicaid enrollment data, current as of September 2014. Only one person was selected per household to reduce the relatedness of the responses and respondent burden. The sample was comprised of 6,750 IHAWP members and 5,400 adult Medicaid members; 1,350 from each of the subgroups.

Both mail and web-based surveys were used. The initial mailings were sent to the sample of IHAWP and Medicaid members in October 2014. A reminder postcard was sent 14 days after the initial mailing. About 14 days after the postcard reminder, a second mailing was sent to those who had not responded to the initial mailing. In the mailed cover letter and on the reminder postcard, enrollees were given the option of completing the survey online and provided the website address for that purpose. In an effort to maximize response rates for the mailed survey, both a premium and an incentive were used in the first mailing: each initial survey packet included a \$2 bill and respondents who completed and returned the survey within two weeks of the mailing were entered into a random drawing for one of ten \$25 Wal-Mart gift cards.

The IowaCare survey conducted during the winter of 2012/2013 used the same field methodology as the 2014 IHAWP and Medicaid surveys (with the exception of the \$25 gift card incentive). The randomly drawn sample was comprised of 6,400 adults.

Response Rates

Response rates for each of the population groups is provided in Table 3. Response rates were adjusted by removing ineligible individuals from the denominator. Individuals were determined to be ineligible to complete a survey because of invalid or out-of-state addresses or they were deceased.

Table 3. Response rates for WP, MPC, MSP-IE, MSP-SSI, and IowaCare2012

Plan	Total Sampled	Completed	Adjusted* Response Rate
WP	4050	1101	32%
MPC	2700	691	28%
MSP-IE	4050	679	19%
MSP-SSI	1350	357	25%
IowaCare 2012	6400	2154	37%

* Adjusted for ineligible – Those who no longer had a valid address or were outside the state of Iowa.

Respondent Characteristics

Table 4 shows the demographic and health status characteristics of the respondents for each of the survey populations. IHAWP respondents are older, are more likely to be male, and have more self-reported health problems than the MSP-IE respondents. MSP-SSI respondents are similar to IHAWP members with regard to age and gender but are also less educated and, not surprisingly, report significantly more health problems than any other group. IowaCare respondents were similar to IHAWP respondents demographically but reported more physical and mental health problems.

Table 4. Demographic and Health Status Characteristics of WP, MPC, MSP-IE, MSP-SSI, and IowaCare 2012 respondents.

	WP N=1101	MPC N=691	MSP-IE N=679	MSP-SSI N=357	IowaCare N=2154
Age					
18-34	23%	28%	64%	15%	12%
35-54	45%	41%	34%	32%	53%
55-64	31%	31%	2%	29%	35%
65 or older	0%	0%	0%	24%	0%
Female	58%	72%	83%	57%	61%
Race/Ethnicity¹					
White	84%	89%	84%	85%	87%
Black	8%	6%	10%	8%	5%
Hispanic	4%	4%	8%	3%	3%
Other ²	5%	3%	5%	8%	5%
Education: > High School Degree	45%	51%	48%	25%	45%
Self-Reported Fair or Poor Physical Health	29%	20%	18%	51%	39%
Self-Reported Fair or Poor Mental Health	24%	14%	22%	34%	34%
Reported at least 1 Functional Limitation³	38%	18%	26%	50%	24%

¹ Race/Ethnicity categories are not mutually exclusive; thus, the percentages may not sum to 100%.

² Other includes Asian, Pacific Islander, American Indian, or other.

³ Functional limitations included physical or medical conditions that a) seriously interfered with a member’s ability to work, attend school, or manage day-to-day activities, b) seriously interfered with a member’s independence, participation in the community, or quality of life, c) required the member to have help with routine needs, such as everyday household chores, doing necessary business, shopping, or getting around for other purposes, or d) required the member to have help with personal care needs, such as eating, dressing, or getting around the house.

Analytic methods

The primary analyses were means test comparisons of 1) WP to MSP-IE members and 2) MPC to MSP-IE members. For completeness, descriptive statistics for MSP-SSI members (data collected at the same time as MSP-IE members – post-IHAWP implementation) and IowaCare members (data collected in 2012, pre-IHAWP implementation) were included.

Statistical means tests between WP/MPC and MSP-SSI were not conducted because the MSP-SSI population is a fundamentally different group demographically and are considerably less healthy than the other groups. The MSP-SSI population would be more similar to the medically exempt IHAWP members, but that group was not surveyed. Thus, the information presented about the MSP-SSI group is for reference only.

A statistical means test between WP/MPC (IHAWP) and IowaCare members (pre-IHAWP) was not conducted because two of the ways these populations differ cannot be adequately accounted for in the analytics. First, there are many fundamental differences in coverage between the former IowaCare program and the IHAWP which make direct comparisons on many of the survey outcomes irrelevant. Second, an assumption that the majority of the sample and respondents to the IHAWP survey would be people who were previously in the IowaCare program was unfounded. Upon analysis, the majority of the respondents to the IHAWP (over 60%) had never been in the IowaCare program which made the intended pre-post comparison less relevant. However, if available, data from the IowaCare 2012 survey is presented for reference.

For all survey analyses presented, the data was weighted to make it representative of all IHAWP and Medicaid members statewide and to account for the fact that there were not equal numbers of enrolled members in each sampled group. Thus, the percentages reported were weighted to reflect the statewide membership in each group. For the inferential statistics, the weight variable was re-based to the actual sample size in order to ensure that, while the adjustments for sampling method were retained, the standard errors used in the statistical testing were not artificially inflated.

Some limitations are inherent to survey research and some were the result of programmatic changes that may affect the interpretation of the results. First, those who chose to respond to the survey may be different from those who chose not to respond which can create biased results. In this evaluation, respondents (both to the Medicaid and the IHAWP surveys) were more likely to be female, white, and older than those who did not respond to the surveys. Second, respondents may have difficulty accurately remembering events which may introduce recall bias. This risk may not be high because of the relatively short time period for recalling events (6 months). Third, there were plan and programmatic changes that occurred during the fielding of these surveys that could have influenced the responses. One of the MPC plans (CoOp) exited the MPC around the time of the administration of this survey and that may have affected the experiences of those members differently than the members of the other MPC plan, Coventry Health as well as the members of the WP and MSP-IE groups.

Provider files

The primary purpose of the provider assessments is to understand how the provider incentives built into the IHAWP 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 IHAWP
- 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.

Results

The results below are presented in a similar order to what was in the original evaluation plan to allow the reader to more easily see the progress on each hypothesis and measure. For some, complete results are presented, including any variation that was required in the type of analysis from what was originally proposed. For others, there is an indication of the type of analysis that will be completed for the final report for June 2016. There are some other measures which, after a more thorough assessment of the available data, are no longer appropriate and this is indicated with the measure.

Access to Care

Question 1 *What are the effects of the Wellness Plan/Marketplace Choice on member access to care?*

Hypothesis 1.1

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

Measure 1 Access to primary care (Measure 1A and 1B)

1A Percent of members who had an ambulatory care visit

Definition

NCQA HEDIS Adults' Access to Preventive/Ambulatory Health Services (AAP)

Proposed Analytic method

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

Variations from the Proposed Analytic method

The current measure includes only the WP/MPC members and FMAP for CY2014 and IowaCare and FMAP for calendar year (CY) 2013.

Results

Tables 5 and 6 provide the rates for Adults' Access to Preventive/Ambulatory Health Services as defined through NCQA HEDIS. Both tables include only those members who were eligible for at least 11 months in 2014 and 11 months in 2013 and met the age criterion 19-64 in both years. Essentially, these tables take those eligible for the measure in 2014 and look back for these same members in 2013.

The data in Tables 5 and 6 indicate that members in IowaCare were the least likely to have had a preventive/ambulatory care visit. These same members when in WP or MPC were more likely to have had a preventive/ambulatory care visit. Of note, those in WP were more likely to have had a visit than those in MPC. None of the three groups (IowaCare, WP or MPC) were as likely to have had a visit as the FMAP group. We suspected that this may be due to the larger proportion of women in the FMAP group, however, on further analyses we found that both women and men in FMAP were more likely to have a visit.

Table 5. Adults’ access to preventive/ambulatory health services by program and age for WP members eligible for at least 11 months in CY 2014 and 11 months in CY 2013

Age		FMAP 2013	IowaCare 2013	FMAP 2014	WP 2014
20-44 years	Number	15,184	5,538	15,444	7,475
	%	87%	63%	89%	83%
45-64 years	Number	1,774	6,601	1,791	8,408
	%	86%	70%	87%	89%
Total	Number	16,958	12,139	17,235	15,883
	%	87%	66%	89%	86%

Table 6. Adults’ access to preventive/ambulatory health services by program and age for MPC members eligible for at least 11 months in CY 2014 and 11 months in CY 2013

Age		FMAP 2013	IowaCare 2013	FMAP 2014	MPC 2014
20-44 years	Number	14,696	1,710	15,444	1,595
	%	87%	70%	89%	80%
45-64 years	Number	1,666	1,582	1,791	1,674
	%	85%	77%	87%	86%
Total	Number	16,362	3,292	17,235	3,269
	%	87%	73%	89%	83%

Table 7 provides the rates for all members eligible for at least 11 months in 2014 without regard to their status in 2013. Members aged 20-44 years in FMAP are most likely to have a visit at over 85%. The proportion of members 20-44 years of age who had a visit in WP and MPC was 79% and 73%, respectively. For those ages 45-64 WP had a rate nearly equal to FMAP (86% vs 87%, respectively), while 80% of those in MPC had a visit.

Table 7. Adults’ access to preventive/ambulatory health services by program and age for members eligible for at least 11 months in CY 2014

Age		FMAP 2014	WP 2014	MPC 2014
20-44 years	Number	28,248	21,742	6,452
	%	87%	79%	73%
45-64 years	Number	3,226	16,515	3,749
	%	87%	86%	80%
Total	Number	31,474	38,257	10,201
	%	87%	82%	76%

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

Proposed Analytic method

Models for RDD and DID are under development.

Measure 2 Follow-up after hospitalization for mental illness (Measures 2A and 2B)

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

Definition

NCQA HEDIS Follow-Up after Hospitalization (FUH) Adult core measure #3

Proposed Analytic method

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

Results

Measure moved to later date to allow for supplemental NEMT survey and analyses.

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

Measure moved to later date to allow for supplemental NEMT survey and analyses.

Measure 3 Access to and unmet need for urgent care

Definition

The 2014 member survey was used for this measure. There are two items from that survey used to measure these concepts:

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.
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.

These two measures were 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 six months prior to the survey.

Proposed analytic method

Means tests between WP/MPC members and three comparison groups (MSP – IE, MSP – SSI, IowaCare) after implementation

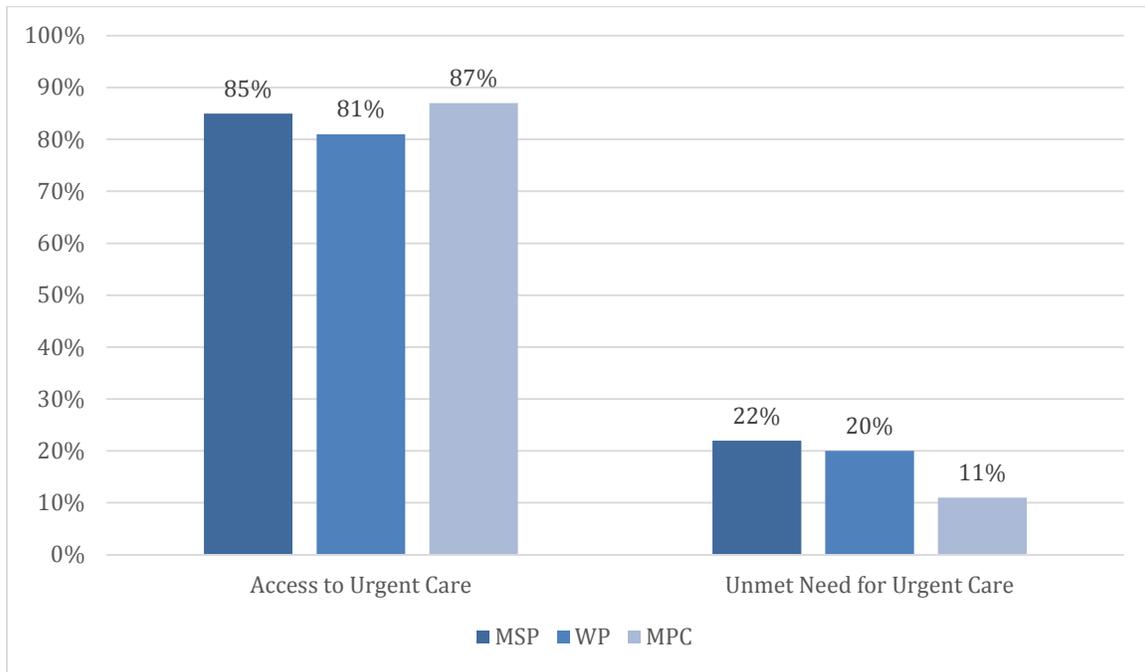
Variations from proposed method

Means tests were used to compare 1) WP members to MSP-IE members and 2) MPC members to MSP-IE members. Statistical comparisons of WP and MPC members to MSP-SSI adult members and pre-implementation IowaCare members were not conducted. Please refer to the methods section for a more detailed description of why these comparisons were not done.

Results

Figure 3 provides the percentages of access to and unmet need for urgent care for WP, MPC, and MSP-IE members. Overall, the majority of all members (MSP, WP, and MPC) reported usually or always having access to urgent care services when needed. MPC members reported the highest access to urgent care (87%) but this was statistically comparable to both MSP (85%) and WP (81%). MSP members (22%) were also statistically comparable to WP members (20%) and MPC members (11%) regarding unmet need for urgent care.

Figure 3. Access to and unmet need for urgent care



Note: Percentages reported are for those who reported a need for urgent care.

While statistical comparisons between WP and MPC members with IowaCare members (pre-implementation) and MSP-SSI members (post-implementation) were not conducted, we can report summary statistics from those groups. Notably fewer IowaCare members in 2012 reported consistent (usually or always) access to urgent care services (64%) with over one-third (38%) reporting an unmet need for those same services. MSP-SSI members post-implementation (84%) reported access to urgent care that was comparable to MSP-IE, WP, and MPC. As with MPC, 11% of MSP-SSI members reported an unmet need for urgent care.

Measure 4 Access to and unmet need for routine care

Definition

The 2014 member survey was used for this measure. There are two items from that survey used to measure these concepts:

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.
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.

Proposed analytic method

Means tests between WP/MPC members and three comparison groups (MSP-IE, MSP-SSI, IowaCare).

Variations from proposed method

We used means tests to compare 1) WP members to MSP-IE members and 2) MPC members to MSP-IE members. Statistical comparisons of WP and MPC members to MSPSSI adult members and pre-implementation IowaCare members were not conducted. Please refer to the methods section for a more detailed description of why these comparisons were not done.

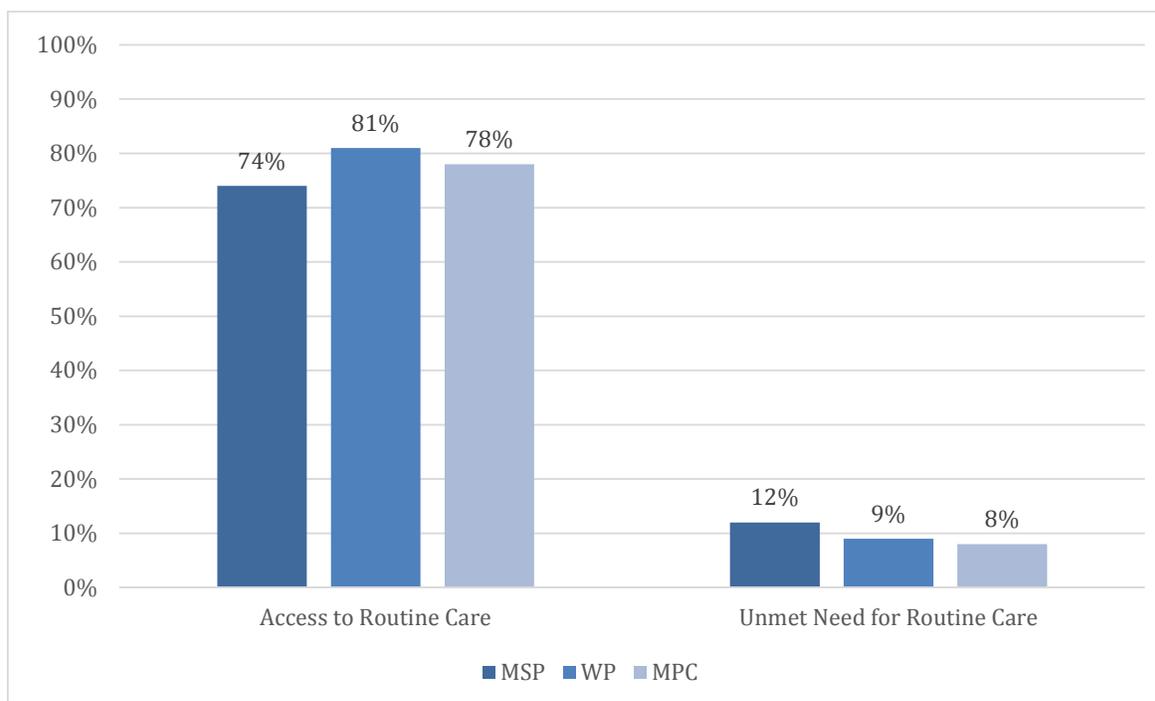
Results

Figure 4 provides the percentages of access to and unmet need for routine care for WP, MPC, and MSP-IE members. Access to routine care was comparable between WP (81%) and MPC (78%) members and between MPC and MSP-IE (74%) members. However, access to routine care was statistically significantly higher for WP members compared to MSP-IE members.

Unmet need for routine care ranged from 8% for MPC to 12% for MSP-IE. There were no statistical differences among the three groups.

As with reported access to urgent care, fewer IowaCare members in 2012 reported consistent (usually or always) access to routine care (68%) and about one-quarter (25%) reported an unmet need for those same services. Access to and unmet need for routine care reported by MSP-SSI members was similar to the other groups in the post-implementation period. The majority of MSP-SSI members (81%) reported access to routine care with 11% reporting an unmet need.

Figure 4. Access to and unmet need for routine care



Measure 5 Timely Appointments, Care, and Information

Definition

The 2014 member survey was used for this measure. This is a CAHPS composite measure designed to assess respondent experience with getting appointments for care as soon as needed, the time spent at the office waiting for the appointment, and receipt of timely answers to questions. Composite measures combine results for closely related items that have been grouped together conceptually and analytically. Five survey items were combined for this measure:

1. When you needed care right away, how often did you get care as soon as you needed?
2. 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?
3. 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?
4. 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?
5. How often did you see a doctor within 15 minutes of your appointment time?

Proposed analytic method

RDD between WP/MPC and MSP-IE at the threshold.

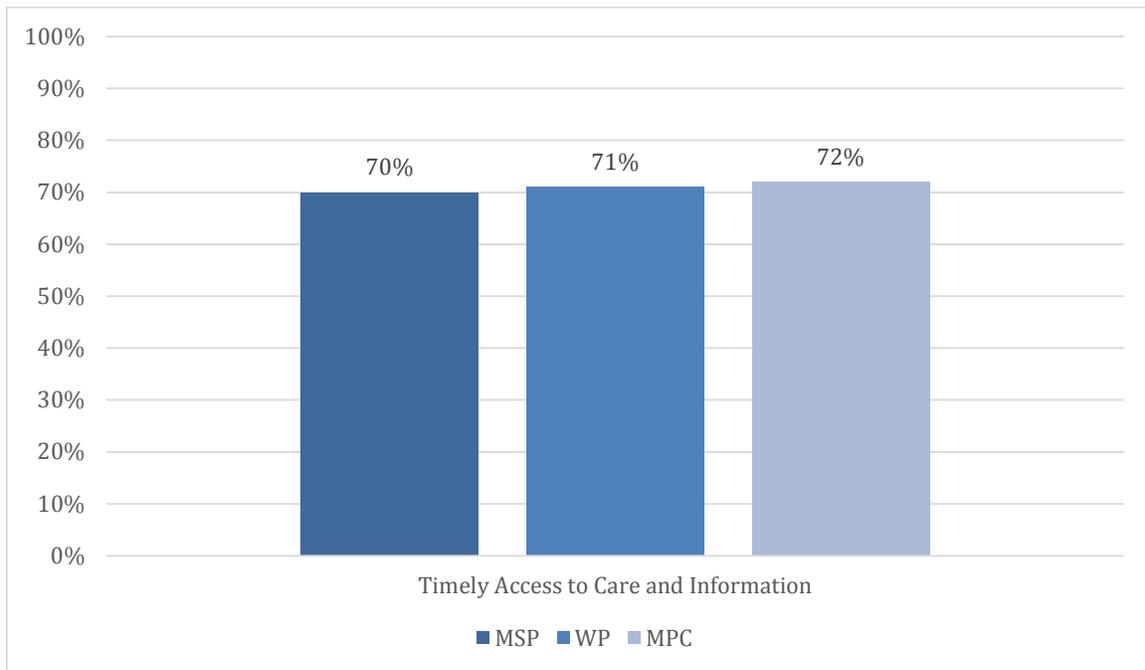
Variations from proposed method

The composite measure changed from three items in the evaluation plan to five items to align with the most recent CAHPS definitions. RDD was not conducted due to sample size limitations at the threshold. Instead, we used means tests to compare 1) WP members to MSP-IE members and 2) MPC members to MSP-IE members.

Results

Figure 5 provides the percentage per group who reported timely access to care and information (as defined by the composite measure). There was no difference in reported timely access to care and information among the three comparison groups (MSP-IE, WP, and MPC) with around 70% reporting usually or always experiencing timely access.

Figure 5. Timely Access to Care and Information



The experiences of MSP-SSI members were similar with 71% reporting access to timely care and information. Less than half (49%) of IowaCare members in 2012 usually or always experience timely access to care and information.

Measure 6 After-hours care

Definition

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 (calculated only for those who responded that they needed after-hours care)
3. Received reminders = the percentage who responded that they received reminders between visits about tests, treatments, or appointments in the last 6 months.

Proposed analytic method

RDD between WP/MPC members and MSP-IE members at the threshold

Variations from proposed method

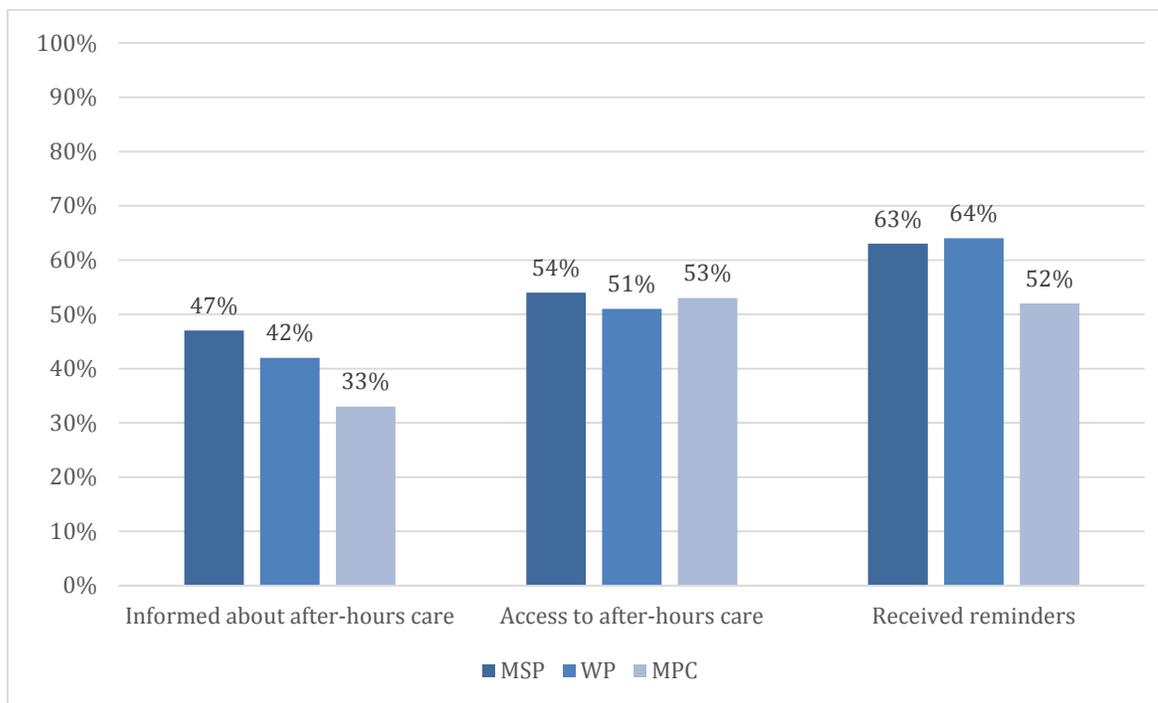
RDD was not conducted due to sample size limitations at the threshold. Instead, we used means tests to compare 1) WP members to MSP-IE members and 2) MPC members to MSP-IE members.

Results

Figure 6 provides the percentage per group reporting receipt of information about after-hours care, usually or always receiving after-hours care, and receipt of test, treatment, or appointment reminders between visits. Less than one-half of MSP-IE (47%) and WP (42%) members reported receiving information from the doctor’s office about what to do for care in the evenings, weekends, or holidays. Significantly fewer MPC members (33%) reported receiving this information.

More than half of MSP-IE (54%), WP (51%), and MPC (53%) members reported that they usually or always got the care they needed after regular business hours; with no significant differences among the groups. And, almost two-thirds of MSP-IE (63%) and WP (64%) members received reminders from their doctors’ offices between visits while significantly fewer MPC members (52%) reported receipt of reminders.

Figure 6. After-hours care



Similar to MSP-IE and WP members, 43% of MSP-SSI members received information from their doctor’s office about how to get care after-hours. However, less than half (40%) reported that they usually or always have access to this care. Over two-thirds (69%) reported receiving reminders. With regard to after-hours care, IowaCare members prior to IHAWP implementation were similar to MPC members post-implementation with 37% reporting receiving information about after-hours care and 54% receiving reminders. Yet, only one-quarter of IowaCare members in 2012 reported usually or always receiving care if they needed it after normal business hours.

Measure 7 Specialist care

Definition

In the survey, specialists were defined to be doctors such as surgeons, heart doctors, allergy doctors, skin doctors, and others who specialize in one area of health care. Respondents were instructed to not include dental visits or care they might have received at a hospital stay when they answered the questions about specialist care.

Access to and unmet need for specialty care was assessed from the surveys in the following manner:

1. Access to specialty care = the percentage who responded that they received an appointment to see a specialist as soon as they needed (calculated only for those who responded that they made at least one appointment to see a specialist).
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 (calculated only for those who responded that they needed care from a specialist).

Proposed analytic method

RDD between WP/MPC members and MSP-IE members at the threshold

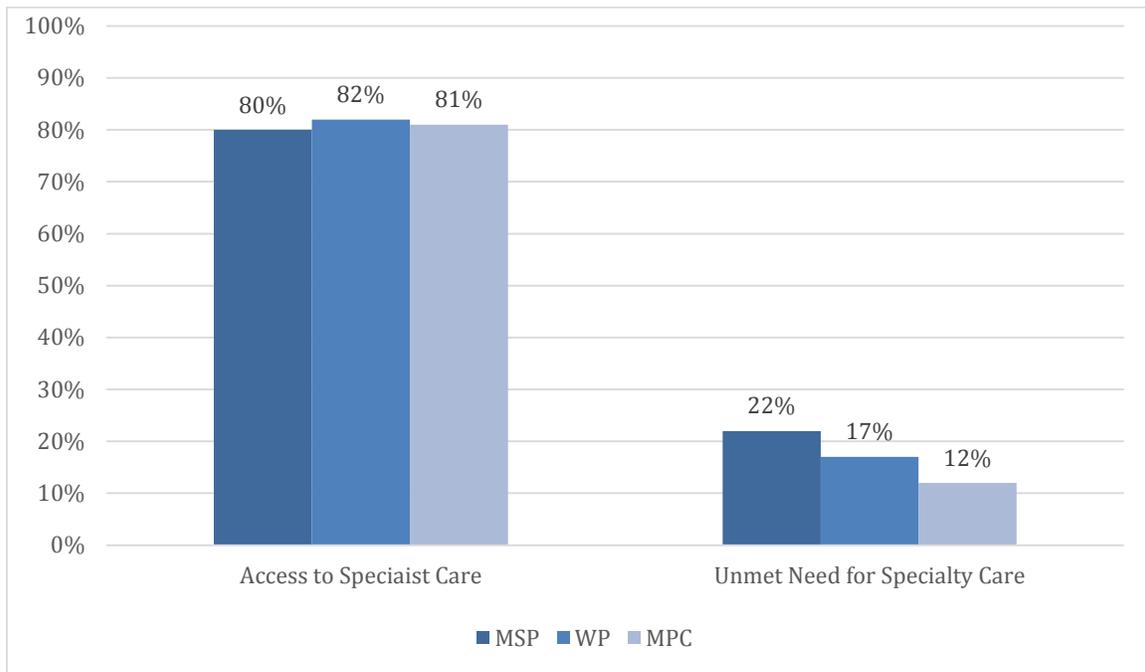
Variations from proposed method

RDD was not conducted due to sample size limitations at the threshold. Instead, we used means tests to compare 1) WP members to MSP-IE members and 2) MPC members to MSP-IE members.

Results

Figure 7 provides the percentage with access to and unmet need for specialist care in these populations. One should use caution when interpreting these results because the total number of respondents who reported having a time when they thought they needed care from a specialist, upon which these responses are based, were very low (MSP-IE n=238, WP n=475, MPC n=254). That being said, for those who needed specialist care, the majority (80-82%) reported that they usually or always got an appointment as soon as they needed. And, almost one-quarter (22%) of MSP-IE members reported an unmet need for specialist care which was similar to WP members (17%) but was significantly higher than reported by MPC members (12%).

Figure 7. Access to and Unmet Need for Specialist Care



Over half (52%) of MSP-SSI members reported that they had a need for specialist care. Of those, over three-quarters (78%) reported that they usually or always got an appointment. MSP-SSI members were similar to WP members with regard to unmet need for specialist care with 16% reporting an unmet need. In 2012, IowaCare members were asked a slightly different question with regard to access to specialist care; namely, how easy it was to get appointments with specialists. Two-thirds of IowaCare members in 2012 reported it was usually or always easy to get specialist appointments with a little over one-quarter (27%) reporting an unmet need for specialist care.

Measure 8 Prescription medication

Definition

In the surveys, access to and unmet need for prescription medication was assessed with the following two measures:

1. Access to prescription medication = the percentage who responded that it was usually or always easy to get prescription medications through their health plan (calculated only for those who responded that they or a health provider thought they needed a prescription medicine for any reason).
2. Unmet need for prescription medication = the percentage who responded that there was a time when they needed prescription medication but could not get it for any reason (calculated only for those who responded that they or a health provider thought they needed a prescription medicine for any reason).

Respondents were instructed to not include birth control when they considered the questions on prescription medications.

Proposed analytic method

RDD between WP/MPC members and MSP-IE members at the threshold

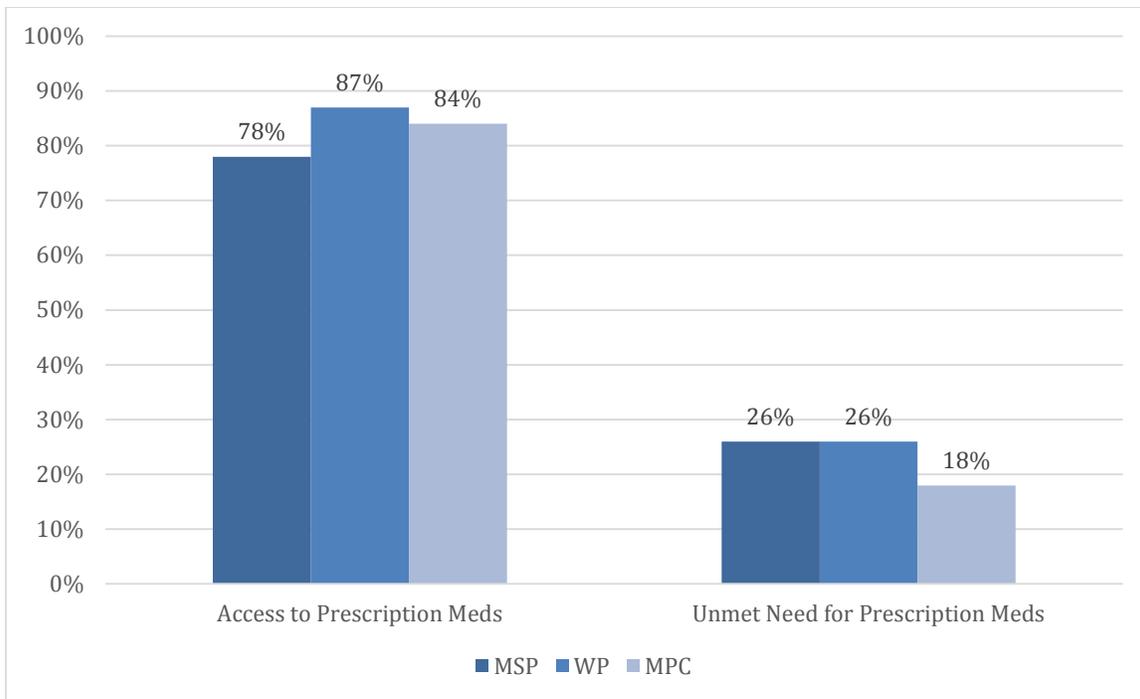
Variations from proposed method

RDD was not conducted due to sample size limitations at the threshold. Instead, we used means tests to compare 1) WP members to MSP-IE members and 2) MPC members to MSP-IE members.

Results

Figure 8 provides the percentages, by group, for access to and unmet need for prescription medications. The vast majority of WP members (87%) and MPC members (84%) reported the most ease in getting prescription medications. A little over three-quarters of MSP-IE members (78%) reported usually or always finding it easy to get medications which was statistically equivalent to MPC members but was significantly less than reported by WP members. There were no statistically significant differences among groups with regard to unmet need for prescription medications.

Figure 8. Access to and Unmet Need for Prescription Medications



Note: Percentages reported are for those who reported a need for prescription medications.

MSP-SSI members reported similar ease of obtaining prescription medications as WP and MPC members with 85% usually or always finding it easy to get their medications. A little over one in five (22%) MSP-SSI members reported an unmet need for prescription medications. In the 2012 survey of IowaCare members, ease of obtaining medications was not asked, and because of the very limited coverage for prescription medications in the IowaCare plan, a comparison of this concept with MSP or IHAWP members may have limited relevance. That fact may also help to explain why more IowaCare 2012 members (43%) reported having an unmet need for medications.

Hypothesis 1.2

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

Measure 9 Breast cancer screening (Measures 9A and 9B)

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

Definition

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

Proposed analytic method

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

Variations from proposed method

The current measure includes only the WP/MPC members and FMAP for CY2014 and IowaCare and FMAP for CY 2013.

Results

Table 8 provides the proportion of women ages 50-64 who had a mammogram in the five study groups. This measure includes only those women eligible for at least 11 months in each of the following years: CY 2014, CY 2013, and CY 2012. With this limitation, the rates contain no women who enrolled in a Medicaid-related program for the first time in CY 2014, those newly covered due to the IHAWP. Rates were the highest among women in WP and MPC. Women in IowaCare had the lowest rate. This provides one indication that women in WP and MPC are more likely to engage in preventive behaviors, though it is unclear why.

Table 8. Percent of women ages 50-64 who had a mammogram CY 2013 and CY 2014

Age		FMAP 2013	IowaCare 2013	FMAP 2014	WP 2014	MPC 2014
50-64 years	Number	129	240	216	2,098	498
	%	45%	37%	42%	53%	49%

9B Whether a women 50-64 had a mammogram to screen for breast cancer

Proposed analytic method

Models for RDD and DID are still under development.

Measure 10 Cervical cancer screening (measures 10A and 10B)

10A Percent of women 21-64 who were screened for cervical cancer

Definition

NCQA HEDIS CCS; NQF 0032; Adult core measure #4

Proposed analytic method

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

Variations from proposed method

The current measure includes only the WP/MPC members and FMAP for CY2014 and IowaCare and FMAP for CY 2013.

Results

The measure of percent women ages 21-64 who were screened for cervical cancer includes more women than the breast cancer screening measure due to the expanded age range. Women included in the cervical cancer screening rate had to be eligible for at least 11 months in each of the following years: CY 2012, CY 2013, and CY 2014. Rates for cervical cancer screening were the highest for women in FMAP across both years and lowest in IowaCare. Future analyses to determine the factors related to obtaining breast cancer or cervical cancer screening should provide clarification as to why these differences occur.

**Table 9. Percent of women ages 21-64 who had cervical cancer screening
CY 2013 and CY 2014**

Age		FMAP 2013	IowaCare 2013	FMAP 2014	WP 2014	MPC 2014
21-64 years	Number	7,628	3,649	7,455	6,244	1,846
	%	30%	14%	27%	26%	22%

10B Whether women aged 21-64 were screened for cervical cancer

Proposed analytic method

Models for RDD and DID are still under development.

Measure 11 Flu shots in past year (Measures 11A and 11B)

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

Data for this measure is not available due to the various sources for flu shots. Though flu shots are covered under the Medicaid program, we are unable to capture flu shots provided at retail outlets or public health sources that do not bill Medicaid.

11B Whether a member aged 21-64 received an influenza vaccination

Data for this measure is not available due to the various sources for flu shots. Though flu shots are covered under the Medicaid program, we are unable to capture flu shots provided at retail outlets or public health sources that do not bill Medicaid.

Measure 12 Chlamydia screening in past year

Percent of women 19-24 years of age who were identified as sexually active and had at least one test for Chlamydia

Definition

NCQA HEDIS CHL; NQF 0033

Proposed analytic method

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

Variations from proposed method

The current measure includes only the WP/MPC members and FMAP for CY2014 and IowaCare and FMAP for CY 2013.

Results

Table 10 provides rates of Chlamydia screening for women ages 19-24. The Chlamydia screening rate is calculated for women who are sexually active as defined by CPT codes indicating pregnancy and/or contraception related services or contraceptive prescriptions. The numbers of women ages 19-20 within the programs for whom we are able to determine sexual activity are small, making the results unstable over time. Therefore, we will remove this measure in the future.

**Table 10. Chlamydia screening for women 19-24 years of age by program and age
CY 2013 and CY 2014**

Age		FMAP 2013	IowaCare 2013	FMAP 2014	WP 2014	MPC 2014
19-20 years	Number	44	8	41	58	18
	%	4%	3%	5%	6%	7%
21-24 years	Number	194	53	193	124	32
	%	5%	4%	5%	6%	4%
Total	Number	238	61	234	182	50
	%	5%	4%	5%	6%	5%

Measure 13 Comprehensive diabetes care: Hemoglobin A1c (Measures 13A and 13B)

13A Percent of members with type 1 or type 2 diabetes who had Hemoglobin A1c testing

Definition

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

Proposed analytic method

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

Variations from proposed method

None

Results

WP and MPC have a higher proportion of members diagnosed with diabetes than FMAP, as might be expected as many of these adults were originally in the IowaCare program in which 9% of members were identified as having diabetes. Members with diabetes in WP and MPC were more likely to have a Hemoglobin A1c than those in FMAP.

For this measure members with diabetes had to be eligible for 11 months in both CY 2013 and CY 2014. Once again, excluding the members in WP and MPC who were newly covered through the expansion and not previously covered in IowaCare. The rate of Hemoglobin A1c in IowaCare members with diabetes was 82% in

2013 leading us to expect a similar rate in WP and MPC during 2014. The rate within the two programs together (IHAWP) is 85%, so despite a lower rate in MPC in CY 2014 than in IowaCare in CY 2013, the combined rate is higher. The rate is essentially unchanged for the FMAP population between CY 2013 and CY 2014.

Table 11. Proportion of population age 19-64 identified as having diabetes with Hemoglobin A1c, CY 2013 and CY 2014

Age		FMAP 2013	IowaCare 2013	FMAP 2014	WP 2014	MPC 2014
Proportion with diabetes	Number	1,661	4,851	2,055	4,472	1,108
	%	5%	9%	6%	10%	8%
Hemoglobin A1c rate	Number	1,224	3,974	1,543	3,887	878
	%	74%	82%	75%	87%	79%

13B Whether a member with type 1 or type 2 diabetes had Hemoglobin A1c testing

Proposed analytic method

Models for RDD and DID are still under development.

Measure 14 Comprehensive diabetes care: LDL-C screening (Measures 14A and 14B)

There were two measures that were attempted to evaluate comprehensive diabetes care in the IHAWP population:

14A Percent of members with type 1 or type 2 diabetes who had LDL-C screening

Definition

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

Proposed analytic method

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

Variations from proposed method

None

Results

The rate of LDL-C screening for members with diabetes is much lower than that for Hemoglobin A1c with a different pattern between the programs and years. The IowaCare rate is quite low, perhaps indicating an inability to detect the testing when performed in Federally Qualified Health Centers (FQHCs). Global reimbursement for services provided during a visit, may mask the provision of this test. In addition, the highest rate of LDL-C screening was found in MPC members with diabetes and not WP members. The WP members had rates of LDL-C screening comparable to FMAP members. Further delineation of contributing factors may occur with additional analyses.

Table 12. Proportion of population age 19-64 identified as having diabetes with LDL-C screening, CY 2013 and CY 2014

Age		FMAP 2013	IowaCare 2013	FMAP 2014	WP 2014	MPC 2014
Proportion with diabetes	Number %	1,661 5%	4,851 9%	2,055 6%	4,472 10%	1,108 8%
Hemoglobin A1c rate	Number %	441 27%	272 5%	567 28%	1,255 28%	352 32%

14B Whether a member with type 1 or type 2 diabetes had LDL-C screening

Proposed analytic method

Models for RDD and DID are still under development.

Measure 15 Annual monitoring for patients on persistent medication

Percent of members on a persistent medication (ACE/ARB, digoxin, diuretic, anticonvulsant) who were monitored

Proposed analytic method

Measure moved to later date to allow for supplemental NEMT survey and analyses.

Measure 16 Preventive care

Definition

There are two measures from the survey assessing the access to and unmet need for preventive care defined as follows:

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.
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.

Proposed analytic method

RDD comparing WP/MPC members and MSP-IE members at the threshold

Variations from proposed method

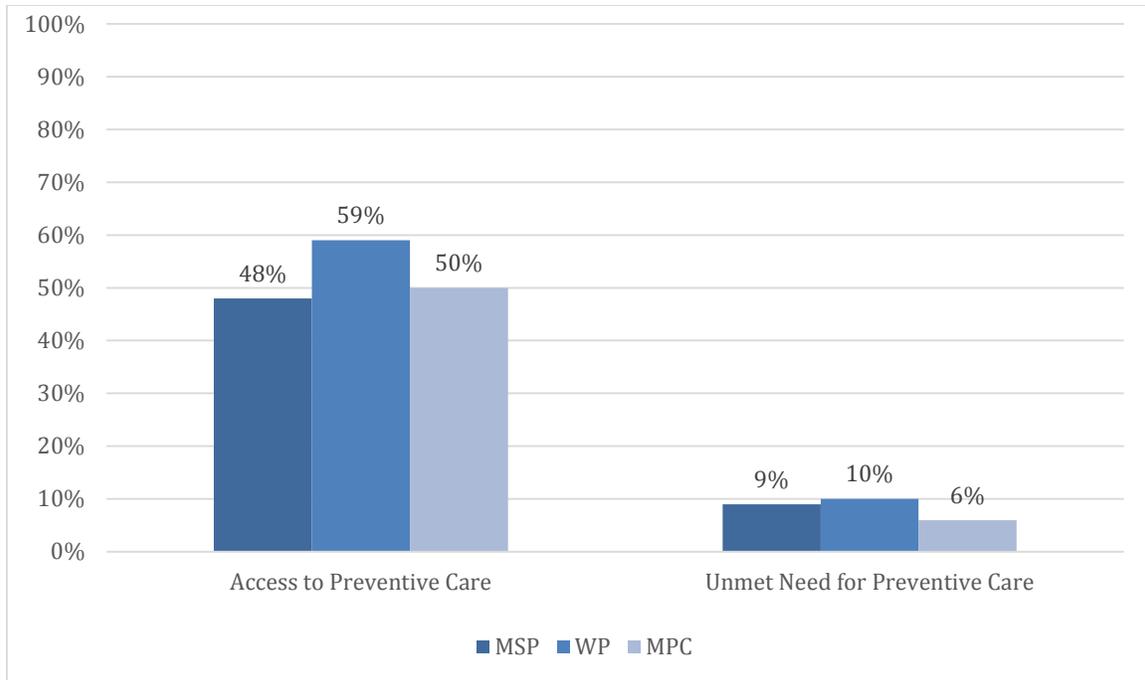
RDD was not conducted due to sample size limitations at the threshold. Instead, we used means tests to compare 1) WP members to MSP-IE members and 2) MPC members to MSP-IE members.

Results

Figure 9 provides a look at member experiences with preventive care. Around 60% of WP members had a preventive care visit which was significantly higher than MSP-IE (48%) and MPC (50%) members. MSP-SSI members reported similar use of preventive services (56%) but IowaCare members in 2012 reported lower use (38%).

Percentages of unmet need were comparable across the three groups (WP, MPC, MSP-IE) with around 10% experiencing an unmet need for preventive services.

Figure 9. Access to and Unmet Need for Preventive Care



Around 10% of MSP-SSI members also experienced an unmet need for these services. Over one-fifth (22%) of IowaCare members in 2012 reported this unmet need.

Hypothesis 1.3

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

Measure 17 Anti-depressant medication management (Measures 17A and 17B)

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

Definition

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

Proposed analytic method

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

Variations from proposed method

None

Results

Rates provided in Table 13 indicate that members with major depressive disorder (MDD) were much more likely to receive effective acute phase and continuation phase treatment than those in IowaCare or those in FMAP during CY 2013 or CY 2014.

Table 13. Proportion of population age 19-64 identified as having major depressive disorder with effective acute phase and continuation phase treatment, CY 2013 and CY 2014

Age		FMAP 2013	IowaCare 2013	FMAP 2014	WP 2014	MPC 2014
Proportion with major depressive disorder	Number	1,437	560	1,391	1,149	281
	%	4%	1%	4%	3%	2%
Effective acute phase treatment	Number	563	241	574	687	183
	%	39%	43%	41%	60%	65%
Effective continuation phase treatment	Number	361	147	370	562	150
	%	25%	26%	27%	49%	53%

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

Proposed analytic method

Models for RDD and DID are still under development.

Measure 18 Mental health utilization (Measures 18A and 18B)

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

Proposed analytic method

Protocols for mental health utilization are still being developed and tested.

18B Number of mental health services a member received

Proposed analytic method

Protocols for mental health utilization are still being developed and tested.

Measure 19 Behavioral/emotional care

Definition

There are two measures from the survey to assess access to and unmet need for mental/emotional health care defined as follows:

1. Access to treatment or counseling for a mental or emotional health problem = the percentage who responded that they usually or always found it easy to get the treatment or counseling for a mental or emotional health problem through their health plan (calculated only for those who responded that they had a need for this kind of treatment or counseling).
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 (calculated only for those who responded that they had a need for this kind of treatment or counseling).

Proposed analytic method

RDD comparing WP/MPC members and MSP-IE members at the threshold

Variations from proposed method

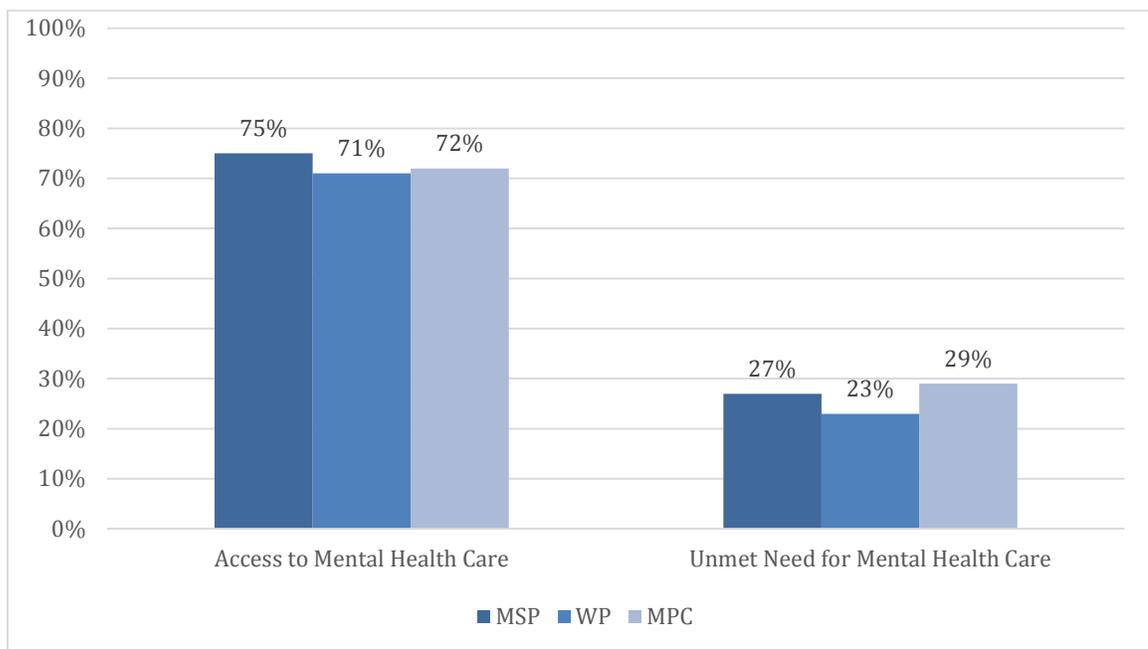
RDD was not conducted due to sample size limitations at the threshold. Instead, we used means tests to compare: 1) WP members to MSP-IE members and 2) MPC members to MSP-IE members with regard to unmet need for mental/emotional health care. Respondent numbers were small with regard to members who reported having had any treatment or counseling for a mental or emotional health problem (MSP-IE: n=111, WP: n=141, MPC: n=67) so we did not conduct statistical testing of the access to mental/emotional health care concept.

Results

For those who reported having received treatment for a mental or emotional health problem, around three-quarters reported that it was usually or always easy to get the treatment they needed using their health plan (MSP-IE: 75%, WP: 71%, MPC: 72%).

The groups were similar with regard to unmet need for mental health care services with 27% of MSP-IE, 23% of WP, and 29% of MPC members reporting an unmet need.

Figure 10. Access to and unmet need for mental or emotional health care



Note: Percentages reported are for those who reported a need for mental or emotional health care.

Slightly higher percentages of MSP-SSI members (79%) reported easy access to treatment when they needed it for a mental or emotional health problem. This item was not asked of IowaCare members in the 2012 survey. MSP-SSI members were similar to these groups with 27% reporting an unmet need for mental health care while IowaCare members in 2012 had a higher percentage (44%) of unmet need for these services.

Hypothesis 1.4

Wellness Plan/Marketplace Choice 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 (Measures 20A and 20B)

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

Proposed analytic method

The protocol for determining non-emergent ED visits is still being developed.

20B Whether member had a non-emergent ED visit

Proposed analytic method

The protocol for determining non-emergent ED visits is still being developed.

Measure 21 Follow-up ED visits (Measures 21A and 21B)

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

Definition

Original measure

Proposed analytic method

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

Variations from proposed method

None

Results

Rates of ED visits and follow-up ED visits were highest for FMAP members in both CY 2013 and CY 2014, while they were the lowest for IowaCare members. This measure is challenging. Because IowaCare members were only allowed to obtain *covered* ED care through the University of Iowa Health Care (Iowa City, Iowa) or Broadlawns Medical Center (Des Moines, Iowa), causing some ED visits to be missed with the claims data used for these analyses. Other analyses using the Iowa Hospital Association (IHA) outpatient visit data which includes all ED visits provided by hospitals located in Iowa has shown that IowaCare members received additional care at non-covered EDs while in IowaCare, a rare occurrence in the other programs. This deflates the IowaCare ED rate artificially.

Without the IowaCare population, the rates of ED and follow-up ED visits are lowest for MPC members and WP members, which are both lower than FMAP members in CY 2013 or CY 2014. Clearly, the results for 2015 will allow more meaningful comparisons between groups over time. In addition, we continue to utilize the IHA data to determine the rates not only for those who were on IowaCare and switched coverage but for those who were covered by MPC and WP but were not covered under a Medicaid-related program during 2013.

Table 14. Proportion of population age 19-64 identified as having an index ED visit with at least one readmission within 30 days, CY 2013 and CY 2014

Age		FMAP 2013	IowaCare 2013	FMAP 2014	WP 2014	MPC 2014
Proportion with index ED visit	Number	13,048	8,029	15,474	16,862	3,472
	%	40%	16%	43%	36%	26%
Proportion with follow-up ED visits	Number	3,977	1,670	4,489	4,352	711
	%	30%	21%	29%	26%	20%

21B Whether member had an ED visit within the first 30 days after index ED visit

Proposed analytic method

Models for RDD and DID are still under development.

Measure 22 Ambulatory Care

Definition

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

Proposed analytic method

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

Variation from Proposed Analysis

None

Results

Protocols for ambulatory care are being developed.

Hypothesis 1.5

Wellness Plan/Marketplace Choice 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

Definition

We examined member experiences with transportation to and from health care visits. There were several questions concerning the concept of access to transportation (related to health care visits) in the surveys:

- 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).
- 4) Use of the Medicaid NEMT benefit = the percentage who reported ever having used transportation paid for by Medicaid to get to or from a health care visit.
- 5) 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.

Proposed analytic method

RDD comparing WP/MPC members and MSP-IE members at the threshold

Variations from proposed method

RDD was not conducted due to sample size limitations at the threshold. Instead, we used means tests to compare:

1) WP members to MSP-IE members, and 2) MPC members to MSP-IE members with regard to these transportation items. Following discussions with CMS, we added multivariable modeling to evaluate the association of a variety of characteristics with unmet need for NEMT and the association of unmet need for NEMT and plan type along with other characteristics with health services utilization measures. The results of these models can be found in the Areas of Emphasis section on NEMT toward the end of this interim report.

Results

In the surveys, members were asked: “*When you need to get health care, what is the type of transportation you use most often to get to your visit?* (Please choose only one answer.)” The majority of respondents from all three groups drove themselves (77% MSP-IE, 65% WP, 82% MPC) or were driven by family or friends (17% MSP-IE, 24% WP, 14% MPC) to their health care appointments. Around 2% of MSP-IE, 3% of WP and 1% of MPC members reported no reliable way to get to their health care visits.

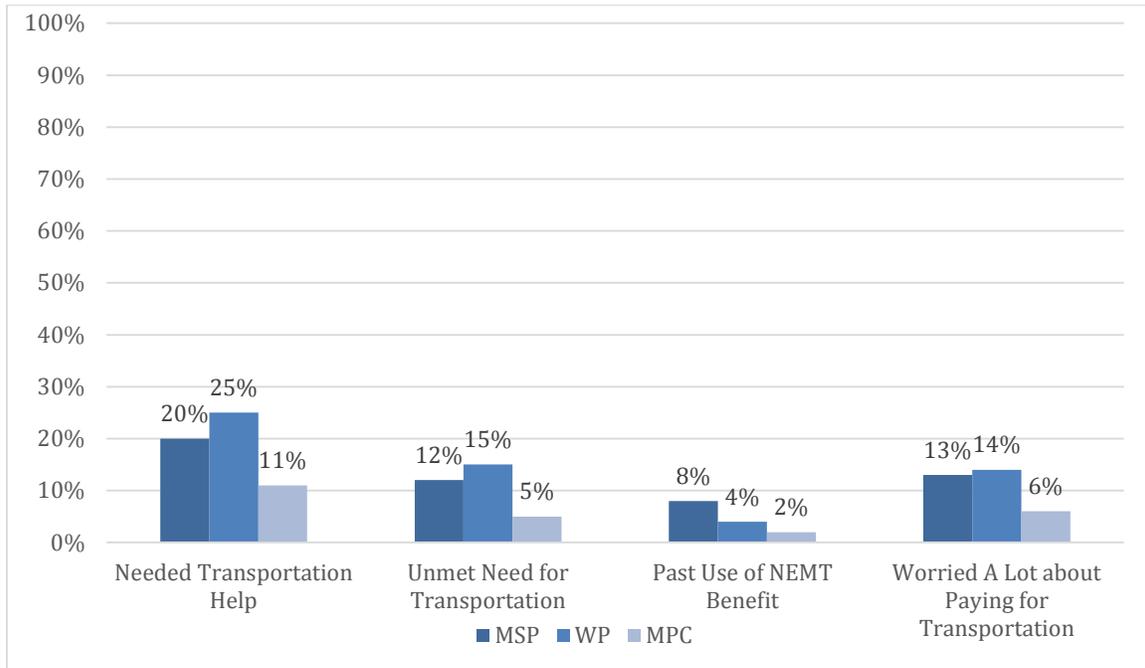
One-quarter of WP members reported usually or always needing assistance from other sources to get to a health care visit which was significantly higher than reported by MSP-IE members (20%). Yet, 11% of MPC members reported needing this help which was significantly lower than reported by MSP-IE members. A little over half (51%) of MSP-SSI members needed help from others to get to their health care visits. IowaCare members in 2012 were not asked this series of questions. However, 18% of IowaCare members in 2012 did report that they usually or always had a problem finding transportation to appointments when they needed routine care.

WP and MSP-IE members reported similar percentages of unmet need for transportation to health care visits (MSP-IE: 12%, WP: 15%) but a significantly lower percentage of MPC members (5%) reported unmet transportation needs when compared to MSP-IE members. Almost one-quarter (23%) of MSP-SSI members reported an unmet need for transportation to health care visits.

When members were asked if they had ever used transportation paid for by Medicaid to get to appointments, 8% of MSP-IE members replied that they had which was, as expected, significantly higher than reported by WP (4%) and MPC (2%) members. Almost 20% of MSP-SSI members had used transportation paid for by Medicaid.

Finally, significantly higher percentages of MSP-IE members (13%) and WP members (14%) reported worrying a great deal about their ability to pay for the cost of transportation to or from a health care visit when compared to MPC members (6%). Yet, the worry was the highest for MSP-SSI members with 22% worried a great deal about paying for transportation.

Figure 11. Member Experiences with Transportation to Health Care Visits



Hypothesis 1.6

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

Measure 24 EPSDT utilization (Measures 24A and 24B)

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

Variations from proposed method

Member numbers for this measure are low, we continue to investigate the best method for reporting this measure.

24B Whether member had an EPSDT visit

Variations from proposed method

Models for RDD and DID may be removed in the future due to low member numbers for this measure.

Churn

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

Hypothesis 2.1

Wellness Plan/Marketplace Choice members will experience equal or less churning.

Measure 25 Gaps in coverage in past 12 months

Survey Definition

One survey item was used to assess gaps in insurance coverage in the year prior to the survey. Only WP and MPC member surveys included this item. MSP-IE and MSP-SSI members were not asked this question. The measure was defined in the following way:

Time without insurance = number of months in the previous year when the respondent did not have health insurance coverage.

Proposed analytic method

RDD comparing WP/MPC members and MSP-IE members at the threshold

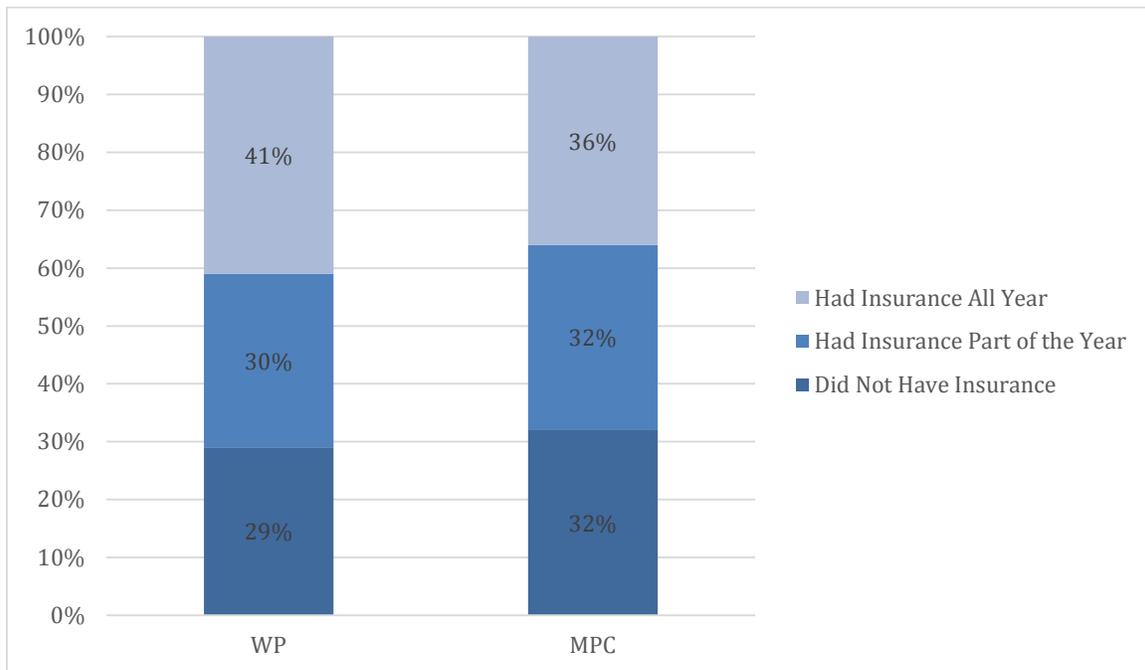
Variations from proposed method

RDD was not conducted due to sample size limitations at the threshold. We also did not have an MSP-IE comparison group for this item. Instead, we used means tests to compare WP members to MPC members.

Survey Results

Figure 12 provides a comparison of insurance coverage between WP and MPC members. Around 30% of all IHAWP members reported that they did not have any health insurance coverage in the year prior to the IHAWP. There were no significant differences in past insurance coverage between WP and MPC members.

Figure 12. Insurance Coverage in the Year Before IHAWP



Measure 26 Consecutive months covered by an insurance plan

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

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

Whether member: 1) did not change plans or lose eligibility; 2) changed plans or lost eligibility once; 3) changed plans or lost eligibility 2-3 times; or 4) changed plans or lost eligibility 4 or more time.

Administrative claims definition

Program churn can be defined as the movement of enrollees into and out of Medicaid programs with or without a gap in coverage.

Administrative claims method

For our assessment of churn we compare the Medicaid population including IowaCare in CY2013 (the year prior to the start of the IHAWP) to the Medicaid population and IHAWP in CY2014.

Variations from proposed method

None

Results

There were 10,042 IowaCare members who were not auto-enrolled into IHAWP. Of those, 2,299 members were subsequently covered through the Medicaid State Plan (MSP) or IHAWP leaving 7,743 not receiving coverage through MSP or IHAWP during CY2014. Those covered through MSP were enrolled through income eligibility (N=501), disability eligibility (N=31), the Family Planning Waiver (a program providing access only to family planning services, N=108), and Medicaid for Employed People with Disabilities (N=2). 1,000 people were

subsequently enrolled in WP and 657 were enrolled in Marketplace Choice. The gap between IowaCare coverage and coverage through another program varied from no gap (N=711) to 11 months (N=89) as shown in Figure 13.

Figure 13. Gap in coverage for those not auto-enrolled in IHAWP, CY 2014

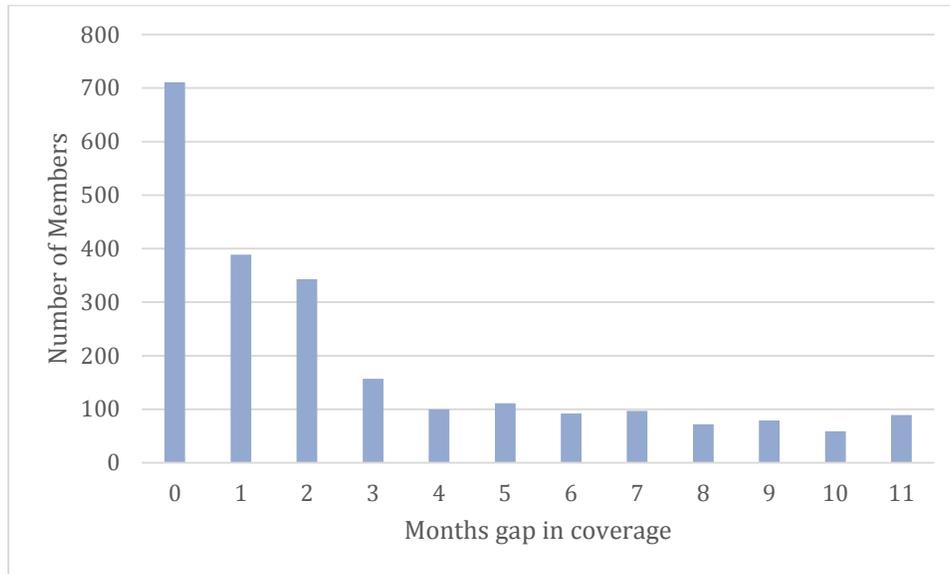


Table 15 provides the number of switches and length of gaps in coverage by program and year for both the year prior to the IHAWP and the first year of the program. Four groups are used in these comparisons: 1) FMAP CY 2013 and CY 2014; 2) IowaCare for CY 2013; 3) WP; and 4) MPC. Though members may have moved between programs, they are categorized according to the program of first enrollment for Table 15. A switch is indicated whenever there is a change in program during the year. Members in FMAP are generally the least likely to experience a switch and tend to have the smallest gaps in coverage, while those auto-enrolled from the IowaCare program were most likely to have a switch, however, most of these switches did not involve a gap in coverage. This indicates that there was a change in program commensurate with a change in circumstances. Though changes in program are not always simple or easy for members, those that do not result in gaps of coverage may be considered 'positive' churn within the publicly provided programs.

Table 15. Number and percent of members with at least one switch and the months of gap during switch period by program, CY 2013 and CY 2014

	FMAP CY 2013	IowaCare CY 2013	FMAP CY 2014	WP CY 2014	MPC CY 2014
At least one switch	5,071 (9%)	20,123 (25%)	7,607 (14%)	15,628 (15%)	7,077 (23%)
0 months gap	3,336 (6%)	15,468 (19%)	5,932 (11%)	13,644 (13%)	6,098 (20%)
1-6 month gap	1,315 (2%)	3,573 (4%)	1,319 (2%)	1,805 (2%)	877 (3%)
7-11 month gap	401 (1%)	1,002 (1%)	323 (1%)	172 (<1%)	95 (<1%)
12-16 month gap	19 (<1%)	80 (<1%)	33 (<1%)	7 (<1%)	7 (<1%)

Figure 14. Comparison of IowaCare and FMAP members with at least one switch and the months of gap during switch period by program, CY 2013

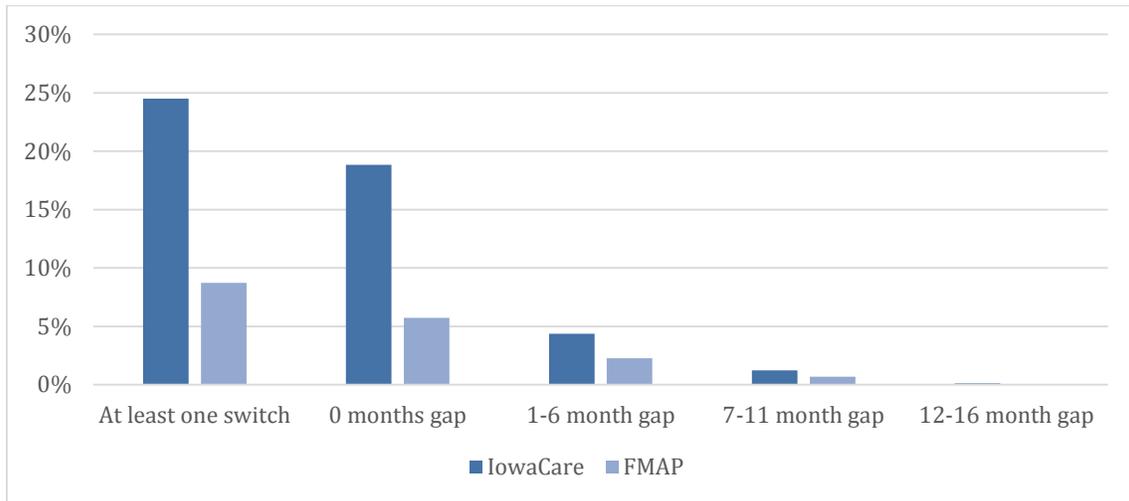
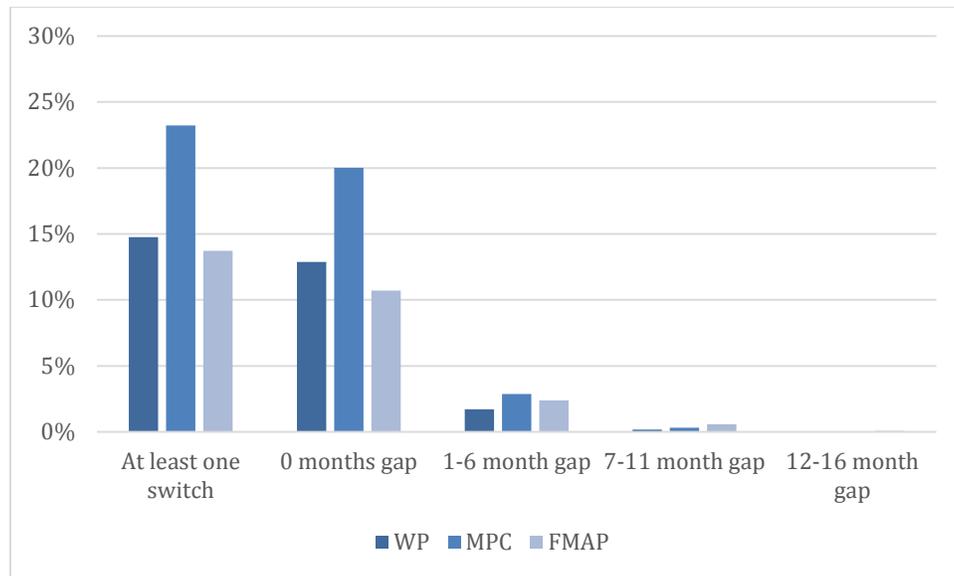


Figure 15. Comparison of WP, MPC, and FMAP members with at least one switch and the months of gap during switch period by program, CY 2014



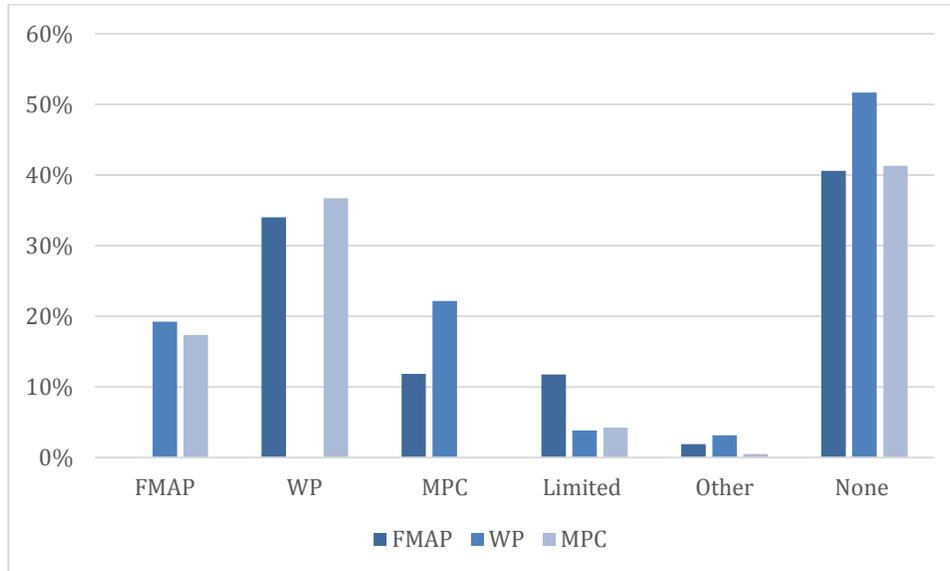
A primary reason for studying churn, particularly in the face of new programs, is to determine whether members who would have lost coverage are able to retain that coverage. Over 10,000 members lost their IowaCare coverage when that program was terminated and replaced with the IHAWP. Of these, 2,299 members were able to obtain coverage again during the year, leaving 7,743 with no coverage from a public insurance program. During CY 2014 the crucial question is what proportion of members who lost coverage in the FMAP were able to obtain coverage either in WP or MPC and what proportion of members who lost coverage in WP were able to obtain coverage in MPC. During CY 2014, 8,301 FMAP members, 19,634 WP members and 6,709 MPC members lost coverage and did not obtain any additional months of coverage through Medicaid or IHAWP by April 2015. Additionally, there were 39,898 times when members had to switch out of a program. Of these, 17,382 members switched 17,778 times upward, moving from FMAP to either WP or MPC or moving from WP to MPC, **retaining** coverage when it would not have been possible

without IHAWP. Additionally, 5,730 members moved from WP and MPC to FMAP or from MPC to WP 12,195 times. Table 16 provides the raw number of members and the program they switched out of and the program they moved into. The proportion of members moving from program to program is shown in Figure 16. Some members moved into limited coverage programs which include the Family Planning Waiver, Medicaid for Employed People with Disabilities, and dual Medicare/Medicaid eligibility (Limited), while some members entered 'Other' programs which include specified waivers.

Table 16. FMAP, WP, and MPC member switches, CY 2014

Program member entered	Program member left		
	FMAP	WP	MPC
FMAP	0	7,431	2,733
WP	6,838	0	5,792
MPC	2,380	8,560	0
Limited	2,363	1,470	665
Other	376	1,212	78
Total	11,957	18,673	9,268

Figure 16. The proportion of members leaving FMAP, WP and MPC and the program they entered, CY 2014



'Positive churn', movement into another program as income increases, represents a success for programs aiming to increase health care coverage, while the complete loss of coverage may represent a failure of the system to maintain coverage. Though members may leave the system for many reasons such as moving out of the state or obtaining employer-based health insurance, elopement may also indicate a loss of the physical, cognitive or emotional resources to maintain coverage. Table 17 compares those who made a positive movement by maintaining coverage while their income increased to those who lost coverage and had not

regained it by April 2015. The primary differences between the two groups are that those who experience positive churn are more likely to be white, more likely to be female, and older than those who lose coverage.

Table 17. Demographic characteristics of members with positive churn and members who lost coverage, CY 2014

	Positive churn N (%)	Lost coverage N (%)
Program		
FMAP	4,982 (29%)	8,301 (20%)
WP	8,251 (48%)	19,634 (46%)
MPC	524 (3%)	6,079 (14%)
All other programs	3,625 (21%)	8,314 (20%)
Gender		
Female	11,363 (65%)	22,208 (53%)
Male	6,019 (35%)	20,120 (47%)
Race		
White	11,343 (65%)	21,678 (51%)
Black	1,427 (8%)	3,623 (8%)
American Indian	195 (1%)	444 (1%)
Asian	406 (2%)	721 (2%)
Hispanic	640 (4%)	2,427 (6%)
Pacific Islander	125 (1%)	147 (1%)
Multiple-Hispanic	172 (1%)	470 (1%)
Multiple-Other	126 (1%)	231 (1%)
Undeclared	2,948 (17%)	12,587 (30%)
Age		
18-21 years	731 (4%)	3,528 (8%)
22-30 years	5,094 (29%)	13,741 (33%)
31-40 years	5,080 (29%)	10,780 (26%)
41-50 years	3,481 (20%)	7,280 (17%)
51 and over	2,996 (17%)	6,999 (17%)
County rural/urban status		
Metropolitan	10,553 (61%)	26,271 (62%)
Non-metropolitan, urban	752 (4%)	1,715 (4%)
Non-metropolitan, rural	6,077 (35%)	14,342 (34%)
Total	17,382	42,328

Hypothesis 2.2

Wellness Plan and Marketplace Choice 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 or Marketplace Choice

Measure 29 Continuity of care and satisfaction if they need to change to a new primary care physician when enrolled with a new plan

Definition

Continuity of care was measured by assessing through the survey 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. The following measures were used:

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.
3. Ease of change = Percentage who reported that it was ‘Somewhat easy’ or ‘Very easy’ to change from their assigned primary care provider.

It should be noted that measure (1) was only assessed for those who identified that they had someone they considered to be their personal doctor. Measure (2) was only assessed for those who identified that they were automatically assigned a primary care provider and measure (3) was only assessed for those who decided to change to a new primary care provider from the one they were assigned.

With regard to continuity with a personal doctor (measure 1), several questions were asked only of IHAWP members. For those with a personal doctor, members were asked “Is your personal doctor the same person who was your personal doctor before you enrolled in your new health plan?” Response options included: Yes, I have the same personal doctor; No, I have a different personal doctor; and I did not have a personal doctor before enrolling in [the IHAWP].

Proposed analytic method

Means tests between WP/MPC members and three comparison groups (MSP – income eligible (IE), MSP – SSI, IowaCare).

Variations from proposed method

We did not have an MSP-IE comparison group for these assessments. Instead, we used means tests to compare WP members to MPC members. These questions were also not asked of MSP-SSI members or on the IowaCare survey.

Results

Figure 17 describes continuity of care with providers for IHAWP members. With regard to continuity with a personal doctor (i.e., remaining with the same personal doctor after enrollment in the IHAWP), significantly more MPC members (64%) than WP members (43%) reported having the same personal doctor as before enrolling in the IHAWP ($p < .0001$). However, significantly more WP members (20%) compared to MPC members (13%) reported having a personal doctor after IHAWP enrollment when they did not have one before ($p = .002$).

As part of the IHAWP enrollment process, members may have been automatically assigned to a primary care provider (PCP) and were given the option to change to a different provider from the one to which they were assigned. Significantly more WP members (57%) than MPC members (30%) reported being automatically assigned to a PCP ($p < .0001$). And, of those who were auto-assigned to a PCP, significantly more WP members (41%) than MPC members (28%) decided to change to a different PCP ($p = .01$) with around two-thirds of the members reporting that it was ‘very easy’ to change from their assigned PCP to a different one (67% WP, 67% MPC).

Measure 30 Regular source of care – Personal Doctor

Definition

The surveys included the following item that was used to assess regular source of care: “Do you have a personal doctor [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.]?” Regular source of care was defined as the percentage who responded that they currently had a personal doctor.

Proposed analytic method

Means tests between WP/MPC members and three comparison groups (MSP – income eligible (IE), MSP – SSI, IowaCare).

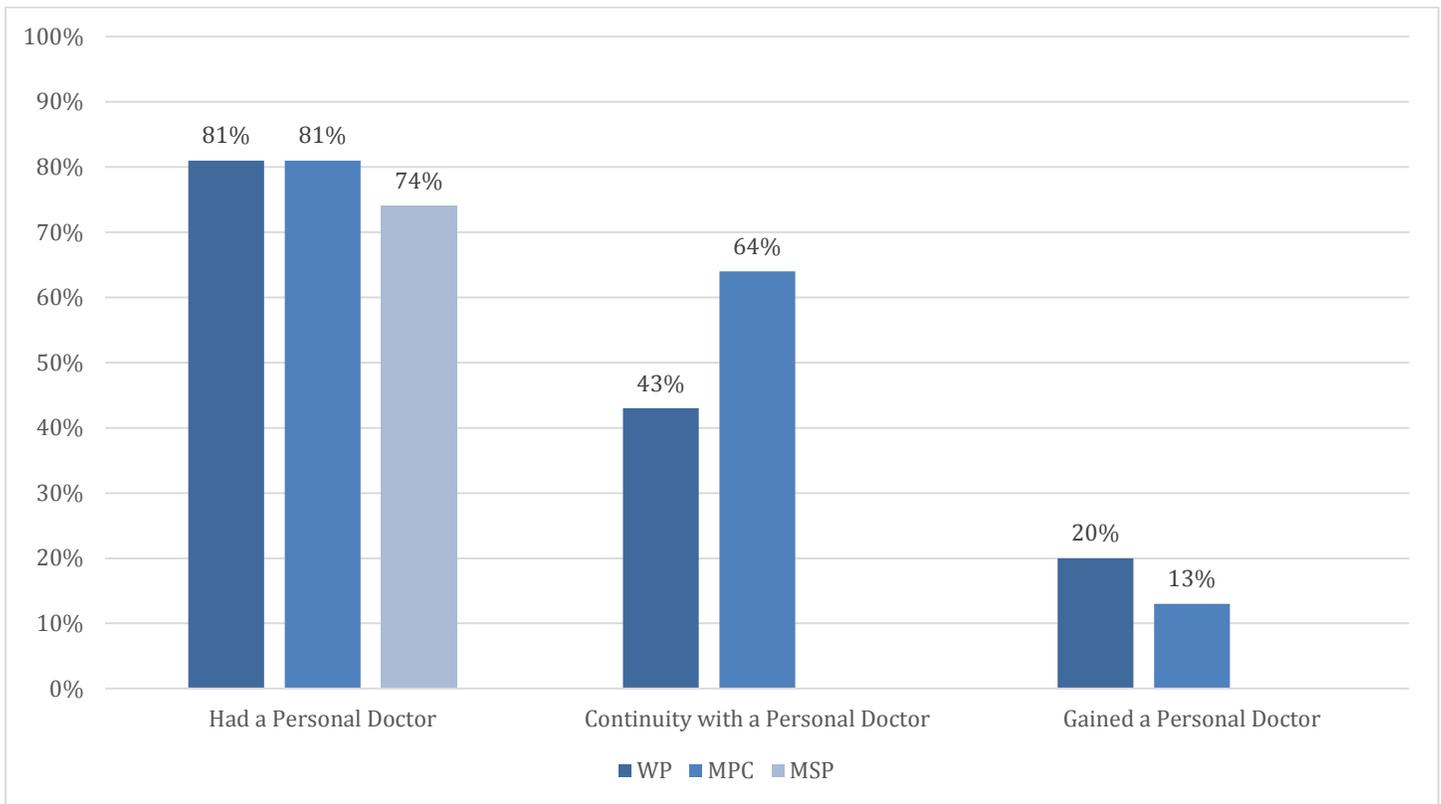
Variations from proposed method

We used means tests to compare 1) WP members to MSP-IE members and 2) MPC members to MSP-IE members. Statistical comparisons of WP and MPC members to MSP-SSI adult members and pre-implementation IowaCare members were not conducted.

Results

Figure 17 describes member experiences with having a regular source of care and continuity with that care. The majority of members reported having a regular source of care (MSP-IE: 81%, WP: 81%, MPC: 74%). Significantly fewer MPC members reported a usual source of care when compared to MSP-IE.

Figure 17. Having a Personal Doctor and Continuity of Care



Most MSP-SSI members (89%) reported having a personal doctor while 67% of IowaCare members in 2012 were able to identify having a personal doctor.

Quality of Care

Question 3 *What are the effects of the Wellness Plan/Marketplace Choice on member quality of care?*

Hypothesis 3.1

WP/MPC members will have equal or better quality of care.

Measure 31 Avoidance of antibiotic treatment in adults with acute bronchitis

Proposed analytic method

Measure is still being developed.

Measure 32 Use of appropriate medications for people with asthma

Definition

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

Proposed analytic method

Measure is still being developed.

Measure 33 Medication management for people with asthma**Proposed analytic method**

Measure is still being developed.

Measure 34 Pharmacotherapy management of COPD exacerbation (Measures 34A and 34B)

34A The percent of chronic obstructive pulmonary artery disease (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

Proposed analytic method

Measure is still being developed.

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

Proposed analytic method

Measure is still being developed.

Measure 35 Cholesterol management for patients with cardiovascular conditions (Measures 35A and 35B)

35A Percent of members who were discharged alive for acute myocardial infarction (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

Proposed analytic method

Measure moved to later date to allow for supplemental NEMT survey and analyses.

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

Proposed analytic method

Measure moved to later date to allow for supplemental NEMT survey and analyses.

Measure 36 Self-reported receipt of flu shot**Definition**

The surveys asked members “Have you had a flu shot since September 1, 2013 [the year prior to the survey]?” This measure is the percentage of respondents who reported having received a flu shot. We calculated this measure for all respondents (age 19-64) and also for the limited age range (50-64) to reflect the CMS measure.

Proposed analytic method

Means tests between WP/MPC members and three comparison groups (MSP-IE, MSP-SSI, IowaCare).

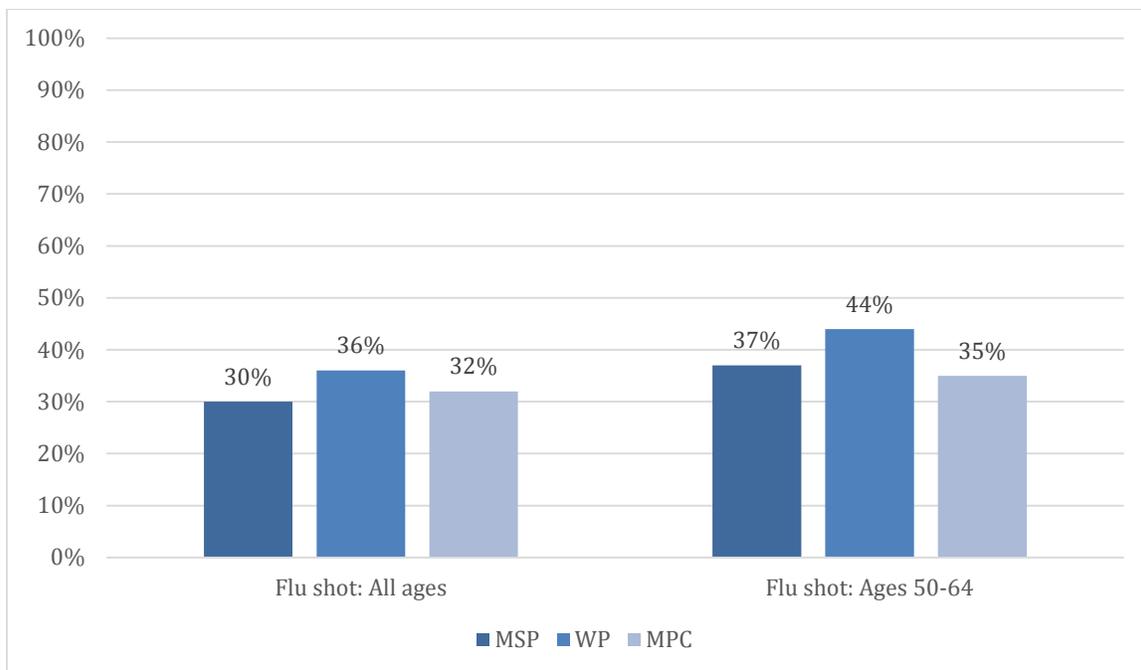
Variations from proposed method

We used means tests to compare 1) WP members to MSP-IE members and 2) MPC members to MSP-IE members. Statistical comparisons of WP and MPC members to MSP-SSI adult members and pre-implementation IowaCare members were not conducted.

Results

Figure 18 provides a summary of the results of members reporting receipt of a flu shot. Over all age groups, a significantly higher percentage of WP members (36%) reported receiving a flu shot compared to MSP-IE members (30%). MPC members were similar to MSP-IE members. Almost half (49%) of MSP-SSI members received a flu shot. Higher percentages of older adults (50-64) reported receiving a flu shot but, likely due to the smaller sample sizes (MSP-IE: n=33, WP: n=502, MPC: n=304), there were no significant differences among the three groups.

Figure 18. Receipt of a Flu Shot



Measure 37 Emergency department use

Definition

To assess potentially avoidable emergency department (ED) use, we asked one item on the survey for those respondents who reported at least one ED visit in the previous six months: “Do you think the care you received at your most recent visit to the emergency room could have been provided in a doctor’s office if one was available at the time?” We assessed the percentage of respondents who responded in the affirmative to that question as those whose ED use was potentially avoidable.

Proposed analytic method

Means tests between WP/MPC members and three comparison groups (MSP-IE, MSP-SSI, IowaCare).

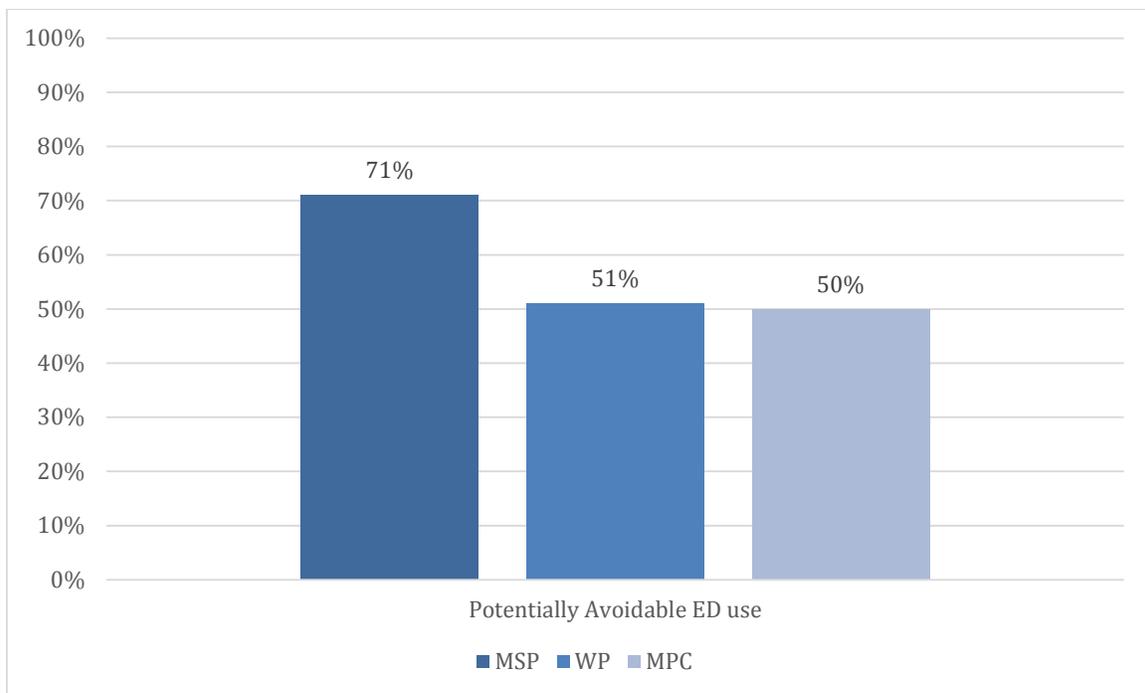
Variations from proposed method

We used means tests to compare: 1) WP members to MSP-IE members; and 2) MPC members to MSP-IE members. Statistical comparisons of WP and MPC members to MSP-SSI members and pre-implementation IowaCare members were not conducted.

Results

Figure 19 provides a snapshot of potentially avoidable ED use by members. In general, MSP-IE members reported the most use of the ED in the past six months (35%; n=232) as compared to WP members (29%; n=309) and MPC members (25%; n=170). Around half of WP members (51%) and MPC members (50%) reported potentially avoidable ED use which was statistically lower than reported by MSP-IE members (71%). MSP-SSI members were similar to WP and MPC members with 51% reporting potentially avoidable ED use while IowaCare members in 2012 fell in between (63%).

Figure 19. Self-Reported Emergency Department Use



Hypothesis 3.2

Wellness Plan/Marketplace Choice 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, congestive heart failure (CHF), short-term complications from diabetes or asthma per 100,000 Medicaid members

Proposed analytic method

Measure moved to later date to allow for supplemental NEMT survey and analyses.

Measure 39 Admission rate for COPD (Measures 39A and 39B)

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

Proposed analytic method

Measure moved to later date to allow for supplemental NEMT survey and analyses.

39B Whether member had an admission for COPD

Proposed analytic method

Measure moved to later date to allow for supplemental NEMT survey and analyses.

Measure 40 Admission rate for diabetes short-term complications (Measures 40A and 40B)

40A Number of discharges for diabetes short-term complications per 100,000 Medicaid members

Proposed analytic method

Protocol is being developed for final report.

40B Whether member had an admission for diabetes short-term complications

Proposed analytic method

Protocol is being developed for final report.

Measure 41 Admission rate for CHF (Measures 41A and 41B)

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

Proposed analytic method

Measure moved to later date to allow for supplemental NEMT survey and analyses.

41B Whether member had an admission for CHF

Proposed analytic method

Measure moved to later date to allow for supplemental NEMT survey and analyses.

Measure 42 Admission rate for asthma (Measures 42A and 42B)

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

Proposed analytic method

Measure moved to later date to allow for supplemental NEMT survey and analyses.

42B Whether member had an admission for asthma

Proposed analytic method

Measure moved to later date to allow for supplemental NEMT survey and analyses.

Measure 43 Inpatient utilization-general hospital/acute care**Definition**

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

Proposed analytic method

Protocol being developed for final report.

Measure 44 Plan “all cause” hospital readmissions**Definition**

For members ages 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

Proposed analytic method

Protocol being developed.

Measure 45 Rate of hospital admissions in past 6 months**Definition**

We used the survey to assess reported hospital admissions. For this measure, 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.

Proposed analytic method

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

Variations from proposed method

Neither RDD nor DID analyses were conducted due to sample size limitations. We used means tests to compare WP members and MPC members to MSP-IE members. We provide statistics for MSP-SSI and IowaCare members but no statistical comparison testing was done with these two groups and the others.

Results

Figure 20 provides the percentages of members who reported at least one hospital stay. A significantly higher percentage of MSP-IE members reported a hospital admission (16%) compared to WP members (11%) and MPC members (8%). The highest percentage of hospital admissions were reported by MSP-SSI members (21%) while reporting by IowaCare members in 2012 (12%) was similar to WP and MPC members.

Measure 46 Rate of 30 day hospital readmissions

Definition

The survey question was “Did you ever have to go back into the hospital soon after being allowed to go home because you were still sick or had a problem?” and was only asked of those who reported at least one hospital stay.

Proposed analytic method

RDD comparing WP/MPC members and MSP-IE members at the threshold

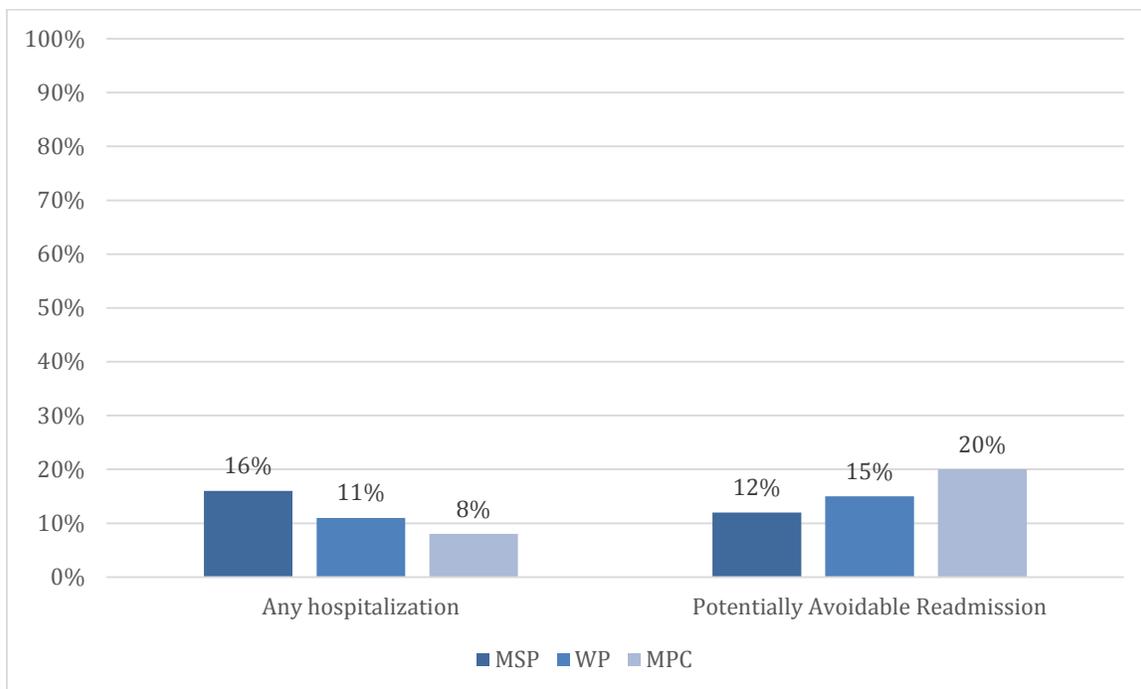
Variations from proposed method

This measure has changed since the evaluation plan. This survey item did not include a time frame for readmission in the question and thus, we cannot define the measure as a rate of 30 day hospital readmission. RDD was not conducted due to sample size limitations at the threshold. Instead, we used means tests to compare 1) WP members to MSP-IE members and 2) MPC members to MSP-IE members with regard to these transportation items.

Results

Figure 20 provides the hospital readmission percentages for MSP-IE, WP, and MPC members. There were no significant differences in percentage of hospital readmission between MSP-IE (12%) and WP members (15%) or MPC members (20%).

Figure 20. Self-Reported Hospital Admissions and Readmissions



Over one-third (34%) of MSP-SSI members and almost one-quarter (23%) of IowaCare members in 2012 reported a hospital readmission.

Hypothesis 3.3

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

Measures 47 through 50 provide an assessment of member experiences with their providers during office visits. Figure 21 provides the percentages by group for each of these measures.

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.

Definition

Communication between providers and members was assessed using a six-item composite measure comprised of the following questions:

1. How often did your personal doctor explain things in a way that was easy to understand?
2. How often did your personal doctor listen carefully to you?
3. How often did your personal doctor give you easy to understand information about your health questions or concerns?
4. How often did your personal doctor seem to know the important information about your medical history?
5. How often did your personal doctor show respect for what you had to say?
6. How often did your personal doctor spend enough time with you?

A response of usually or always to these questions denoted a good communication experience with the provider. A composite measure defined by CAHPS and incorporating these six items was used to provide a summary measure of member satisfaction with communication with their personal doctor.

Proposed analytic method

Means tests between WP/MPC members and three comparison groups (MSP-IE, MSP-SSI, IowaCare).

Variations from proposed method

We used means tests to compare: 1) WP members to MSP-IE members, and 2) MPC members to MSP-IE members. Statistical comparisons of WP and MPC members to MSP-SSI adult members and pre-implementation IowaCare members were not conducted.

Results

Figure 21 (found after measure 50) provides the percentage of members who usually or always experienced good communication with their provider. The vast majority of MSP-IE (87%), WP (88%), and MPC (91%) members reported usually or always having good communication with their provider and there were not significant differences among these groups. Good communication with a provider was also experienced by the majority of MSP-SSI (88%) members post-IHAWP and IowaCare members (81%) pre-IHAWP.

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 patients in taking care of their own health (self-management support).

Definition

Self-management support was assessed using a two-item composite measure comprised of the following questions:

1. Did anyone in a doctor's office talk with you about specific goals for your health?
2. 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?

An affirmative response to these questions denoted good self-management support from the provider. A composite measure defined by CAHPS and incorporating these two items was used to provide a summary measure of member satisfaction with how their provider supported them in taking care of themselves.

Proposed analytic method

Means tests between WP/MPC members and three comparison groups (MSP-IE, MSP-SSI, IowaCare).

Variations from proposed method

We used means tests to compare; 1) WP members to MSP-IE members, and 2) MPC members to MSP-IE members. Statistical comparisons of WP and MPC members to MSP-SSI adult members and pre-implementation IowaCare members were not conducted.

Results

Figure 21 (found after measure 50) provides the results of this analysis. A little over half (51%) of WP members, 37% of MSP-IE members, and 43% of MPC members experienced self-management support. Similar to WP members, 50% of MSP-SSI members reported self-management support from their provider. Prior to IHAWP implementation, 44% of IowaCare members reported self-management support during their office visits.

Measure 49 Attention to mental/emotional health (Comprehensive care)

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.

Definition

Comprehensiveness of care was assessed using a three-item composite measure comprised of the following questions about discussions of mental/emotional health:

1. Did anyone in a doctor's office ask you if there was a period of time when you felt sad, empty, or depressed?
2. Did you and anyone in a doctor's office talk about things in your life that worry you or cause you stress?

3. 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?

An affirmative response to these questions denoted provider attention to the members’ mental/emotional health. A composite measure defined by CAHPS and incorporating these three items was used to provide a summary measure of member satisfaction with their provider on this attribute.

Proposed analytic method

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

Variations from proposed method

Neither RDD nor DID analyses were conducted due to sample size limitations. We used means tests to compare: 1) WP members to MSP-IE members, and 2) MPC members to MSP-IE members. Statistical comparisons of WP and MPC members to MSP-SSI adult members and pre-implementation IowaCare members were not conducted.

Results

Figure 21 (found after measure 50) provides the results of this analysis. Almost half (46%) of MSP-IE members, 47% of WP members, and 42% of MPC members reported that their provider paid attention to their mental/emotional health during office visits. Results were similar for MSP-SSI members (43%) in the post-IHAWP period and IowaCare members (42%) in the pre-IHAWP period.

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 method to assess the shared decision making component of the PCMH.

Definition

Shared decision-making regarding prescription medications was assessed using a three-item composite measure comprised of the following questions:

1. When you talked about starting or stopping a prescription medicine, how much did the doctor or other health provider talk about the reasons you might want to take a medicine?
2. When you talked about starting or stopping a prescription medicine, how much did the doctor or other health provider talk about the reasons you might not want to take a medicine?
3. When you talked about starting or stopping a prescription medicine, did the doctor or other provider ask you what you thought was best for you?

A composite measure defined by CAHPS and incorporating these three items was used to provide a summary measure of member satisfaction with how well providers shared decision making with them about prescription medications use.

Proposed analytic method

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

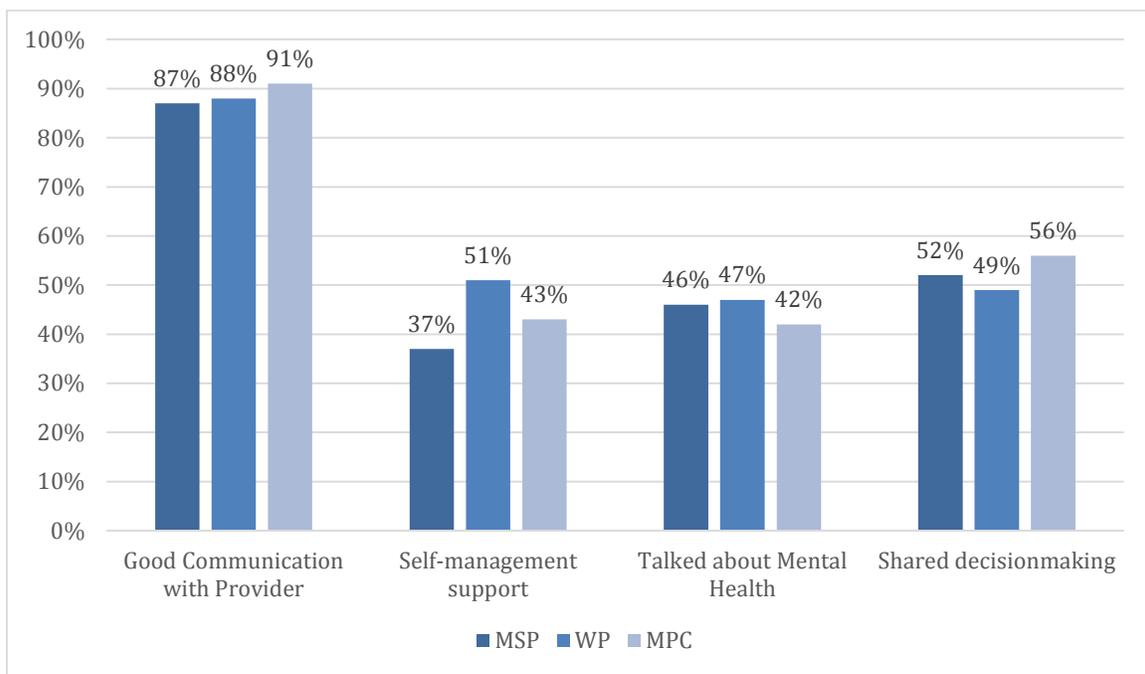
Variations from proposed method

Neither RDD nor DID analyses were conducted due to sample size limitations. We used means tests to compare: 1) WP members to MSP-IE members, and 2) MPC members to MSP-IE members. Statistical comparisons of WP and MPC members to MSP-SSI adult members and pre-implementation IowaCare members were not conducted.

Results

Figure 21 below provides the results of this analysis. Around half of the members from each group (52% of MSP-IE members, 49% of WP members, and 56% of MPC members) reported that their provider shared decision making with them regarding prescription medications. Results were similar for MSP-SSI members (52%) in the post-IHAWP period. A composite for this measure was not calculated for IowaCare members in the pre-IHAWP period (2012).

Figure 21. Member Experiences During Office Visits



Measure 51 Care coordination

There are three individual items in the surveys 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.

Definition

The three items and associated measure definitions related to different aspects of providing care coordination were:

1. Did you get any reminders from a doctor's office between visits?
(Defined as the percentage of respondents who received reminders)
2. When your doctor's office ordered a blood test, x-ray, or other test for you, how often did someone from the doctor's office follow up to give you those results?
(Defined, only for those whose doctor's office ordered any testing, as the percentage who reported that their doctor's office usually or always followed-up with them to give them the test results)
3. How often did your personal doctor's office seem informed and up-to-date about the care you got from specialists?
(Defined, only for those who reported that they got care from a specialist, as the percentage whose doctor's office usually or always seemed informed and up-to-date about the care they got from specialists)

Proposed analytic method

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

Variations from proposed method

Neither RDD nor DID analyses were conducted due to sample size limitations. We used means tests to compare: 1) WP members to MSP-IE members, and 2) MPC members to MSP-IE members. Statistical comparisons of WP and MPC members to MSP-SSI adult members and pre-implementation IowaCare members were not conducted.

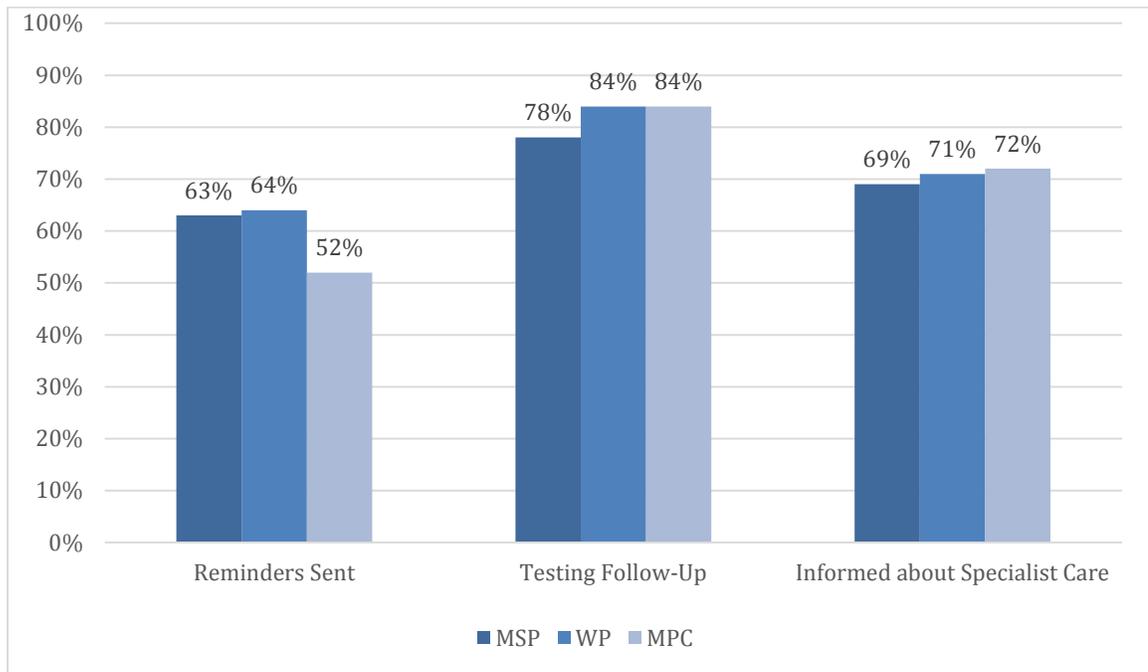
Results

Figure 22 provides the results of the analyses of these care coordination concepts. Almost two-thirds of MSP-IE (63%) and WP (64%) members received reminders from their doctors' offices between visits while significantly fewer MPC members (52%) reported receipt of reminders. Over two-thirds (69%) of MSP-SSI members reported receiving reminders while 54% of IowaCare members prior to IHAWP implementation reported receiving reminders.

The majority of WP and MPC members (84% each) whose doctor's office ordered medical testing reported that the office usually or always followed-up with them to give them the results. Significantly fewer MSP-IE members (78%) reported the same when compared to WP members. Similar to WP and MPC, 86% of MSP-SSI members reported that their doctor's office followed-up with them about medical test results. And, for IowaCare members in 2012 (pre-IHAWP implementation), three-quarters (75%) reported receiving their test results from their doctors' offices which is similar to MSP-IE post-IHAWP implementation.

Finally, there were no significant differences among the three groups with regard to reporting their doctor's office being informed and up-to-date about specialist care (MSP-IE: 69%, WP: 71%, MPC: 72%). Similarly, 75% of MSP-SSI members experienced this aspect of care coordination. Yet, fewer IowaCare members prior to IHAWP implementation (57%) reported that their doctors' office seemed informed about any specialist care they received.

Figure 22. Care Coordination



Measure 52 Rating of personal doctor

Measure 53 Rating of all health care received

Measure 54 Rating of health care plan

Definition

Survey respondents were asked to rate various aspects of the health care they received and also their health plan on a 0 to 10 scale, where 0 was defined as the worst possible and 10 as the best possible. Ratings were obtained for:

1. Personal Doctor (Measure 52)
2. All Health Care Received (Measure 53)
3. Health Plan (Measure 54)

For the analysis, each measure was defined as the percentage of respondents who rated the particular item as a '9' or '10' which indicates the highest possible satisfaction.

Proposed analytic method

Means tests between WP/MPC members and three comparison groups (MSP-IE, MSP-SSI, IowaCare).

Variations from proposed method

We used means tests to compare: 1) WP members to MSP-IE members, and 2) MPC members to MSP-IE members. Statistical comparisons of WP and MPC members to MSP-SSI adult members and pre-implementation IowaCare members were not conducted.

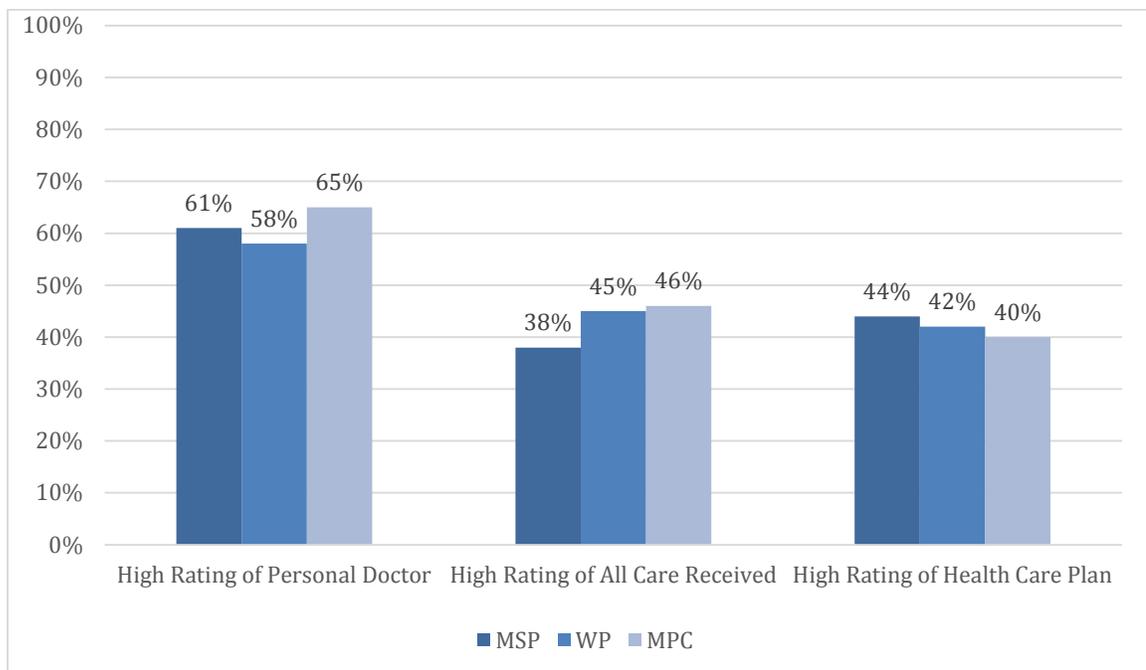
Results

Figure 23 provides the results of the analyses of member satisfaction with their personal doctor, health care, and health plan. There were no significant differences among plans with regard to the percentage with the highest satisfaction with their personal doctor (MSP-IE: 61%, WP: 58%, MPC: 65%). MSP-SSI members were equivalent to MSP-IE members in the percentage with the highest rating of their personal doctor (61%). Half of IowaCare members in 2012 reported the highest level of satisfaction with their personal doctor.

There were significant differences between IHAWP members and MSP-IE members in satisfaction with all of the health care received. More WP members (45%) and MPC members (46%) reported high satisfaction compared to MSP-IE members (38%). Similar to MPC, around half (46%) of MSP-SSI members reported high satisfaction with their health care while one-third of IowaCare members in 2012 (33%) were highly satisfied with all of the health care they received.

MSP-IE, WP, and MPC members reported similar percentages of being highly satisfied with their health plan (44%, 42%, 40%, respectively). More than half (53%) of MSP-SSI members rated their health plan highly but less than one-third (29%) of IowaCare members in 2012 did the same.

Figure 23. Ratings of Health Care and Health Plan



Cost

Question 4 *What are the effects of the Wellness Plan/Marketplace Choice on the costs of providing care?*

Hypothesis 4.1

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

Measure 55 Compare Wellness Plan/Marketplace Choice PMPM costs to those in the Medicaid State 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

Definition

Original measure

Proposed analytic method

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 six 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 analysis 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 analysis.

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 analysis will include varying the groups included in the analysis, 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.

$$PMPM_{it} = \alpha_i + \beta_1 Group_{it} * POST_t + \beta_2 Group_{it} + \beta_3 Post_t + \mathbf{x}'\beta_4 + \beta_5 Year_t + u_{it}$$

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 analysis 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 analysis have indicated that this option does not appear to have a race-based bias or systematic component. We will perform the analysis 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.⁷ 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 analysis 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 analysis indicate that the RUCC is sufficient.

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

⁷ http://www.kingsfund.org.uk/sites/files/kf/field/field_document/PARR-combined-predictive-model-final-report-dec06.pdf

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.

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

Variations from proposed method

For the interim report we made a number of changes to the proposed analyses.

1. We provide the results for ED costs and prescription costs in an effort to refine the cost model and understand one of the most important outcomes of coverage-ED cost. Leaving total costs for annual report in June 2016.
2. We did not include payment structure in the model.
3. We did not include members with basis of eligibility disability or those determined as medically exempt from WP or MPC.
4. We moved the RDD to the annual report in June 2016.

Results

The analyses included 228,015 individuals who were: 1) less than 65 years old as of January 1, 2014 and over 19 years old as of December 31, 2014; 2) eligible in FMAP, SSI, WP or MPC for at least one month during the study period (January 2012-December 2014); 3) not eligible for reduced coverage programs such as family planning; 4) not eligible for Medicare; and 5) not considered medically exempt from IHAWP. This resulted in 4,872,313 monthly data points. Tables 18 and 19 below show the characteristics of the FMAP population compared to the IHAWP population and the WP population compared to the MPC population. Those in IHAWP were more likely to be older, less likely to be female, and more likely to have a mental health problem. There are no significant differences between the WP and MPC populations.

We used a fixed effects regression modeling technique that included monthly information for each member for the months they were in the study. The maximum number of months of data available for a member in the analyses was 36, while the minimum was 1. As this model allows for data for members in the three groups for the period before and after implementation, each member may serve as his/her own control. This method of predicting cost changes is quite robust.

It is important to remember that the cost estimates are based on claims and encounter data. Claims data reflects the actual amount of money paid by the Medicaid program for health care services, however, encounters represent the amount of money paid by the Qualified Health Plans (QHPs: Coventry and CoOpportunity), not the amount paid by the Medicaid program. Premiums reflect the actual amount paid by the Medicaid program for those in the QHPs. Additional analyses are being undertaken to determine what the cost would have been to the state for the MPC population should they have been covered as though in the Medicaid program. This estimate will be compared to the state premium expenditure to estimate savings to the state.

Table 18. Descriptive characteristics of FMAP and IHAWP members, CY 2014

Variable	Definition	FMAP Mean	IHAWP Mean
<i>Demographic/Socioeconomic</i>			
Age	Age in years	32.89	38.72
Female	1 if Female	0.77	0.52
Black	1 if Black	0.10	0.08
Hispanic	1 if Hispanic	0.05	0.04
White	1 if White	0.65	0.63
Other	1 if Other Race	0.05	0.05
Above 100% of FPL	1 if Higher than 100% of FPL	0.01	0.22
<i>Chronic Conditions</i>			
Mental health problem	1 if has condition	0.38	0.25
Substance abuse	1 if has condition	0.08	0.07
Asthma	1 if has condition	0.12	0.07
Diabetes	1 if has condition	0.07	0.09
CAD	1 if has condition	0.07	0.08
Obesity	1 if has condition	0.18	0.13
Hypertension	1 if has condition	0.13	0.20
COPD	1 if has condition	0.02	0.04
<i>Health Services</i>			
Rx Fill	1 if 1 or more Rx Filled during month	0.40	0.32
Rx Spending	Total monthly Rx spending	18.66	18.11
ED Visit	1 if 1 or more ED Visits during month	0.08	0.05
ED Spending	Total Monthly ED spending	41.99	34.93

Table 19. Descriptive Characteristics of MCP and WP members, CY 2014

Variable	Definition	MCP Mean	WP Mean
<i>Demographic/Socioeconomic</i>			
Age	Age in years	38.56	38.77
Female	1 if Female	0.60	0.50
Black	1 if Black	0.06	0.08
Hispanic	1 if Hispanic	0.05	0.04
White	1 if White	0.65	0.63
Other	1 if Other Race	0.05	0.04
Above 100% of FPL	1 if Higher than 100% of FPL	0.82	0.04
<i>Chronic Conditions</i>			
Mental health problem	1 if has condition	0.23	0.26
Substance abuse	1 if has condition	0.05	0.08
Asthma	1 if has condition	0.07	0.08
Diabetes	1 if has condition	0.08	0.09
CAD	1 if has condition	0.07	0.08
Obesity	1 if has condition	0.13	0.14
Hypertension	1 if has condition	0.18	0.21
COPD	1 if has condition	0.03	0.04
<i>Health Services</i>			
Rx Fill	1 if 1 or more Rx Filled during month	0.30	0.32
Rx Spending	Total monthly Rx spending	23.09	16.54
ED Visit	1 if 1 or more ED Visits during month	0.04	0.06
ED Spending	Total Monthly ED spending	38.23	33.88

Table 20 provides the results from linear regression modeling for estimating ED use and cost and prescription medicine use and cost. In comparing WP per member per month (PMPM) cost and use to FMAP PMPM cost and use, the ED and prescription medicine PMPM cost and use are all significantly less. These comparisons are critical as both the cost and utilization are determined from claims and not encounters, providing a direct comparison. Regression results for MPC PMPM cost and use compared to FMAP PMPM cost and use indicates that MPC members had significantly higher ED and prescription medicine cost, while use was significantly lower. This may be the result of differences in fee schedules and formularies. We will investigate these differences further for the final report, including the completion of the RDD analyses.

Table 20: Regression Results Comparing IHAWP versus FMAP: 2014

Variable	Rx Fills (Likelihood)	ED Visit (Likelihood)	Rx Spending (Total/Mo)	ED Spending (Total/Mo)
WP	-0.064***	-0.009***	-2.58***	-1.72***
(compared to FMAP)	(0.0007)	(0.0004)	(0.3270)	(0.5538)
MPC	-0.085***	-0.025***	11.00***	11.10***
(compared to FMAP)	(0.0016)	(0.0009)	(0.6628)	(1.1224)

Standard errors in parentheses

*** Significant at p < .01

Models control for age, gender, race, income, chronic conditions

Incremental cost effectiveness

Incremental cost effectiveness measures will be provided in the June 2016 final report. 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.

The ratios shown below do not reflect any risk adjustment, however, we will adjust the rates used in the calculations for differences in population risk strata. After comparing the populations on a variety of characteristics we will weigh the rates to normalize the population statistic. Depending on the numbers of members in each group and the accuracy of income data, we will analyze the rates for each population at the income threshold.

Measure 1A Adult access to preventive/ambulatory health services

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

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

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

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

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

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

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

Measure 11A Flu vaccinations for adults ages 19-64

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

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

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

ED Cost (MPC)-ED Cost (MSP/WP)

Flu Vaccinations(MPC)-Flu Vaccinations(MSP/WP)

This outcome measure will be utilized as the denominator for two 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

Total Cost (MPC)-Total Cost (MSP/WP)

Mental Health Utilization(MPC)-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 two 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 four ratios with numerators for total cost, primary care cost, ED cost and specialist cost. Access to comprehensive care should result in increased access to and cost of primary care and specialist care, however, this increased access to less costly care options should also result in lower ED costs and lower total costs.

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

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 four 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.

Premiums and Cost Sharing

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

Hypothesis 5.1

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

Measure 56 Awareness of Premium

Measure 57 Ease of Obtaining Annual Physical Exam

Measure 58 Hardship of Monthly Premium

Definition

Several items in the survey were used to assess the effect of the premium as an incentive for patients to engage in healthy behaviors. Survey respondents were given the following information about this initiative as an introduction to the questions: “During your first year in this health plan, you are supposed to get a physical

exam. If you do not, you may have to pay a premium [\$5 in the WP survey and \$10 in the MPC survey] in your second year in the program (depending on your income).” The following measures were used to assess the healthy behaviors/premium initiative.

1. Awareness of the premium (Measure 56) = the percentage of respondents who reported being aware of the premiums.
2. Ease of obtaining the yearly physical exam (Measure 57) = the percentage of respondents who reported that it would be ‘very easy’ for them to obtain a yearly physical exam.
3. Hardship of a monthly premium [WP \$5/month, MPC \$10/month] (Measure 58) = the percentage who reported that they would be ‘a great deal’ worried if they had to pay a monthly premium.

Proposed analytic method

Measure 56 & 58:

Means tests between WP/MPC members and three comparison groups (MSP-IE, MSP-SSI, IowaCare).

Measure 57

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

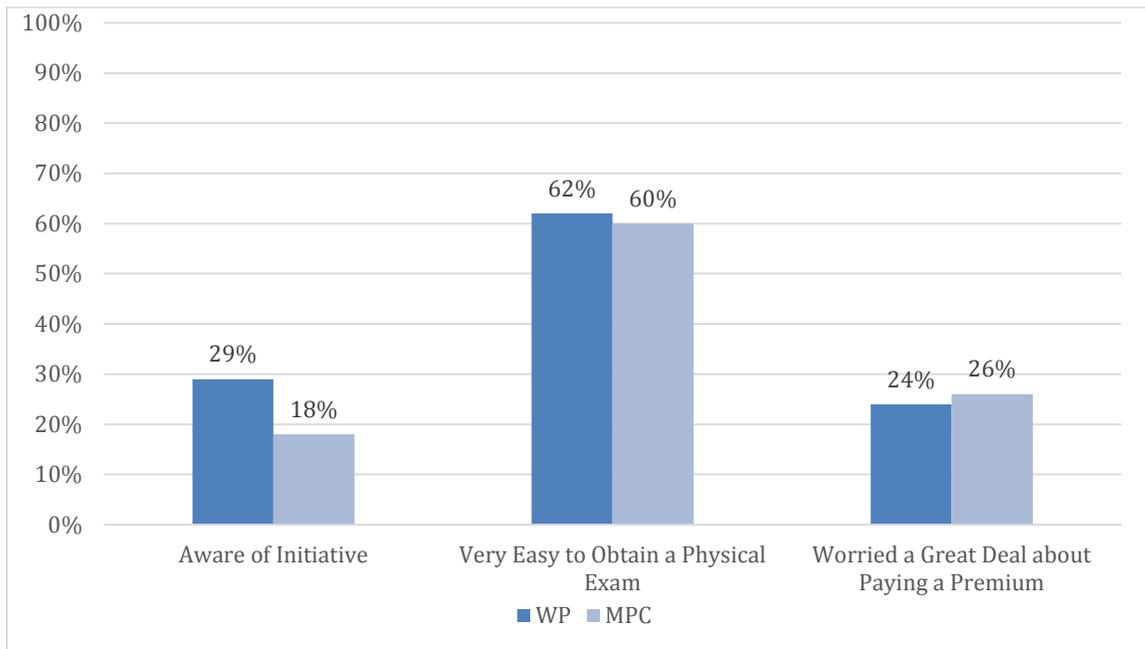
Variations from proposed method

Because premiums and incentives were not a part of the MSP-IE or MSP-SSI programs, we did not ask these questions in those member surveys. And, due to sample size constraints, we were not able to conduct RDD or DID analyses for Measure 57. Thus, for all three measures, we used means tests only to compare WP members to MPC members. Although premiums were part of the IowaCare program, the associated healthy behaviors were not so we did not include any consideration of IowaCare members in these analyses.

Results

Figure 24 provides the results of the analyses of Measures 56-58 for the WP and MPC members. Less than one-third of IHAWP members were aware of the physical exam requirement/premium payment of the healthy behavior initiative with significantly more WP members (29%) aware of this IHAWP plan policy compared to MPC members (18%). However, the majority of IHAWP members reported that it would be ‘very easy’ to obtain a physical exam (WP: 62%, MPC: 60%). And, around one-quarter reported that it would worry them ‘a great deal’ if they had to pay a premium to keep their health plan (WP: 24%, MPC: 26%).

Figure 24. IHAWP Healthy Behaviors/Premium Initiative



Hypothesis 5.2

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

Measure 59 Awareness of the copayment

Measure 60 Awareness of non-emergent condition

Measure 61 Copayment as a disincentive

Definition

As an introduction to the survey section on this topic, respondents were given the following information which was included in their IHAWP introductory packets: “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-emergency condition beginning next year (i.e. 2015). An emergency is considered to be any condition that could endanger your life or cause permanent disability if not treated immediately.”

The following three measures were derived from three survey items and were 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 (Measure 59) = the percentage of respondents who were aware of the \$8 copayment for inappropriate ER use.
2. Awareness of a non-emergent condition (Measure 60) = the percentage of respondents who reported that it was ‘very easy’ for them to determine when their health condition would be considered emergent.

- Copayment as a disincentive (Measure 61) = the percentage who reported 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.

Proposed analytic method

Means tests between WP/MPC members and three comparison groups (MSP-IE, MSP-SSI, IowaCare).

Variations from proposed method

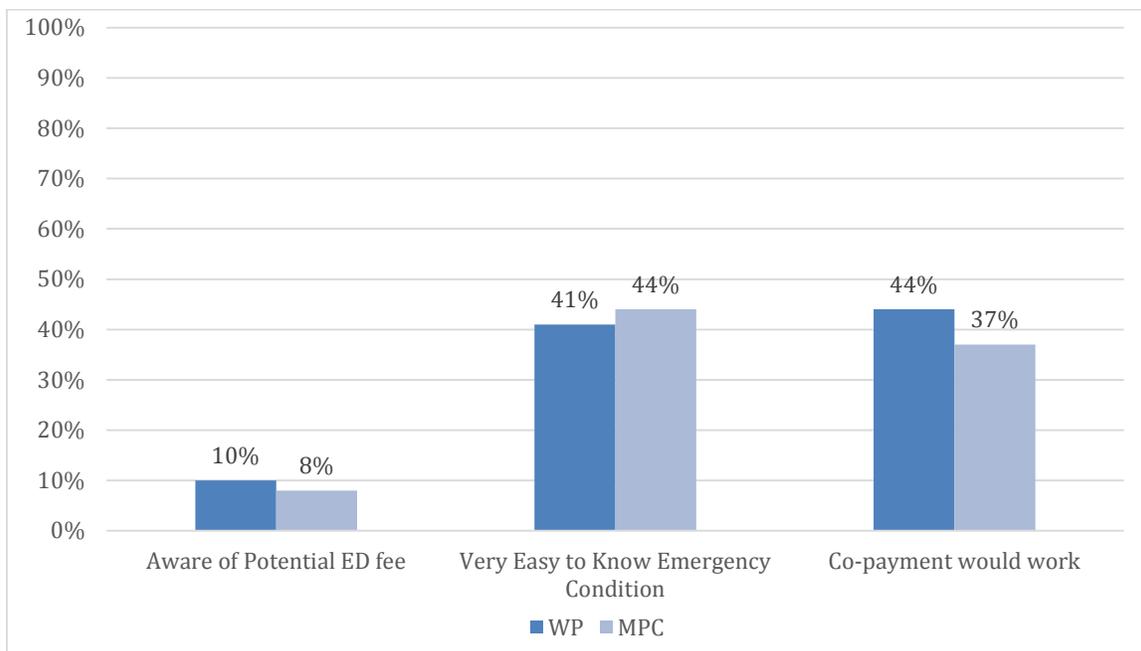
Because this initiative is unique to the IHAWP, these questions were only included in the WP and MPC member surveys. Thus, for measures 59-61, we used means tests to compare WP members to MPC members only.

Results

Figure 25 provides the results of the analyses of Measures 59-61 for the WP and MPC members. We learned, after the surveys were in field, that the State of Iowa did not implement the ED copayment policy. While the initial enrollment packets included this information, the policy never went into effect and members were never charged copayments for ED use. This fact should be kept in mind when considering the following survey results.

As expected, few members reported awareness of the ED copayment (WP: 10%, MPC: 8%) and less than half reported that it would be very easy to know when a health conditions would be considered an emergency (WP: 41%, MPC: 44%). As a way to try to gauge the potential effectiveness of such a policy, we asked respondents if they thought an added \$8 fee would keep them from going to the ED when they had a health condition that they thought could be treated in a doctor’s office instead; somewhat less than half of IHAWP respondents reported that it would. Significantly more WP members (44%) than MPC members (37%) reported that the fee would keep them from using the ED when they could go to a doctor’s office.

Figure 25. Awareness and Effect of Copayment for ED use.



Hypothesis 5.3 (5.4 for Marketplace Choice)

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 (Measures 62A and 62B)

62A Percent of members with a well adult visit

Definition

Well adult visit included a preventive exam CPT code (99385-99387, 99395-99397, 99401-99404, 99411, 99412, 99420, 99429) or any visit code (99201-99205) AND a preventive visit diagnosis code (V70.0, V70.3, V70.5, V70.6, V70.8, V70.9). A 'Well visit' within IHAWP may include a dental visit, however, we have limited the Definition for the current measure to medical visits. The measure will be updated upon receipt and assimilation of the IHAWP dental data.

Proposed analytic method

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

Variations from proposed method

None

Results

Rates of well adult care are highest for WP members regardless of age, with rates for MPC members slightly to moderately lower. For members ages 20-44 the rate for MPC members is 5 percentage points below the rate for WP members, however; for those ages 45-64 years the rate for MPC members is 11 percentage points below WP members. The rate for well adult care for MPC members ages 20-44 is nearly the same as that for FMAP members in both CY 2013 and CY 2014, but the rate is higher than FMAP in both years for MPC members ages 45-64. The rate of adult well care for IowaCare members is significantly lower than any other groups. These results indicate that the IHAWP members are more likely to get preventive care than FMAP members.

Table 21. Adults’ access to preventive health services by program and age, for WP and MPC members eligible for at least 11 months in CY 2014 and 11 months in CY 2013

Age		FMAP 2013	IowaCare 2013	FMAP 2014	WP 2014	MPC 2014
20-44 years	Number	6,606	3,305	7,310	8,087	2,112
	%	22%	12%	23%	29%	24%
45-64 years	Number	402	1,800	667	7,646	1,337
	%	14%	7%	18%	40%	29%
Total	Number	7,008	5,105	7,977	15,733	3,449
	%	21%	10%	22%	34%	26%

62B Whether member had well adult visit

Proposed analytic method

Models for RDD and DID are still under development.

Hypothesis 5.4 (5.5 for Marketplace Choice)

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

One potential healthy behavior that could be incentivized (but currently is not) as part of the IHAWP is smoking cessation. With this in mind, we looked at member experiences at their providers' offices with receiving any advice or treatment for smoking cessation. Questions about smoking cessation were only asked of those who reported currently smoking cigarettes or using tobacco. Over one-third of members reported at least some tobacco use (MSP-IE: 41%, WP: 44%, MPC: 35%).

Definition

Member experiences with provider efforts to encourage smoking cessation were measured using the following items:

1. Advised by provider to quit smoking or using tobacco = the percentage who responded the provider usually or always advised them to quit smoking or using tobacco.
2. Provider recommended medication as treatment = the percentage who responded the provider usually or always recommended or discussed medication (such as nicotine gum, patch, nasal spray, inhaler, or prescription medicine) to assist with quitting smoking or using tobacco.
3. Provider recommended other (non-medication) treatments = the percentage who responded the provider usually or always recommended or discussed methods and strategies other than medication (such as using a telephone hotline, individual or group counseling, or a cessation program) to assist with quitting smoking or using tobacco.

Proposed analytic method

Means tests between WP/MPC members and three comparison groups (MSP-IE, MSP-SSI, IowaCare).

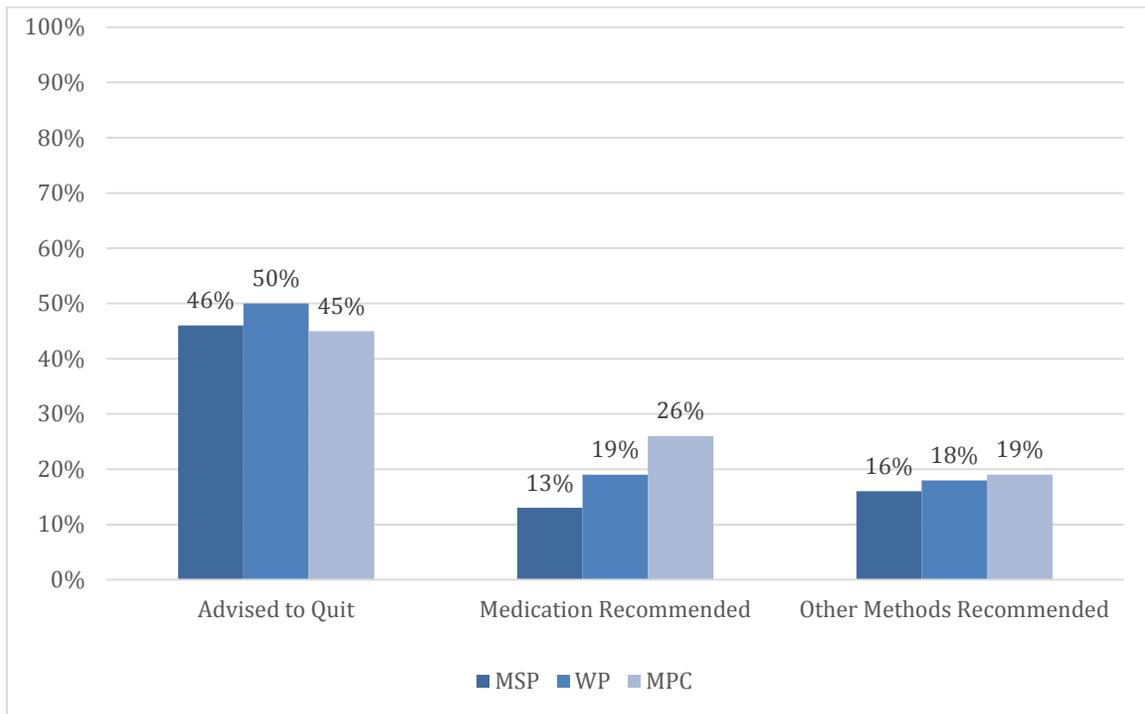
Variations from proposed method

We used means tests to compare 1) WP members to MSP-IE members and 2) MPC members to MSP-IE members. Statistical comparisons of WP and MPC members to MSP-SSI adult members were not conducted. IowaCare members pre-IHAWP implementation (2012) were not asked these questions.

Results

Figure 26 provides a summary of member experiences with provider efforts to encourage smoking cessation. Around half of members who were smokers were advised by their doctor or other health provider to quit smoking or using tobacco (MSP-IE: 46%, WP: 50%, MPC: 45%). Significantly more MPC members (26%) were recommended medication as a smoking cessation aid compared to MSP-IE members (13%). Less than one in five members were recommended non-medication methods to help them quit smoking or using tobacco (MSP-IE: 16%, WP: 18%, MPC: 19%).

Figure 26. Member Experiences with Smoking Cessation Efforts



Note: Percentages reported are for those who reported currently smoking cigarettes or using tobacco.

Provider Network Adequacy

Analyses of provider network adequacy were completed and contained in a June 2015 report entitled 'Evaluation of Provider Adequacy in the Iowa Health and Wellness Plan during the First Year', found at <http://ppc.uiowa.edu/publications/evaluation-provider-adequacy-iowa-health-and-wellness-plan-during-first-year>.

Question 6 *What is the adequacy of the provider network for Wellness Plan/Marketplace Choice 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.

Iowa Marketplace Choice members will have the same access to an adequate provider network as those in the Wellness Plan and 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

Definitions

Primary care providers

Primary care providers (PCPs) were defined as physicians, physician assistants or nurse practitioners specializing in General Practice, Family Practice, or Internal Medicine. Obstetrics & Gynecology providers

(OB/GYNs) were also included as PCPs for women. Internal Medicine specialists with a secondary specialty (e.g., cardiology or endocrinology) and clinics or providers with no specialty information were excluded. Providers working in Rural Health Clinics and Federally Qualified Health Centers were included in this evaluation. Supply counts of unique PCPs were identified by National Provider Identifier (NPI).

In addition to evaluating the supply of PCPs contracted with each program, we also evaluated the supply of PCPs who had submitted at least one claim to programs they were contracted with during CY 2014 (“treating providers”). To identify treating MSP providers, we examined claims submitted for care provided to the adult FMAP population, ages 19-64 years, since this population is the most comparable to the WP population.

The IME network of contracted PCPs was compared to the list of Coventry providers in order to evaluate panel overlap between programs; providers were matched by NPI.

Specialists

The supply of medical specialists and other licensed health care professionals was evaluated. Medical specialties of interest included cardiology, endocrinology, oncology/hematology, and pulmonology. Other providers of interest included chiropractors, optometrists, and podiatrists. These provider specialties and types were included because a previous survey of the IowaCare population conducted by the PPC identified the most commonly reported chronic medical conditions (e.g., hypertension, back or neck problems, diabetes, etc.), which are likely to require services from these providers.⁸

Mental Health Providers

Mental health providers included psychiatrists, psychologists, licensed social workers, and any other providers with a specialty of mental or behavioral health.

Hospitals

All hospitals in Iowa, including critical access hospitals, were included in this evaluation.

Safety Net Providers

All Federally Qualified Health Centers (FQHC) and Rural Health Centers (RHC) were included in this evaluation.

Proposed analytic method

Geocoding

Address data were cleaned prior to geocoding removing incomplete addresses and post office boxes from the dataset. Geocoding was carried out in multiple steps. Locations were initially geocoded using an address locator created in ESRI ArcMap using the "North American Detailed Streets" dataset maintained by ESRI. Addresses incorrectly located or not located after this process were located using a combination of ESRI geocoding API and Google Maps geocoding API. Only members and providers with successfully geocoded addresses were included in this evaluation.

Distance Calculations

Two distance outcomes were evaluated for the study populations: 1) distance to the nearest PCP among all members and 2) distance to the treating PCP among members with a qualifying visit to a PCP. The first

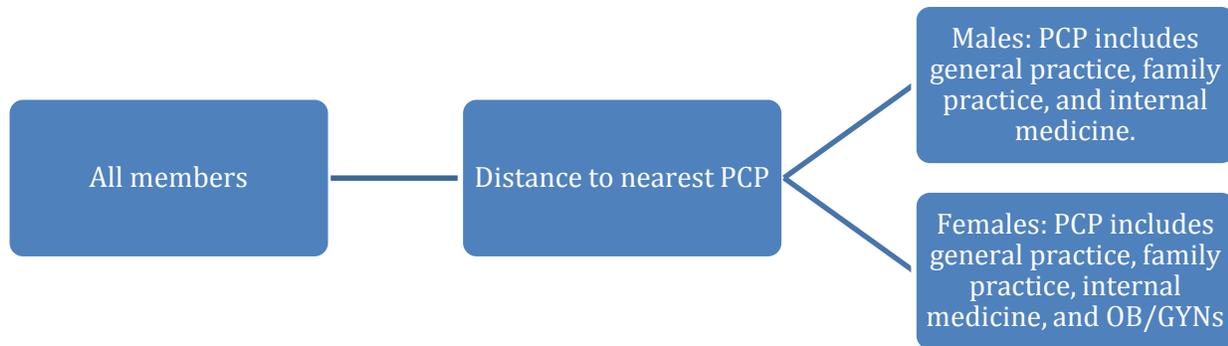
⁸ Evaluation of the IowaCare Program: Information about the Medical Home Expansion. 2013. University of Iowa Public Policy Center. At: http://ir.uiowa.edu/ppc_health/81/. Accessed July 9, 2015.

outcome is one of potential access within the network; the second outcome reflects realized, or actual, access to primary care services.

Distance to nearest PCP

Distance to the nearest PCP was calculated for all members of the study population (Figure 27). To determine the nearest provider for each member, a network dataset was created using the North American Detailed Streets dataset maintained by ESRI. Non road pathways (i.e. bike trails) were omitted and a travel time for each section of roadway was calculated using the posted speed limit and section length. A small subset of roads lacking speed limit data were edited to have a 15 mph speed limit in order to avoid inflated travel times. The ESRI Network Analyst OD Cost Matrix tool was used to determine the closest provider to each enrollee and calculated the travel time and distance for each enrollee to the closest provider along the fastest travel route on the network (Manhattan distance).

Figure 27. Distance to the nearest PCP

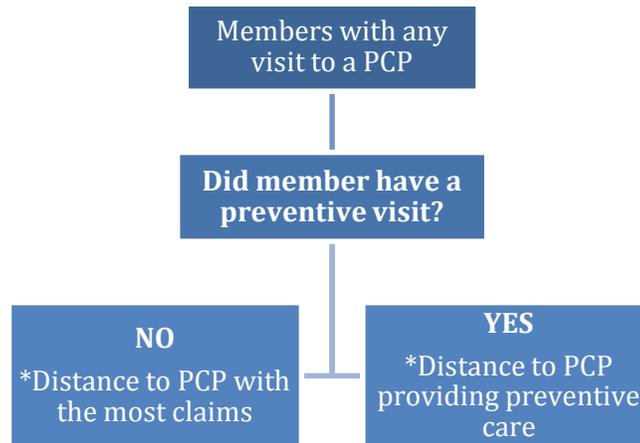


Distance to the treating PCP

Network distance and travel time to the treating provider was calculated for members with a qualifying ambulatory or preventive visit to a PCP, defined in accordance with the HEDIS 2014 measure of adults’ access to preventive/ambulatory health services.⁹ Members with a claim for preventive care, as defined by the V70.X diagnosis codes or 99385 or 99386 CPT codes, were mapped to the PCP who provided this care. For members with a PCP visit but no claims for preventive care, we calculated distance to the PCP who submitted the most claims on behalf of each member (Figure 28). In cases of ties, members were assigned to the closest PCP.

⁹ HEDIS 2014 Summary Table of Measures, Product Lines and Changes. 2015. NCQA. At: <http://www.ncqa.org/HEDISQualityMeasurement/HEDISMeasures/HEDIS2014.aspx>. Accessed July 2, 2015.

Figure 28. Distance to the treating PCP



Variations from proposed method

None

Results

Wellness Plan and Medicaid State Plan members can access services from any provider contracted with Iowa Medicaid Enterprise (IME). Workforce supply for the MSP/WP network was compared with the Coventry (MPC) provider network.

Unique PCP and mental health providers were identified by NPI. Overall, 3,057 primary care providers (PCPs) in Iowa were contracted with MSP in 2014, and 2,710 PCPs were contracted with Coventry (Table 22). PCPs include family and general practitioners, internists, and OB/GYNs, along with nurse practitioners and physician assistants who provide primary care services.

There were 159 hospitals in Iowa that were in the MSP network and 116 contracted with Coventry. Information about mental health providers contracted with Coventry was not available at the time of this evaluation; however, there were 1,765 mental health providers in Iowa contracted with MSP during 2014.

Table 22. Contracted health care providers in Iowa by program (2014)

	MSP/WP	Coventry
Primary care providers	3,057	2,710
Mental health providers	1,765	**
Hospitals	159	116

**Not available at the time of this evaluation.

Primary Care Providers

In 2014, there were 3,057 PCPs contracted with MSP (Table 23). Active providers include all providers who submitted at least one claim for care provided to a member during 2014. Approximately 8% of these contracted PCPs (n=249) had submitted a claim for care provided to an FMAP member during 2014. Nine percent of MSP-contracted PCPs (n=274) had submitted a claim for care provided to a WP member.

In 2014, there were 2,445 PCPs contracted with Coventry. Approximately 37% of these (n=899) had submitted a claim for care provided to a Marketplace Choice member.

Note that it is not possible to directly compare the supply of specific primary care provider types between MSP/WP and Coventry. Medicaid categorizes nurse practitioners and physician assistants by their specialty, while Coventry does not indicate specialty for these providers.

Approximately 48% (n=1,456) of PCPs contracted with MSP/WP were also contracted with Coventry.

Table 23. Primary care providers in Iowa by program (2014)

	MSP/WP			Coventry	
	Contracted	Submitted ≥ 1 claim MSP	Submitted ≥ 1 claim WP	Contracted	Submitted ≥ 1 claim
Family Practice	1,740	149	166	1,594	713
General Practice	444	37	39	22	9
Internal Medicine	536	4	12	321	83
OB/GYN	332	55	52	3	0
Nurse Practitioners**	NA	NA	NA	12	3
Physician Assistants**	NA	NA	NA	249	82
Other	5	5	5	13	2
Total	3,057	249	274	2,445	899

** Medicaid includes a specialty for nurse practitioners and physician assistants, so these providers are counted by their respective specialties. Coventry does not designate a specialty for nurse practitioners or physician assistants; they have all been counted in this report as PCPs.

Medical specialists and other health care professionals

In general, Coventry had more contracted providers in select medical specialties than the MSP/WP network, while the MSP/WP network had more contracted chiropractors, optometrists, and podiatrists (Table 24). Note that even though there were 213 cardiologists contracted with MSP/WP and Coventry, these two groups are not identical.

Table 24. Selected contracted medical specialists and other health care professionals in Iowa by program (2014)

	MSP/WP	Coventry
Medical specialists		
Cardiologists*	213	213
Endocrinologists	15	27
Oncologists/Hematologists	38	106
Pulmonologists	47	68
Other health care professionals		
Chiropractors	1,920	448
Optometrists	829	254
Podiatrists	310	131

*Includes surgeons

Mental Health Providers

There were 1,765 unique mental health providers contracted with MSP/WP, excluding providers in the Iowa Plan for Behavioral Health network (Table 25).

For this evaluation we did not include providers in the Iowa Plan for Behavioral Health network. Most MSP members are automatically enrolled in the Iowa Plan, a managed care program for the delivery of mental health and substance abuse treatment; WP members are eligible for a limited set of services covered by the Iowa Plan.

At the time of this evaluation, we did not have access to a list of mental health providers contracted with Coventry.

Table 25. Contracted mental health providers in Iowa by program (2014)

	MSP/WP	Coventry**
Psychiatrists	367	
Psychologists	315	
Licensed social workers	443	
Nurse practitioners	152	
Other credentialed providers	488	
Total	1,765	

**Not available at the time of this evaluation.

For this evaluation, we did not include PCPs as mental health providers, even though they represent an important source of mental health care. Future evaluations will assess the role of PCPs in providing mental health services to members of these programs.

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

Definition

Original measure

Proposed analytic method

Process measures

Variations from proposed method

This measure has been removed due to the removal of CoOpportunity as a QHP and the difficulty in assessing the plan documents.

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

Definition

Original items

Proposed analytic method

RDD comparing WP/MPC members and Medicaid State Plan adults at the threshold

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

Variations from Proposed Analyses

The provider survey did not occur in the second year due to the impending change to all managed care in Iowa Medicaid.

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

Qualitative assessment of provider opinions on aspects of the plan

Definition

Original items

Proposed analytic method

RDD comparing WP/MPC members and Medicaid State Plan adults at the threshold

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

Variations from proposed method

The provider survey did not occur in the second year due to the impending change to all managed care in Iowa Medicaid.

Measure 68 Comparison of network overlap between plans

Assessment of provider inclusion and overlap by plan and county

Definition

Original measure

Proposed analytic method

Process measures for WP/MPC and Medicaid State Plan members

Variations from proposed method

Due to differences in how providers were identified by Coventry and the MSP, we were unable to compare overlap at the individual provider level. Number of primary care providers – defined as those who submitted at least 1 claim during 2014 – were mapped by county. Due to low numbers, medical specialists and other health care professionals are tabulated at the program level.

Results

Figure 29. Active Primary Care Providers in Iowa

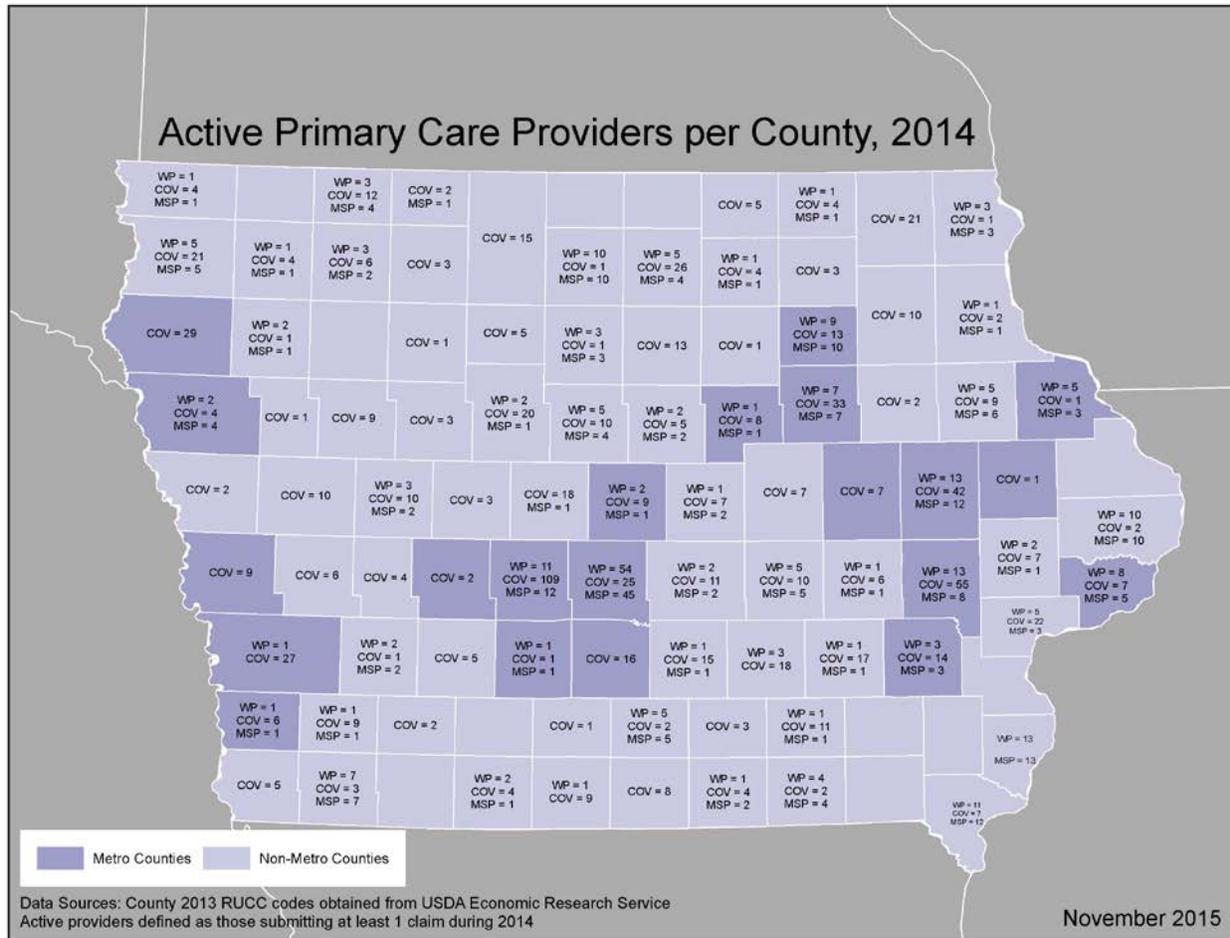


Table 26. Selected contracted medical specialists and other health care professionals in Iowa by program (2014)

	MSP/WP	Coventry
Medical specialists		
Cardiologists*	213	213
Endocrinologists	15	27
Oncologists/Hematologists	38	106
Pulmonologists	47	68
Other health care professionals		
Chiropractors	1,920	448
Optometrists	829	254
Podiatrists	310	131

*Includes surgeons

Measure 69 (MARKETPLACE CHOICE only) Provider network inclusion of safety net providers.

Proportion of safety net providers in the covered counties included in the provider network

Definition

Original

Proposed analytic method

Process measures for MPC members

Variations from proposed method

Due to its termination, CoOpportunity Health network was not analyzed. Safety net network was displayed with maps.

Results

There are 58 FQHCs (Figure 30) and 308 RHCs (Figure 31) in Iowa. Additional FQHCs in Illinois (n=8), Nebraska (n=8), and South Dakota (n=8) are also contracted with Iowa Medicaid.

Figure 30. Locations of FQHCs in Iowa

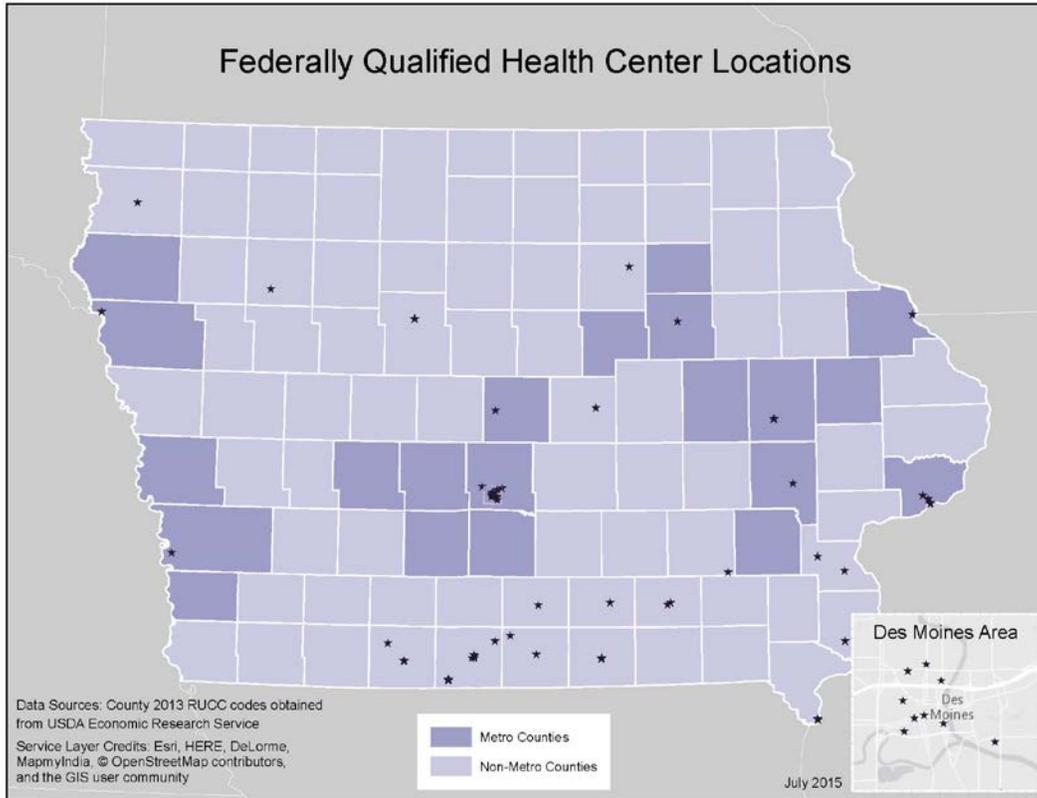
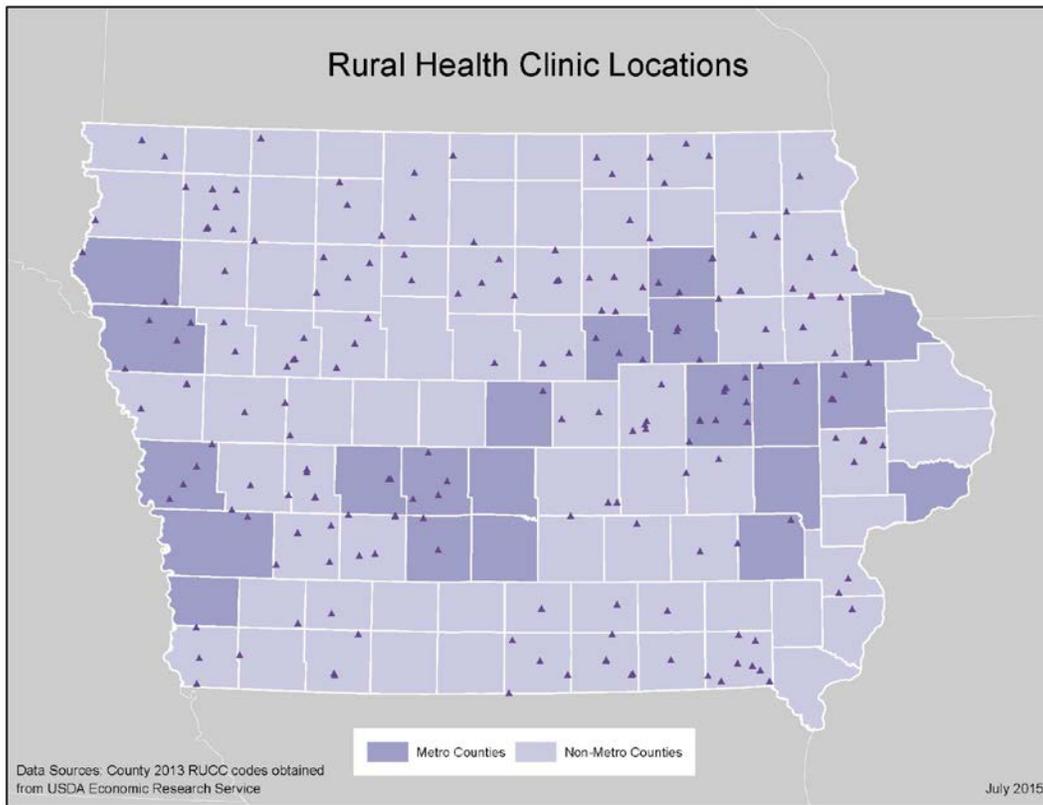


Figure 31. Locations of Rural Health Clinics in Iowa



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.

Non-Emergency Medical Transportation (NEMT)

Per agreement with CMS through a waiver, the state of Iowa has not been required to assure NEMT to and from providers for the IHAWP population. This waiver authority was to sunset after one year, to allow for reevaluation of this authority after the state and CMS considered its impact on access to care.

Upon further discussions with the IME and CMS, additional analytic methods were proposed to evaluate NEMT. The additional research questions and methods follow.

Question 1 Is the presence or absence of the NEMT benefit associated with unmet need for transportation to health care visits?

To model the factors related to unmet NEMT need, we used data from the Fall 2014 survey.

We modelled unmet NEMT need using logistic regression.

$$\text{Unmet NEMT need}_{it} = \alpha_i + \beta_1 \text{Group}_{it} + \beta_2 \text{Group}_{it} + \mathbf{x}'\beta_4 + u_{it}$$

Unmet NEMT need-Survey respondents provided a yes or no answer to the following question: 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.

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. We will use dummy indicators for whether a member was in the Marketplace Choice (0,1), Wellness Plan (0,1) or enrolled in Medicaid State Plan (MSP) due to low income (0,0). This approach allows us to use MSP (the group with an NEMT benefit) as the comparison group.

X represents a matrix of covariates including:

Age-self-reported. Dichotomous: 18-40, 40 plus. Reference group in the models is Age 18-40.

Gender-self-reported.

Race/Ethnicity-self-reported. Each are dichotomous indicators. Race: White (Reference group = non-white), Black or African American (Reference group = non-Black), Hispanic (Reference group = non-Hispanic), Other includes Asian, Native Hawaiian or Other Pacific Islander, American Indian or Alaska Native, and other (Reference group = White, Black, or Hispanic).

Education- self-reported. Dichotomous: High School or Less (Reference group), More than High School.

Income-Percent poverty will be included as it appears on the enrollment files. Tertiles based on plan type: MSP-IE & WP: 0, 1%-50%, 51% +, MPC: 0 – 109%, 110% - 124%, 125% +. Reference group is the lowest tertile.

Number of chronic conditions-Self-reported. Physical Health Conditions categorical: 0, 1-2, 3 or more. Mental Health Conditions dichotomous: 0, 1 or more. Dual Physical and Mental Health Issues (yes/no): reported at least 1 physical and 1 mental health condition. Reference group for these variables is no conditions.

Health Status-3 self-reported measures were included: 1) Physical Health: Fair/Poor vs. Good/Very Good/Excellent (Reference group); 2) Mental Health: Fair/Poor vs. Good/Very Good/Excellent (Reference group); 3) Functional Limitations (yes/no): Reported any of four possible functional limitations which included physical or medical conditions that a) seriously interfered with a member’s ability to work, attend school, or manage day-to-day activities, b) seriously interfered with a member’s independence, participation in the community, or quality of life, c) required the member to have help with routine needs, such as everyday household chores, doing necessary business, shopping, or getting around for other purposes, or d) required the member to have help with personal care needs, such as eating, dressing, or getting around the house.

Rural/urban-Rural-urban continuum codes (RUCC) provided through the US Department of Agriculture. Rural residence is the reference group.

Distance to nearest primary care provider-Each respondent address and the addresses of primary care providers in the plan network were geocoded. The distance from the member's home to the nearest active primary care provider (at least 1 claim in the past 6 months) will be calculated. Distance to PCP in tertiles: 0 – 0.65 miles, 0.66 – 1.8 miles, 1.9 miles or more. Reference group is the lowest tertile.

The following two covariates were proposed in the evaluation plan but were not included in the analyses.

Needing assistance-Survey responses will be dichotomized as follows: needing assistance usually/always or needing assistance never/sometimes for the following question: In the last 6 months, how often did you need assistance from other sources (such as friends, family, public transportation, etc.) to get to your health care visit.

This variable was too highly correlated with the outcome variable (unmet NEMT need) to be included as a covariate.

IowaCare Health Home regions-During the IowaCare program there were eight health home regions. These regions were service areas built around six federally qualified health centers and academic medical centers.

The majority (> 60%) of respondents to the fall 2014 survey were never in the IowaCare program. Thus, this variable was deemed to not be relevant to the model and was not included.

Question 2 Does unmet NEMT need affect utilization of well care, acute care or the emergency department?

To assess whether unmet NEMT need was associated with utilization of health care services, we used data from the fall 2014 survey linked to administrative data.

We modelled health care utilization (well visit, acute care visit, Ed use) using logistic regression.

$$Utilization_{it} = \alpha_i + \beta_1 GroupWP_i + \beta_2 GroupMPC_i + \beta_3 Unmet Need + \beta_4 GroupWP_i * UnmetNeed + \beta_5 GroupMPC_i * UnmetNeed + \beta_6 x' + u_i$$

Utilization-Claims data was used to determine whether or not the survey respondent utilized care in the 6 months prior to the survey. There were three unique dependent variables: had a well visit, had an acute care visit, and used the emergency department.

Well visit = visit including a preventive exam CPT code (99385-99387, 99395-99397, 99401-99404, 99411, 99412, 99420, 99429) or any visit code (99201-99205) AND a preventive visit diagnosis code (V70.0, V70.3, V70.5, V70.6, V70.8, V70.9).

Acute care visit = Defined as any MD or ARNP visit that is NON-behavioral/emotional, NON-maternal, and NON-well visit. Had to occur in an office setting-office, outpatient clinic, rural health clinic, or FQHC according to the place of service. Had to be CPT codes between 99210 and 99215.

Outpatient ED visit = An ED visit that did not result in a hospitalization. Defined as revenue code on an institutional claim of 450-459. If they were in the ER for more than one day we used the first day as the date of service.

Unmet NEMT need (β_3)- Survey respondents provided a yes or no answer to the following question: 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.

Group (β_1, β_2)-represents a series of indicator variables that provide study group comparisons. The variables will capture whether the individual was in the program of interest. We will use dummy indicators for whether a member was in the Wellness Plan (β_1 above) or Marketplace Choice (β_2 above). MSP (the group with an NEMT benefit) is the comparison/reference group.

Group*Unmet Need Interaction (β_4, β_5) – represents interaction terms that jointly model the effect of the absence of NEMT benefit (GroupWP, GroupMPC) with reported unmet need for transportation to health care visits (Unmet NEMT need).

X' represents a matrix of covariates including:

Age- self-reported. Dichotomous: 18-40 (Reference group), 40 plus.

Gender-Self-reported.

Race/Ethnicity- self-reported. Each are dichotomous indicators. Race: White (Reference group = non-white), Black or African American (Reference group = non-Black), Hispanic (Reference group = non-Hispanic), Other includes Asian, Native Hawaiian or Other Pacific Islander, American Indian or Alaska Native, and other (Reference group = White, Black, or Hispanic).

Education- self-reported. Dichotomous: High School or Less (Reference group), More than High School.

Income-Percent poverty will be included as it appears on the enrollment files. Tertiles based on plan type: MSP-IE & WP: 0, 1%-50%, 51% +, MPC: 0 – 109%, 110% - 124%, 125% +. The lowest tertile is the reference group.

Number of chronic conditions-Self-reported. Physical Health Conditions categorical: 0, 1-2, 3 or more. Mental Health Conditions dichotomous: 0, 1 or more. Dual Physical and Mental Health Issues (yes/no): reported at least 1 physical and 1 mental health condition. Reference group for these variables is no conditions.

Health Status-3 self-reported measures were included: 1) Physical Health: Fair/Poor vs. Good/Very Good/Excellent (Reference group); 2) Mental Health: Fair/Poor vs. Good/Very Good/Excellent (Reference group); 3) Functional Limitations (yes/no): Reported any of four possible functional limitations which included physical or medical conditions that a) seriously interfered with a member’s ability to work, attend school, or manage day-to-day activities, b) seriously interfered with a member’s independence, participation in the community, or quality of life, c) required the member to have help with routine needs, such as everyday household chores, doing necessary business, shopping, or getting around for other purposes, or d) required the member to have help with personal care needs, such as eating, dressing, or getting around the house.

Rural/urban-Rural-urban continuum codes (RUCC) provided through the US Department of Agriculture will be included. Rural residence is the reference group.

Distance to nearest primary care provider-Each respondent address and the addresses of primary care providers in the plan network were geocoded. The distance from the member's home to the nearest active primary care provider (at least 1 claim in the past 6 months) was calculated. Distance to PCP in tertiles: 0 – 0.65 miles, 0.66 – 1.8 miles, 1.9 miles or more. The lowest tertile is the reference group.

Distance to nearest hospital ED-Each respondent address and the addresses of all EDs in Iowa were geocoded. The distance from the member's home to the nearest ED was calculated. Distance to ED in tertiles: 0 – 1.9 miles, 2.0 – 6.0 miles, > 6.0 miles. The lowest tertile is the reference group.

The following covariate was proposed in the evaluation plan but was not included in the analyses because there was little variation in this variable. The reason was that to be eligible for the survey sample, IHAWP and MSP-IE members had to have been in their plan for the six months prior to the survey. So, no one had less than six months of enrollment. Also, since it was the first year of the IHAWP (2014) and the survey was in October of 2014, the maximum number of months of enrollment for IHAWP could only be 9 months while for MSP-IE members, it could be 12.

Months of enrollment-Number of months enrolled in the IHAWP or MSP-IE during the 12 months prior to the survey.

The comparison of the variables related to NEMT by groups (MSP-IE, WP, MPC) are provided in Question 1, hypothesis 1.5. The results of the additional analysis (Question 1 and Question 2) of the merged 2014 survey data to associated administrative claims is below.

Results

Table 27 provides, by group, the descriptive statistics for all of the dependent (outcome) and independent (covariate) variables used in the models for Question 1 and Question 2.

Table 27. Descriptive Characteristics of the 2014 NEMT Survey Groups

Characteristic	WP N=1101	MSP N=670	MPC N=691
Outcome (dependent) variables			
Unmet Need for Health Care Transportation	15.1%	12.4%	5.1%
Had at least 1 Well Visit	28.2% Range: 0-2	14.5% Range: 0-2	15.4% Range: 0-2
Had at least 1 Acute Care Visit	65.9% Range: 0-30	58.0% Range: 0-16	30.0% Range: 0-9
Had at least 1 ED Visit	23.4% Range: 0-10	27.1% Range: 0-9	16.3% Range: 0-7
Independent variables			
Age > 40	66.2%	21.2%	59.4%
Male	42.2%	16.9%	28.2%
Race: White	84.2%	83.5%	88.9%
Race: Black	8.2%	9.7%	5.6%
Race: Hispanic	3.9%	7.7%	3.8%
Race: Other	5.0%	5.2%	3.0%
Education: Greater than High School	44.9%	48.3%	50.8%
Income: FPL – lowest category	51.22% FPL: 0	40.0% FPL: 0	32.8% FPL: 0 - < 110
Income: FPL – middle category	12.5% FPL: > 0 – 50	35.6% FPL: > 0 – 50	34.1% FPL: 110 - < 125
Income: FPL – highest category	36.3% FPL: > 50	24.4% FPL: > 50	33.2% FPL: 125+
# Physical Health Conditions: 0	14.6%	24.9%	18.8%
# Physical Health Conditions: 1-2	35.1%	42.4%	42.0%
# Physical Health Conditions: 3 or more	50.4%	32.8%	39.2%
Self-Reported Physical Health: Fair or Poor	28.2%	18.0%	20.5%
Any Self-Reported Functional Limitations	37.8%	26.5%	17.7%
Self-Reported Mental Health: Fair or Poor	23.7%	21.8%	14.0%
# Mental or Emotional Health Conditions: > 0	45.6%	50.4%	37.8%
Dual Physical and Mental Health Problems	42.8%	44.7%	35.3%
Residence in an Urban/Metro Area	51.1%	49.3%	53.8%
Distance to PCP: 0 - < 0.66 miles	28.1%	28.7%	49.3%
Distance to PCP: 0.66 - < 1.9 miles	38.2%	35.4%	24.1%
Distance to PCP: 1.9 or more miles	33.6%	35.9%	26.6%
Distance to Hospital: 0 - < 2.0 miles	33.5%	35.0%	36.5%
Distance to Hospital: 2.0 - < 6.1 miles	34.3%	31.5%	31.7%
Distance to Hospital: 6.1 or more miles	32.2%	33.5%	31.8%

Table 28 provides the results for question 1 (Is the presence or absence of the NEMT benefit associated with unmet need for transportation to health care visits?).

Table 28. Factors Associated with Unmet NEMT Need

Factors	Odds Ratio (95% CI)
WP group (Ref: MSP-IE group)	1.34 (0.95, 1.89)
MPC group (Ref: MSP-IE group)	0.48 (0.26, 0.86) *
Age > 40 (Ref: Age ≤ 40)	0.98 (0.73, 1.32)
Male (Ref: Female)	0.81 (0.60, 1.08)
White (Ref: Non-white)	0.88 (0.51, 1.50)
Black (Ref: Non-black)	2.05 (1.12, 3.76) *
Hispanic (Ref: Non-Hispanic)	1.99 (1.12, 3.53) *
Other Race (Ref: White, Black, Hispanic)	1.45 (0.81, 2.61)
Education > High School (Ref: High School or Less)	0.85 (0.65, 1.11)
Income: FPL middle (Ref: FPL lowest)	1.36 (0.97, 1.90)
Income: FPL highest (Ref: FPL lowest)	0.62 (0.44, 0.86) †
Has any functional limitation (Ref: None)	2.62 (1.91, 3.59) †
Fair/Poor Self-Reported Physical Health (Ref: Good/Very Good/Excellent)	1.29 (0.93, 1.81)
Fair/Poor Self-Reported Mental Health (Ref: Good/Very Good/Excellent)	1.35 (0.97, 1.87)
# Physical Health Conditions: 1-2 (Ref: 0)	1.56 (0.77, 3.14)
# Physical Health Conditions: 3+ (Ref: 0)	1.84 (0.90, 3.80)
Any Mental Health Condition (Ref: 0)	1.89 (0.68, 5.26)
Had both a physical and mental health condition	1.02 (0.36, 2.94)
Urban residence (Ref: Non-Urban residence)	1.18 (0.90, 1.55)
Distance to PCP: 0.66 – 1.8 miles (Ref: 0 – 0.65 miles)	0.79 (0.58, 1.08)
Distance to PCP: 1.9 miles or more (Ref: 0 – 0.65 miles)	0.91 (0.65, 1.26)

* Statistically significant at $p < .05$; † Statistically significant at $p < .01$

With regard to the main effects of interest, there was no association between being in the WP (compared to MSP-IE) and reporting an unmet need for NEMT. Those in an MPC plan were less likely than MSP-IE members to report an unmet need for NEMT. Other factors were also related to reporting an unmet need for NEMT. Blacks (compared to non-Blacks) and Hispanics (compared to non-Hispanics) were around 2 times as likely to report an unmet NEMT need. Members who reported having any functional limitations were 2.6 times as likely to experience unmet NEMT need. Finally, those with the highest income levels as measured by FPL (compared to the lowest levels) were less likely to report having ever had an unmet need for NEMT.

Table 29 provides the results for question 2 (Does unmet NEMT need affect utilization of well care, acute care or the emergency department?). Three sets of models were fit to answer this question – one for each of the utilization types (well care visit, acute care visit, and emergency department visit). The first set of models included interaction terms for group (WP, MPC) by unmet NEMT need. There were no significant interaction terms in any of the three models. Therefore, the interaction terms were removed and the models were fit with only the main effects and covariates. The results in Table 29 include the models with only the main effects of group (WP, MPC) and unmet NEMT need (no interaction terms) plus the other covariates as described above.

Table 29. Factors associated with having a well visit, acute care visit, or ED visit

Factors	Well Visit Odds Ratio (95% CI)	Acute Care Visit Odds Ratio (95% CI)	ED Visit Odds Ratio (95% CI)
Unmet NEMT need	0.69 (0.50, 0.96) *	0.82 (0.61, 1.09)	1.90 (1.44, 2.50) †
WP group (Ref: MSP-IE group)	2.48 (1.86, 3.30) †	1.30 (1.02, 1.64) *	0.90 (0.69, 1.17)
MPC group (Ref: MSP-IE group)	0.98 (0.66, 1.46)	0.29 (0.21, 0.40) †	0.76 (0.52, 1.10)
Age > 40 (Ref: Age ≤ 40)	1.22 (0.97, 1.53)	1.04 (0.85, 1.27)	0.60 (0.47, 0.75) †
Male (Ref: Female)	0.61 (0.49, 0.77) †	0.53 (0.43, 0.65) †	0.81 (0.64, 1.02)
White (Ref: Non-white)	0.80 (0.50, 1.29)	0.95 (0.62, 1.46)	1.15 (0.72, 1.86)
Black (Ref: Non-black)	0.63 (0.36, 1.10)	0.91 (0.56, 1.49)	2.58 (1.53, 4.35) †
Hispanic (Ref: Non-Hispanic)	1.67 (1.05, 2.66) *	1.36 (0.87, 2.14)	1.11 (0.68, 1.82)
Other Race (Ref: White, Black, Hispanic)	0.68 (0.38, 1.20)	0.56 (0.35, 0.91) *	0.58 (0.33, 1.02)
Education > High School	1.17 (0.95, 1.43)	0.93 (0.77, 1.11)	0.71 (0.58, 0.88) †
Income: FPL middle (Ref: FPL lowest)	0.97 (0.73, 1.29)	0.90 (0.71, 1.14)	1.04 (0.79, 1.36)
Income: FPL highest (Ref: FPL lowest)	0.95 (0.76, 1.20)	0.88 (0.72, 1.09)	0.87 (0.68, 1.11)
Has any functional limitation (Ref: None)	1.03 (0.79, 1.35)	2.03 (1.59, 2.60) †	1.83 (1.41, 2.36) †
Fair/Poor Self-Reported Physical Health	1.09 (0.81, 1.47)	1.38 (1.04, 1.82) *	1.15 (0.87, 1.52)
Fair/Poor Self-Reported Mental Health	0.81 (0.59, 1.09)	0.97 (0.73, 1.28)	1.40 (1.06, 1.84) *
# Physical Health Conditions: 1-2 (Ref: 0)	1.04 (0.74, 1.47)	1.74 (1.29, 2.34) †	1.36 (0.91, 2.05)
# Physical Health Conditions: 3+ (Ref: 0)	0.99 (0.68, 1.44)	3.04 (2.18, 4.23) †	1.74 (1.13, 2.68) *
Any Mental Health Condition (Ref: 0)	1.25 (0.69, 2.25)	0.75 (0.44, 1.26)	0.96 (0.48, 1.92)
Had both a physical and mental health condition	0.78 (0.42, 1.45)	1.12 (0.64, 1.96)	1.29 (0.62, 2.68)
Urban residence	1.31 (1.05, 1.62) *	0.90 (0.74, 1.09)	0.81 (0.65, 1.01)
Distance to PCP: 0.66 – 1.8 miles (Ref: 0 – 0.65 miles)	0.93 (0.72, 1.18)	1.14 (0.91, 1.44)	1.19 (0.92, 1.54)
Distance to PCP: 1.9 miles or more (Ref: 0 – 0.65 miles)	0.84 (0.61, 1.16)	1.36 (1.02, 1.81) *	1.54 (1.10, 2.15) *
Distance to ED: 2.0 – 6.0 miles (Ref: < 2.0 miles)	1.24 (0.96, 1.60)	0.74 (0.58, 0.94) *	1.22 (0.94, 1.60)
Distance to ED: 6.1 miles or more (Ref: < 2.0 miles)	0.89 (0.64, 1.24)	0.73 (0.54, 0.98) *	0.80 (0.57, 1.13)

* Statistically significant at $p < .05$; † Statistically significant at $p < .01$

Well visits

Those with an unmet need for NEMT were less likely to have had a well visit than those with no unmet need and yet, independently, those in the WP were 2.5 times more likely than those in the MSP-IE group to have had a wellness visit. There was no interaction effect between being in the WP and having an unmet NEMT need. A few other demographic factors were related to having a well visit. Hispanics were 1.7 times more likely to have a well visit than non-Hispanics and those living in an urban area were 1.3 times as likely compared to those in rural areas. Finally, males were less likely to have a well visit compared to females. Interestingly, health status indicators were not related to well visits.

Acute care visits

Having an unmet NEMT need was not related to having had an acute care visit. Yet, WP members were more likely and MPC members were less likely (when compared to MSP-IE members) to have had an acute care visit. Again, there were no interaction effects between plan and unmet NEMT need. Members with functional limitations, self-reported fair or poor physical health, any physical health conditions, and those who lived

farthest from their PCP were more likely to have had an acute care visit while males, those of a race other than white, black, or Hispanic, and those who lived farthest from their nearest ED/hospital were less likely to have had an acute care visit.

ED visits

Members who had an unmet NEMT need were 1.9 times as likely to have visited an ED. There was no statistical association between having had an ED visit and being in either the WP or MPC plan (compared to MSP-IE). Blacks and those with functional limitations, poor/fair self-reported mental health, and 3 or more physical conditions were more likely to have visited an ED. Also, those who lived farthest from their nearest PCP were more likely to have utilized the ED. Members over 40 years old and who had more than a high school education were less likely to have had an ED visit.

Behavioral/emotional health services

Results on 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, and measure 49.

Churning

Results on the impact of churning is embedded in Research Question 2, hypothesis 2.1, measures 25-27 and hypothesis 2.2, measures 28-30.

Copayment for non-emergency use of the emergency department

The impact of these incentives is included in Research Question 1, hypothesis 1.4 and Research Question 5, hypothesis 5.3.

Healthy Behavior incentives

In this report, results related to the impact of incentives is embedded in Research Question 5, Hypothesis 5.1, and Measures 56-58. For the Marketplace Choice evaluation, the effect of disenrollment was not investigated because no members were disenrolled or were requested to pay premiums in 2014.

Medically Exempt members

Results for this area of emphasis will be included in the 2017 report.

Limitations

As with all evaluations, there are limitations to the interpretation of these. Survey data, for example, are based on self-reported information and the recall of the member. Response bias is also a potential threat to validity. Non-response bias tests were conducted to determine if the characteristics of respondents differed significantly from non-respondents. Administrative data are collected for billing and tracking purposes and do not always reflect the service provided accurately.

There may be a propensity for members who have the most to gain from 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 proposed specific analytical tools within this evaluation document and even went so far as to link analytical strategies to hypotheses, we have had to change the methods and approaches for some measures due to small numbers, difficulty identifying the relevant populations, or unanticipated complexity in the measure design. We are still investigating the use of propensity scoring, instrumental variables analysis, and survival analysis as possible techniques. We have encountered difficulty obtaining some of the data required for the analyses such as the pharmaceutical data for the QHPs. In addition, we have found it much more difficult and laborious to integrate the new data formats and fields with our existing data repository hindering our ability to complete some of the administrative data based outcomes for the interim report. We continue efforts to clean and assimilate data more quickly.

Appendix A



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

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



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

Plan Benefits	Medicaid State Plan	Iowa Health and Wellness Plan	
		Iowa Wellness Plan	Iowa Marketplace Choice Plan
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
<u>Delivery System</u>			
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	Iowa Health and Wellness Plan	
		Iowa Wellness Plan	Iowa Marketplace Choice Plan
		<p>NOTE: Medically Exempt individuals will be enrolled in the Medicaid State Plan benefit with the option to Opt-out</p>	<p>NOTE: Medically Exempt individuals will be enrolled in the Medicaid State Plan benefit with the option to Opt-out</p>
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 <p>*Mental Health Parity Required</p>	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 <p>*Mental Health Parity Required</p>
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	
		Iowa Wellness Plan	Iowa Marketplace Choice Plan
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>