Iowa's Application Certification Statement - Section 1115(f) Five Year Extension

This document, together with the supporting documentation outlined below, constitutes Iowa's application to the Centers for Medicare & Medicaid Services (CMS) for a 5-year extension of its approved demonstration entitled, Iowa Wellness Plan – Project #11-W-00289/5, pursuant to section 1115(f) and section 1915(h)(2) of the Social Security Act.

Type of Request (*select one only*):

_____ **Section 1115(f) extension with no program changes**

This constitutes the state's application to the Centers for Medicare & Medicaid Services (CMS) to extend its demonstration without any programmatic changes. The state is requesting to extend approval of the demonstration subject to the same Special Terms and Conditions (STCs), waivers, and expenditure authorities in effect for the period [insert current demo period].

The state is submitting the following items that are necessary to ensure that the demonstration is operating in accordance with the objectives of title XIX and/or title XXI as originally approved. The state's application will only be considered complete for purposes of initiating federal review and federal-level public notice when the state provides the information as requested in the below appendices.

- **Appendix A:** A historical narrative summary of the demonstration project, which includes the objectives set forth at the time the demonstration was approved, evidence of how these objectives have or have not been met, and the future goals of the program.
- **Appendix B:** Budget/allotment neutrality assessment, and projections for the projected 3-year extension period. The state will present an analysis of budget/allotment neutrality for the current demonstration approval period, including status of budget/allotment neutrality to date based on the most recent expenditure and member month data, and projections through then end of the current approval that incorporate the latest data. CMS will also review the state's Medicaid and State Children's Health Insurance Program Budget and Expenditure System (MBES/CBES) expenditure reports to ensure that the demonstration has not exceeded the federal expenditure limits established for the demonstration. The state's actual expenditures incurred over the period from initial approval through the current expiration date, together with the projected costs for the requested 3-year extension period, must comply with CMS budget/allotment neutrality requirements outlined in the STCs.
- **Appendix C:** Interim evaluation of the overall impact of the demonstration that includes evaluation activities and findings to date, in addition to plans for evaluation activities over the 3-year extension period. The interim evaluation should provide CMS with a clear analysis of the state's achievement in obtaining the outcomes

expected as a direct effect of the demonstration program. The state's interim evaluation must meet all of the requirements outlined in the STCs.

- **Appendix D:** Summaries of External Quality Review Organization (EQRO) reports, managed care organization and state quality assurance monitoring, and any other documentation of the quality of and access to care provided under the demonstration.
- **Appendix E:** Documentation of the state's compliance with the public notice process set forth in 42 CFR 431.408 and 431.420.

____✓____ **Section 1115(f) extension with program changes**

This constitutes the state's application to the Centers for Medicare & Medicaid Services (CMS) to extend its demonstration with minor demonstration program changes. In combination with completing the Section 1115 Extension Template, the state may also choose to submit a redline version of its approved Special Terms and Conditions (STCs) to identify how it proposes to revise its demonstration agreement with CMS.

With the exception of the proposed changes outlined in this application, the state is requesting CMS to extend approval of the demonstration subject to the same STCs, waivers, and expenditure authorities currently in effect for the period of January 1, 2017 through December 31, 2019, as amended effective October 26, 2017.

The state's application will only be considered complete for purposes of initiating federal review and federal-level public notice when the state provides the information requested in Appendices A through E above, along with the Section 1115 Extension Template identifying the program changes being requested for the extension period. Please list all enclosures that accompany this document constituting the state's whole submission.

1. Section 1115 Extension Template
2. Appendices A – E
3. Interim Evaluation
4. Dental Wellness Plan Interim Evaluation
5. Healthy Behaviors Interim Evaluation

The state attests that it has abided by all provisions of the approved STCs and will continuously operate the demonstration in accordance with the requirements outlined in the STCs.

Signature: [redacted] **Date:** 6-19-19

CMS will notify the state no later than 15 days of submitting its application of whether we determine the state's application meets the requirements for a streamlined federal review under section 1115(f). The state will have an opportunity to modify its application submission if CMS determines it does not meet the requirements of section 1115(f). If CMS reviews the state's submission and determines that the proposed changes significantly alter the original objectives and goals of the existing demonstration as approved, CMS has the discretion to process this application full scope pursuant to regular statutory timeframes for an extension or as an

Centers for Medicare & Medicaid Services

Section 1115 Demonstration
FAST TRACK Extension Template for Program Changes

Proposed Demonstration Changes for the Extension Period

A. General Description. Provide an overall description of the changes the state proposes for the extension of the demonstration. Specifically, include information on the expected impact these proposed program changes will have on populations covered by the demonstration and how it furthers the approved objectives and goals of the demonstration.

DHS requests a modification to the Iowa Wellness Plan special terms and conditions (STCs) to align with current program operations for retroactive eligibility. In accordance with Iowa Senate File 2418 (2018), the State requests the STCs be updated to reflect the waiver of retroactive coverage does not apply to applicants who are residents of nursing facilities. This technical change is consistent with the goals of the Medicaid program as the State is requesting to reinstate a benefit that would otherwise be required in the absence of CMS' approval of a waiver of Section 1902(a)(34) of the Social Security Act.

B. Expenditure Authorities. List any proposed modifications, additions to, or removal of currently approved expenditure authorities. Indicate how each new expenditure authority is necessary to implement the proposed changes and also how each proposed change furthers the state's intended goals and objectives for the requested extension period.

DHS requests no modifications to expenditure authorities.

C. Waiver Authorities. List any proposed modifications, additions to, or removal of currently approved waiver authorities. Indicate how each new waiver authority is necessary to implement the proposed changes and also how each proposed change furthers the state's intended goals and objectives for the requested extension period.

DHS currently has a waiver of Section 1902(a)(34) related to retroactive eligibility. Specifically, the current special terms and conditions (STCs) indicate this waiver enables "the state not to provide three months of retroactive eligibility coverage for state plan populations. The waiver of retroactive eligibility does not apply to pregnant women (and during the 60-day period beginning on the last day of the pregnancy) and infants under one year of age." The State requests this STC be updated in alignment with Iowa Senate File 2418 (2018), as documented in our letter to CMS on September 4, 2018, and subsequent CMS acknowledgement on September 25, 2018. As noted in that correspondence, effective for Medicaid applications filed on or after July 1, 2018, DHS provides up to three months retroactive coverage for applicants who are residents of a nursing facility at the time of application and are otherwise Medicaid-eligible. Therefore, the State requests an aligning technical change to the STCS to reflect current DHS policy and operations.

D. Eligibility. List any proposed changes to the population(s) currently being served under the demonstration.

If the state is proposing to add populations, please refer to the list of Medicaid Eligibility Groups at: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/Downloads/List-of-Eligibility-Groups.pdf when describing Medicaid

State plan populations, and for an expansion eligibility group, please provide a plain language description of the group(s) that is sufficiently descriptive to explain to the public.

If the state is proposing to remove any demonstration populations, please include in the justification how the state intends to transition affected beneficiaries into other eligible coverage as outlined in the Special Terms and Conditions (STCs).

DHS requests no modifications to the populations currently served under the demonstration.

E. Benefits and Cost Sharing. Describe any proposed changes to the benefits currently provided under the demonstration and any applicable cost sharing requirements. The justification should include any expected impact these changes will have on current and future demonstration enrollment.

DHS requests no modifications to the benefits or cost sharing under the demonstration.

F. Delivery System. Describe any proposed changes to the healthcare delivery system by which benefits will be provided to demonstration enrollees. The justification should include how the state intends a seamless transition for demonstration enrollees and any expected impact on current and future demonstration enrollment.

DHS requests no modifications to the healthcare delivery system under the demonstration.

G. Budget/Allotment Neutrality. Describe any proposed changes to state demonstration financing (i.e., sources of state share) and/or any proposed changes to the overall approved budget/allotment neutrality methodology for determining federal expenditure limits (other than routine updates based on best estimate of federal rates of change in expenditures at the time of extension).

DHS requests no modifications to state demonstration financing or budget neutrality.

H. Evaluation. Describe any proposed changes to the overall demonstration evaluation design, research questions or hypotheses being tested, data sources, statistical methods, and/or outcome measures. Justification should include how these changes furthers and does not substantially alter the currently approved goals and objectives for the demonstration.

DHS requests no modifications to the demonstration evaluation for the Dental Wellness Plan. As outlined in Appendix C, modifications are proposed to the evaluation design hypotheses to align with recent CMS release of evaluation design guidance for eligibility and coverage §1115 waivers, where applicable to the Iowa Wellness Plan.

I. Other. Describe proposed changes to any other demonstration program feature that does not fit within the above program categories. Describe how these change(s) furthers the state's intended goals and objectives for the requested extension period.

DHS requests no additional modifications to the demonstration.

State Contact Person(s)

Please provide the contact information for the state's point of contact for this demonstration extension application.

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Section 1115 Demonstration Extension
Section 1115(f) Fast Track Application Supporting Documentation
Appendices A - E

Iowa Wellness Plan
Project #11-W-00289/5

State of Iowa
Department of Human Services

June 20, 2019

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APPENDIX A: Historical Summary

Initial Waiver Approval: 2014 - 2016

In 2013, the Iowa Legislature passed with bi-partisan support the Iowa Health and Wellness Plan (IHAWP) to provide access to healthcare for uninsured, low-income Iowans, using a benefit design intended to improve health outcomes for beneficiaries. The IHAWP design sought to improve outcomes, increase personal responsibility, and ultimately lower costs. Key goals were to ensure the IHAWP population had access to high-quality local provider networks and modern benefits that worked to improve health outcomes; and to drive healthcare system transformation by encouraging a shift to value based payments that align with important developments in both the private insurance and Medicare markets.

The IHAWP sought to provide a comprehensive, commercial-like benefit plan that ensures provision of the Essential Health Benefits, indexed to the State Employee Plan benefits, with supplemental dental benefits similar to those provided on the Medicaid State Plan. Through a unique incentive program, the IHAWP also sought to promote responsible health care decisions by coupling a monthly required financial contribution with an incentive plan for members to actively seek preventive health services to earn an exemption from the monthly contribution requirement. Original IHAWP options included the following:

1. The Iowa Wellness Plan (IWP), which covered adults ages 19 to 64, with household incomes at or below 100% of the Federal Poverty Level (FPL); and
2. The Marketplace Choice Plan (MPC), which covered adults ages 19 to 64, with household incomes of 101% through 133% of FPL.

On December 10, 2013, the Centers for Medicare and Medicaid Services (CMS) approved the Iowa Wellness Plan §1115 Demonstration Waiver (Project #11-W-00289/5) and the Marketplace Choice §1115 Demonstration Waiver (Project # 11-W-00288/5), thereby enabling the State to implement the IHAWP on January 1, 2014.

Iowa Medicaid originally administered the IWP through several delivery systems including independent primary care physicians (PCPs), accountable care organizations (ACOs), and managed care organizations (MCOs). Services provided by independent PCPs and ACOs were provided on a fee-for-service basis, while MCOs were compensated based on capitation.

The MPC Demonstration allowed enrolled members to select from participating commercial health care coverage plans available through the Health Insurance Marketplace. Medicaid paid MPC member premiums and cost sharing to the commercial health plan on behalf of the member, and members had access to the network of local health care providers and hospitals served by the commercial insurance plan. Historically, members could elect to receive coverage through one of two qualified health plans (QHPs); however, there are no longer any QHPs available to serve the population, thereby eliminating coverage options for the MPC Demonstration. These members were subsequently enrolled in the IWP Demonstration, pursuant to the December 2015 amendment noted below.

Amendments During Initial Waiver Period

Several amendments to the IHAWP waivers were approved during the original Demonstration

period. On May 1, 2014, CMS approved the State's request to amend both the IWP and MPC Demonstrations to provide tiered dental benefits to all expansion adults in Iowa with incomes up to and including 133% FPL through a prepaid ambulatory health plan (PAHP). This model was designed to promote and encourage healthy preventive care-seeking behaviors among members, and to ensure competitive reimbursement rates for providers and a reduction in administrative barriers. Core dental benefits included basic preventive and diagnostic, emergency, and stabilization services, implemented through the IWP and MPC alternative benefit plans (ABPs), while tiered "Enhanced," and "Enhanced Plus" earned benefits were provided to beneficiaries through the IWP and MPC Demonstrations, based on beneficiary completion of periodic exams.

In addition to the above amendment, CMS twice approved the State's request to extend its waiver of the non-emergency medical transportation (NEMT) benefit from both the IWP and MPC Demonstrations. When CMS originally approved this authority, on January 1, 2014, it was scheduled to sunset on December 31, 2014, with the possibility of extending based on an evaluation of the impact on access to care. Initial experience demonstrated that lack of NEMT services was not significantly impeding IHAWP member access to care. In fact, from January to June 2014, 39% of members received at least one service and over 14% of members completed physical exams in the first eight months, as compared to an annualized figure of 6.5% for Medicaid overall. After reviewing initial data on the impact of the waiver on access, CMS approved an extension of the NEMT waiver through July 31, 2015. Thereafter, CMS and the State established criteria necessary for the State to continue the NEMT waiver beyond July 31, 2015. Specifically, the State agreed to compare survey responses of the IHAWP members to survey responses of persons receiving "traditional" Medicaid benefits through the State Plan. Iowa conducted the analysis and found that the survey responses of the two populations did not have statistically significant differences. In light of those results, CMS approved a second amendment through June 30, 2016.

Additionally, on December 24, 2015, CMS approved the State's request to amend the IWP Demonstration to allow persons with incomes at or below 133% FPL who were previously eligible for the MPC Demonstration to be eligible for the IWP Demonstration. The transition of existing MPC Demonstration members into the IWP Demonstration took place on January 1, 2016. On February 23, 2016, CMS approved the State's request to implement a managed care delivery system for the IWP Demonstration, concurrent with the §1915(b) High Quality Healthcare Initiative Waiver, effective April 1, 2016.

Initial Waiver Extension & Amendments: 2017 - 2019

On November 23, 2016, the State received approval to extend the IWP for an additional three year period. This initial extension was approved with no program modifications. Subsequently, the State submitted two amendment requests during the renewal period. The first amendment, approved by CMS on July 27, 2017, modified the Dental Wellness Plan (DWP) component of the Demonstration based on analysis of independent evaluation findings and stakeholder feedback. Through this amendment, the State implemented an integrated dental program for Medicaid enrollees aged 19 and over. The redesigned DWP incorporated an innovative incentive structure to improve oral health by encouraging utilization of preventive dental services and compliance with treatment plans. Movement of adult enrollees to the DWP was designed to

provide a seamless experience for enrollees and dental providers as individuals transition through different eligibility categories. Under the modified DWP, incentives were created for enrollees to appropriately utilize preventive dental services and maintain oral health through the elimination of premium requirements for enrollees who complete preventive dental service requirements. An earned benefit structure was maintained; however, the original tiered benefit structure was eliminated to address the concern that few enrollees were eligible for tier two and tier three DWP benefits under the original DWP structure due to enrollee churn. Under the modified earned benefit structure, to maintain comprehensive dental benefits after their first year of enrollment without a premium obligation, enrollees must complete State designated "healthy behaviors." This structure is intended to create incentives for members to establish a dental home and encourage the receipt of preventive dental services to promote oral health and preventable oral disease conditions. Enrollees over 50% FPL who fail to complete these healthy behaviors within their first year of enrollment are required to contribute financially toward their dental health care costs through monthly premium contributions. Failure to make monthly premium payments result in the enrollee being eligible for basic dental services only for the remainder of the benefit year.

Additionally, the State received authority in October 2017 to waive the three month retroactive eligibility period, except for pregnant women and infants under age one. In accordance with House File 653, passed by the Iowa Legislature in 2017, the State implemented a policy whereby an applicant's Medicaid coverage is effective the first day of the month in which the application for Medicaid was filed. The State subsequently notified CMS, in accordance with Iowa Senate File 2418 (2018), of its intent to reinstate the three-month retroactive Medicaid coverage benefit for applicants who are residents of a nursing facility at the time of application. This change became effective for new Medicaid applications filed on or after July 1, 2018.

Demonstration Goals

The IWP seeks to further the objectives of Title XIX by:

1. Improving enrollee health and wellness through the encouragement of healthy behaviors and use of preventive services.
2. Increasing enrollee engagement and accountability in their health care.
3. Increasing enrollee's access to dental care.

Additionally, the DWP seeks to achieve the following goals related to dental services:

1. Ensure member access to and quality of dental services.
2. Allow for the seamless delivery of services by providers.
3. Improve the oral health of DWP enrollees by encouraging engagement in preventive services and compliance with treatment goals.
4. Encourage linkage to a dental home.

Since its inception, the IWP has expanded access to health care throughout Iowa. Trends in quality measures indicate this coverage has improved access to primary care and preventive

services. As further described throughout this extension application, the proportion of IWP enrollees accessing preventive services has increased since initial program implementation and rates of accessing critical healthcare screening services are higher for IWP enrollees as compared to other Medicaid populations. The proposed extension will enable the State to continue its efforts to provide access to health care to otherwise Medicaid ineligible Iowans.

APPENDIX B: Budget Neutrality

In accordance with STC 45 of the current IWP Demonstration, CMS has previously determined that the Demonstration is budget neutral based on the assessment that the waiver authorities granted for the Demonstration are unlikely to result in any increase in federal Medicaid expenditures, and that no expenditure authorities are associated with the Demonstration.

APPENDIX C: Interim Evaluation

Interim evaluations of the IWP and DWP were completed by the University of Iowa Public Policy Center to explore a series of questions and hypotheses related to access, quality and cost of care under the waiver. The evaluations also studied the effects of the healthy behaviors programs.

Specifically, the IWP Interim Evaluation explored the following questions, in accordance with the CMS-approved Evaluation Plan.

1. What are the effects of the IWP on member access to care?
2. What are the effects of the IWP on member insurance coverage gaps and insurance service when their eligibility status changes (churning)?
3. What are the effects of the IWP on member quality of care?
4. What are the effects of the IWP on the costs of providing care?
5. What are the effects of the premium incentive and copayment disincentive programs on IWP enrollees?
6. What is the adequacy of the provider network for IWP enrollees as compared to those in the Iowa Medicaid State Plan?

The DWP Interim Evaluation explored a series of questions and hypotheses regarding enrollee access to dental services, engagement in preventive services and provider attitudes toward the redesigned DWP. Specifically, the evaluation design was approved by CMS to study the following questions:

1. What are the effects of DWP 2.0[1] on member access to care?
2. What are provider attitudes towards the DWP?
3. What are the effects of the benefit structure, including healthy behavior requirements, cost sharing and reduced benefits, on DWP member outcomes?
4. What are the effects of DWP member outreach and referral services?

Full reports are provided as separate attachments to this extension application and a summary of key findings is provided below.

IWP Interim Evaluation Findings

As highlighted below, the IWP Interim Evaluation revealed several key positive findings.

- IWP members had equal access to primary care and specialty services compared to traditional Medicaid enrollees on the majority of measures associated with this hypothesis.

[1] DWP 2.0 refers to the modified Dental Wellness Plan design approved by CMS in July 2017 which replaced the previous tiered benefit structure with a model in which enrollees who complete "healthy behaviors" are exempt from premiums in their second year of enrollment.

- IWP members have increasingly accessed annual, preventive exams since initial waiver implementation.
- IWP members had a lower need for mental and behavioral health services as well as a lower unmet need for these services.
- Utilization of the emergency department for non-emergent care was lower for IWP members compared to traditional Medicaid enrollees.
- While non-emergency medical transportation is not a covered service for IWP members, the reported unmet need for transportation was not statistically different compared to Medicaid members with access to the benefit.
- The amount of churning was comparable between IWP and Medicaid.
- IWP members generally reported equal or higher levels of satisfaction with care than Medicaid members.

Healthy Behaviors Interim Evaluation Findings

As highlighted below, findings from the Healthy Behaviors Interim Evaluation indicated several key positive finding. Additionally, it revealed opportunities for increasing enrollee awareness of the healthy behaviors program. Of note, during the study period, the State's Medicaid program and delivery system underwent a series of changes which likely impacted enrollee understanding and awareness of the healthy behaviors program design. For example, individuals eligible for the MPC Plan and with Coventry were temporarily transitioned to fee-for-service upon the QHP's exit from the market. Now that program enrollment has stabilized, the State looks forward to continuing to study enrollee understanding of the healthy behaviors program and associated completion rates during the waiver extension period. Additionally, the State intends to proactively explore opportunities to increase enrollee awareness through additional outreach strategies and mechanisms.

- Since initial waiver implementation, there has been an increase in wellness exam completion for IWP enrollees with income over 100% FPL.
- Health risk assessment (HRA) completion rates have also increased for IWP enrollees with income over 100% FPL since initial implementation.
- Among IWP members with diabetes, those who completed both healthy behaviors had higher rates of hemoglobin A1c testing in comparison to those who did not complete the IWP healthy behavior activities.
- IWP enrollees with incomes at or below 100% FPL who completed healthy behaviors had significantly lower rates of non-emergent emergency department visits. Additionally, the proportion of IWP members with a return emergency department visit was lower in the group that completed an HRA or both healthy behaviors in the prior year.
- There was a significant association between members reporting they heard about the

healthy behaviors program from their health care provider and completing an HRA; however, the number of enrollees who learned about the program from their provider was low. This presents an opportunity for IME to evaluate options for increasing provider engagement in educating enrollees during the waiver renewal period.

Dental Wellness Plan Interim Evaluation Findings

As highlighted below, the DWP Interim Evaluation revealed several key positive findings.

- Enrollees reported high rates of satisfaction with their dental PAHP; 86% of those surveyed indicated they would recommend their plan to others.
- Individuals who were enrolled in the original DWP and maintained enrollment in DWP 2.0 were more likely to have received a preventive dental visit than those who had transitioned from traditional Medicaid State Plan services into DWP 2.0 in July 2017. While further study is needed to draw more definitive conclusions, this may point to a correlation between exposure to the DWP incentive arrangement and a positive impact on utilization of preventive services.
- The percentage of DWP enrollees with an emergency department visit for non-traumatic dental reasons was lower during the DWP 2.0 Interim Evaluation study period than fiscal year 2017. This may indicate greater ability to access primary oral health care; however, two years do not provide sufficient data for trend analysis. Therefore, DHS looks forward to continuing to study this in the waiver extension period.
- The majority of DWP enrollees reported experiencing timely access to a dentist for emergency care with 71% of surveyed DWP 2.0 enrollees indicating they had an appointment scheduled as soon as they wanted.
- Awareness about the DWP 2.0 healthy behavior requirements was greater than member awareness about tiered coverage in the original DWP.
- The majority of the DWP 2.0 population surveyed had a positive attitude regarding the healthy behavior requirements. Enrollees appeared to find it easy to obtain an annual check-up or cleaning.
- 68% of surveyed DWP 2.0 enrollees reported that the healthy behavior requirements would make them more likely to visit a dentist annually.

The evaluation also revealed opportunities for the DHS to improve enrollee understanding of the DWP healthy behaviors program and associated rates of completion. Of note, individuals who had transitioned from traditional Medicaid State Plan dental benefits in July 2017 were less likely to be aware of the requirement than previous DWP enrollees who transitioned to DWP 2.0. This may indicate enrollee awareness increases with length of enrollment and exposure to an incentive program structure; the DHS will continue to study this during the waiver extension to further understand these correlations. While these findings can likely be attributed to the program's infancy at the time the Interim Evaluation was completed, the DHS is taking a

proactive approach in implementing a variety of policy, operational and contractual modifications to address these findings.

For example, the State will be strengthening PAHP contract language to enhance requirements for enrollee outreach and education efforts. This will include new requirements for direct engagement and targeted outreach to enrollees who have not completed the healthy behavior requirements. Further, DHS is exploring the addition of new PAHP performance measures and incentives tied to enrollee completion of healthy behaviors.

Additionally, effective July 1, 2019, the DHS is implementing a passive enrollment process through which enrollees will no longer receive an initial fee-for-service period prior to enrollment with a dental PAHP. This process improvement is intended to eliminate provider and member confusion regarding delivery system assignment, allow for timelier access to PAHP services and streamline member care. It will also permit PAHPs to begin enrollee engagement and outreach regarding dental benefits sooner.

The DWP Interim Evaluation also revealed opportunities to increase access to dental providers, an expected finding given the State's dental care professional shortage areas.[2] The State continues to diligently work to improve access to care for DWP enrollees. For example, in collaboration with the Iowa Department of Public Health, DHS is exploring permitting certain oral health services provided within the scope of practice of non-dental providers to count toward healthy behavior requirements. This would provide members that may otherwise have difficulty finding a dentist another access point to complete their healthy behaviors. Additionally, DHS is working in collaboration with the external quality review organization (EQRO) vendor to more accurately measure dental providers enrolled in the DWP network and not accepting new patients to allow more targeted recruiting efforts to be completed by the PAHPs.

The State will also continue to monitor healthy behavior completion rates to determine if completion of alternative or additional services should be available for purposes of waiving an enrollee's premium obligation in their second year of enrollment. For example, as the program matures, and more data becomes available through the Final Evaluation Report, the State may consider including additional preventive and restorative codes or removing the oral health self-assessment as a standalone healthy behavior requirement. All future modifications to eligible healthy behaviors would be made in accordance with the State's STCs, through advanced submission of an amended Healthy Behaviors Protocol.

Evaluation Plan for Extension Period

The State intends to study the following research questions and hypotheses during the waiver extension period. These have been developed in alignment with the recent CMS release of evaluation design guidance for eligibility and coverage §1115 waivers, where applicable to the Iowa Wellness Plan, as enumerated in the guidance documents available at https://www.medicaid.gov/medicaid/section-1115-demo/evaluation-reports/evaluation-designs-

[2] Bureau of Health Workforce, Health Resources and Services Administration (HRSA), U.S. Department of Health & Human Services, Designated Health Professional Shortage Areas Statistics: Designated HPSA Quarterly Summary, as of December 31, 2018.

and-reports/index.html.

Proposed IWP Evaluation Parameters

Hypothesis	**Research Question(s)**
Waiver Policy: Premiums Tied to Healthy Behavior Requirements	
Goal: Improve enrollee health and wellness through the encouragement of healthy behaviors and use of preventive services.	
The proportion of IWP enrollees who complete a wellness exam will be greater than among traditional Medicaid enrollees who do not have premiums tied to completion of healthy behaviors.	What are the effects of the premium incentive on Wellness Plan enrollees?
Waiver Policy: Non-Eligibility Periods (Disenrollment for Premium Non-Payment)	
Goal: Increase enrollee engagement and accountability in their health care.	
Medicaid beneficiaries subject to non-eligibility periods for noncompliance with program requirements will have higher rates of compliance with those requirements than other beneficiaries not facing non-eligibility periods.	Are beneficiaries subject to non-eligibility periods for noncompliance with program requirements more likely to comply with those requirements than other Medicaid beneficiaries not subject to non-eligibility periods?
	What are common barriers to compliance with program requirements that have non-eligibility period consequences for noncompliance?
Among beneficiaries who enroll in Medicaid, those subject to non-eligibility periods will have more continuous enrollment than those not subject to non-eligibility periods.	What is the likelihood of enrollment continuity for those subject to non-eligibility periods compared to other Medicaid beneficiaries?
Through greater continuity of coverage, health outcomes will be better for those subject to non-eligibility periods than for other Medicaid beneficiaries.	Do beneficiaries who are subject to non-eligibility periods have better health outcomes than other beneficiaries?
Waiver Policy: Waiver of Retroactive Eligibility	
Goal: Encourages individuals to obtain and maintain health insurance coverage, even when healthy.	
Eliminating retroactive eligibility will increase the likelihood of enrollment and enrollment continuity.	Do eligible people subject to retroactive eligibility waivers enroll in Medicaid at the same rates as other eligible people who have access to retroactive eligibility?
	What is the likelihood of enrollment continuity for those subject to a retroactive eligibility waiver compared to other Medicaid beneficiaries who have access to retroactive eligibility?
	Do beneficiaries subject to retroactive eligibility waivers who disenroll from Medicaid have shorter enrollment gaps than other beneficiaries who have access to retroactive eligibility?

Hypothesis	Research Question(s)
Eliminating retroactive eligibility will increase enrollment of eligible people when they are healthy relative to those eligible people who have the option of retroactive eligibility.	Do newly enrolled beneficiaries subject to the waiver of retroactive eligibility have higher self-assessed health status than other newly enrolled beneficiaries who have access to retroactive eligibility
Through greater continuity of coverage, health outcomes will be better for those subject to retroactive eligibility waivers compared to other Medicaid beneficiaries who have access to retroactive eligibility.	Do beneficiaries subject to the retroactive eligibility waiver have better health outcomes than other beneficiaries who have access to retroactive eligibility?
Elimination or reduction of retroactive coverage eligibility will not have adverse financial impacts on consumers.	Does the retroactive eligibility waiver lead to changes in the incidence of beneficiary medical debt?

Additionally, during the new Demonstration period, Iowa will maintain the original evaluation design of the DWP, which includes study of the hypotheses and research questions outlined below.

Proposed DWP Evaluation Parameters

Research Question	Hypothesis
What are the effects of DWP 2.0 on member access to care?	DWP 2.0 members will have equal or greater access to dental care than either DWP 1.0 or Medicaid State Plan (MSP) members had prior to May 1, 2017.
	DWP 2.0 members will be more likely to receive preventive dental care than either DWP 1.0 or MSP members were prior to May 1, 2017.
	DWP 2.0 members will have equal or lower use of emergency department services for non-traumatic dental care than either DWP 1.0 or MSP members had prior to May 1, 2017.
	DWP 2.0 members will have equal or better quality of care than either DWP 1.0 or MSP members did prior to May 1, 2017.
	DWP 2.0 members will report equal or greater satisfaction with the dental care provided than DWP 1.0 or MSP members did prior to May 1, 2017.
	DWP 2.0 members will report better understanding of their benefits when compared to the DWP 1.0 tiered structure.
	The earned benefit structure will not be perceived by members as a barrier to care in comparison to DWP 1.0.
What are provider attitudes towards the	The DWP 2.0 benefit structure will not be perceived by dentists as a barrier to providing care.

Research Question	Hypothesis
DWP?	Over 50% of DWP 2.0 providers will remain in the plan for at least 3 years.
What are the effects of the benefit structure – including healthy behavior requirements, cost sharing, and reduced benefits – on DWP member outcomes?	The benefit structure for DWP 2.0 members will increase regular use of recall dental exams over the study period.
	The benefit structure will not be seen as a barrier to care by DWP 2.0 members.
	In year 2 of the DWP 2.0 and beyond, use of preventive dental care will be higher than in the first year of the program.
	DWP 2.0 policies will promote member compliance with healthy behavior activities.
What are the effects of DWP member outreach and referral services?	DWP 2.0 member outreach services will address dentists' concerns about missed appointments.
	DWP 2.0 member referral services will improve access to specialty care for DWP 2.0 members as compared to MSP members prior to May 1, 2017.
	DWP 2.0 member outreach will improve DWP 2.0 members' compliance with follow-up visits, including recall exams, as compared to DWP 1.0 and MSP members
	DWP 2.0 member outreach will improve members' access to a regular source of dental care.

APPENDIX D: Quality Assurance Monitoring

The DHS has a robust quality oversight plan for continually monitoring the performance of the managed care organizations (MCOs) and dental PAHPs delivering services to enrollees under the waiver. The Iowa Medicaid Enterprises' (IME) MCO Oversight and Supports Bureau is primarily responsible for monitoring performance and reviewing compliance. Ongoing data collection and performance analysis is made available through a series of monthly, quarterly and annual reports which can be accessed at https://dhs.iowa.gov/ime/about/performance-data. A summary of key findings is provided below.

MCO Quality Assurance Monitoring

Findings from the most recent Managed Care Annual Performance Report, for state fiscal year (SFY) 2018 and conducted in accordance with 2016 Iowa Acts Section 1139.93 reveal several key findings regarding quality and access:

- *Value-Added Services:* Over 86,000 value-added services in four quarters were utilized. The health plans offer numerous value-added services that go above and beyond what traditional Medicaid benefits offer.
- *Timely Helpline Services:* In all quarters for SFY18, all health plans exceeded the timeliness requirements required by their contract. The State also conducts "secret shopper calls" to ensure the quality of helpline services.
- *Claims Requirements*: All MCOs exceeded the contractual expectation that 90% of clean medical payment claims be paid within 30 days for all four quarters of SFY18.
- *Member and Provider Escalated Issues*: Escalated member issues decreased by 50% since SFY17 and escalated provider issues decreased by 81% since SFY17.
- *Health Outcomes*: There has been positive movement on the health outcomes reported when compared to SFY17. For example, non-emergent emergency department use per 1,000 emergency department visits have decreased and increases are seen in HEDIS measured outcomes.
- *Prior Authorization*: Contracted MCOs are completing 100% of prior authorization requests within contractually mandated timeframes.

Dental PAHP Quality Assurance Monitoring

Findings from the most recent dental PAHP quarterly monitoring reports reveal several key findings regarding quality and access in the DWP:

- *Grievances and Appeals:* Enrollee grievance volume was low, with the number of grievances received ranging from 0% to 0.27% of the total population. Additionally, DWP dental PAHPs resolved 100% of appeals within the contractually required timeframes.
- *Claims Requirements:* Both dental PAHPs exceeded the contractual expectation that 90% of clean claims be paid or denied within 14 days.

- *Prior Authorization:* Contracted dental PAHPs processed 100% of prior authorization requests within contractually mandated timeframes.

Quality and Access to Care

MCOs serving IWP enrollees must demonstrate compliance with contractually mandated network adequacy standards. As outlined in the table below, Wellness Plan enrollees have access to network providers in accordance with the MCO's contract requirements. Full network adequacy reports are available at https://dhs.iowa.gov/ime/about/performance-data-GeoAccess

Percentage of Members with Coverage in Time and Distance Standards

Access Standard – 30 Minutes/30 Miles	Amerigroup	UnitedHealth
Adult Primary Care Provider	100%	100%
Hospital	100%	100%
Pharmacy	100%	100%
Outpatient Behavioral Health	100%	100%

Additionally, the average distance to a dental provider is outlined in the table below.

Average Distance to Dentist

	Average Distance to 1st Closest Provider	Average Distance to 2nd Closest Provider
Delta Dental	5.6 miles 6.5 minutes	6.5 miles 7.5 minutes
MCNA	9.6 miles 10.9 minutes	11.5 miles 13.1 minutes

Additionally, studies of key quality measures indicate IWP coverage improved access to primary care and screening:

- The proportion of IWP adults with a preventive/ambulatory health services visit has increased since initial program implementation. In 2017, 86% of IWP enrollees had at least one preventive or ambulatory care visit.[3]
- Rates of women receiving mammograms were consistently highest among women in the IWP from 2014-2017, as compared to other Medicaid populations. In 2017, 68% of women ages 50-64 had a mammogram completed.[4]

[3] Based on the HEDIS 2018 Adults' Access to Preventive/Ambulatory Health Services measure.
[4] Based on the HEDIS 2018 Breast Cancer Screening measure.

- Rates of women between the ages 21-64 who received a cervical cancer screening have also increased since initial program implementation from 24% in 2014 to 47% in 2017.[5]
- The number of non-emergent emergency department visits per 1,000 member months has been lower for members in the IWP compared to parent/caretaker relatives enrolled in traditional Medicaid. Additionally, the proportion of IWP members with an emergency department readmission within 30 days is also lower.
- The rates of well adult care are higher for IWP members compared to parent/caretaker relatives enrolled in traditional Medicaid.

External Quality Review

The IME contracts with Health Services Advisory Group (HSAG) to conduct an annual external quality review (EQR) in accordance with the requirements at 42 CFR §438.350. The EQR provides an annual assessment of each plan's performance related to quality, timeliness and access to care and services. HSAG performs a series of mandatory and optional EQR activities including compliance monitoring, validation of performance improvement projects and performance measures, network adequacy analysis (inclusive of provider capacity and geographic network distribution), encounter data validation, review and validation of the MCOs' enrollee and provider surveys and calculation of performance measures. A high level overview of key findings from the 2018 EQR for the MCOs and Dental PAHPs is provided in the tables below.

MCO Summary EQR Findings

	Amerigroup	**United Healthcare**
Overall Compliance Monitoring Score	96.7%	98.1%
Validation of Performance Improvement Projects	100%	100%
Network Adequacy	Contract standards met for majority of provider types	Contract standards met for majority of provider types

Dental PAHP Summary EQR Findings

	Delta Dental of Iowa	**MCNA**
Overall Compliance Monitoring Score[6]	72%	83%

[5] Based on the HEDIS 2018 Cervical Cancer Screening measure.

[6] Dental PAHPs were required to submit a corrective action plan (CAP) for each of the elements for which the EQRO assigned a performance score of "not met" within 30 days of the final EQR report. The CAP is evaluated for sufficiency based on: 1) completeness of the CAP document in addressing each required action and assigning a responsible individual, a timeline and completion date, and specific actions and applicable interventions that the

	Delta Dental of Iowa	MCNA
Validation of Performance Improvement Projects	Partially Met	Met
Validation of Performance Measures	Reported/Met	Reported/Met
Network Adequacy	In progress	In progress

organization will implement to bring the element into compliance; 2) degree to which the planned activities and interventions meet the intent of the requirement; 3) degree to which the planned interventions are anticipated to bring the organization into compliance with the requirement; and 4) appropriateness of the timeline for correcting the deficiency. Any CAPs not meeting this criteria require resubmission until the DHS standards are met.

APPENDIX E: Public Notice Summary

In accordance with 42 CFR §431.408, the public had an opportunity to comment on this waiver extension through a public notice and comment process that ran from May 10, 2019 through June 10, 2019. The public notice and all waiver documents were posted on the DHS website at https://dhs.iowa.gov/public-notices/iowa-wellness-plan and made available for review at DHS Field Offices. A summary notice was also published on May 10, 2019 in several newspapers of widest circulation, including: (i) The Gazette; (ii) Council Bluffs Nonpareil; (iii) Des Moines Register; (iv) Dubuque Telegraph Herald; (v) Iowa City Press Citizen; (vi) Mason City Globe Gazette; (vii) Sioux City Journal; (viii) Waterloo-Cedar Falls Courier; and (ix) Quad-City Times. Additionally, IME sent an e-News alert regarding the extension application, reaching approximately 3,000 stakeholders. All notices provided the option for individuals to submit written feedback to the State by email or U.S. Postal Service mail. Finally, the State held two public hearings on May 21, 2019 in Des Moines (Executive Committee of the Iowa Medical Assistance Advisory Council, which is Iowa's Medical Care Advisory Committee that operates in accordance with 42 CFR §431.12) and on May 22, 2019 in Coralville (open forum for interested parties to learn about the contents of the extension application, and to comment on its contents). Both hearings provided telephonic capabilities to ensure statewide accessibility.

Summary of Public Comments

There were no attendees at either public hearing. The State received two written comments. The first was focused on the DWP. The commenter indicated there were cases of enrollees who were unaware of the healthy behaviors program, were not notified of their exemption, or had difficulty in claiming a hardship exemption. This commenter was concerned these enrollees would not understand their right to appeal or were not equipped to file an appeal. Further, they acknowledged the steps the IME had taken to respond to these issues including: (i) reviewing individual cases; (ii) weekly phone calls with the University of Iowa Hospitals and Clinics; (iii) planned system updates; and (iv) strengthened provisions in dental PAHP contracts regarding member outreach on exemptions. The commenter further suggested IME review all individuals assessed premiums and had benefit reductions to determine if there were errors, accept late appeals and undertake a full investigation to prevent these issues in the future.

The State appreciates the continued feedback on operations of the Demonstration. In addition to the process improvements implemented by the IME as acknowledged in this comment, the IME is conducting the following activities: (i) preparing communication plans to ensure enrollees and providers are better aware of the medically exempt process; (ii) conducting an expeditious review of all DWP cases in appeal to determine if the premium or benefit reduction was appropriately applied and updating accordingly; and (iii) reviewing the cases of all DWP enrollees to ensure the healthy behaviors requirement, premiums or reductions in benefits were correctly applied, as suggested by the commenter. Finally, technical changes are being implemented to ensure correct programming for all medical exemptions, premium and benefit reductions.

The second commenter indicated support for the Medicaid expansion demonstration and its expanded coverage to an otherwise uninsured population. Further, they encouraged the State to

enter into value-based arrangements with entities outside MCOs, indicating cost savings did not meet original projections and MCOs leaving the market caused disruptions for enrollees. Additionally, the commenter believed the State's request to modify the retroactive waiver for residents of nursing homes to reflect current practice was not technical in nature, did not provide the public with sufficient information to comment and did not address the CMS template or public notice requirements. Finally, the commenter did not believe the state's description of modifications to the evaluation were sufficient.

The State appreciates the commenter's support of continued Medicaid expansion. No modifications were made to the waiver regarding the delivery system through which the IWP operates; the State intends to continue managed care and to implement value-based payment arrangement requirements through the contracted MCOs. Regarding the concern that the extension application does not sufficiently describe the requested waiver authority, the State refers the commenter to 42 CFR §431.412 which permits extension requests to include a statement that the State is requesting the same waiver authorities as those approved in the current demonstration. Further, the public had the opportunity to originally comment on the retroactive waiver changes, which have been in effect since July 2018, both during the legislative session in which the change was legislated and during a public comment period which was held by IME from July 23, 2018 through August 22, 2018 and included two public hearings. Finally, in response to the concern that insufficient detail was provided regarding the evaluation parameters, as the IME intends to align with the CMS requirements for eligibility and coverage §1115 waiver evaluations, the State has added a cross reference and hyperlink to the CMS guidance to further afford the public the opportunity to identify the federal guidelines which will drive the ultimate evaluation plan development post waiver approval.

Post-Award Forums

The most recent post-award forum, as required under the IWP Special Terms and Conditions and 42 CFR §431.420, was held on May 7, 2019, to allow the public an opportunity to comment on the progress of the Demonstration. A few questions were posed during the forum. Specifically, one attendee requested clarification if IME collects data on the number of enrollees currently employed. Additionally, clarification was requested regarding how dental benefit plan enrollment is tracked and displayed to providers. Finally, questions were posed regarding enrollment data, including whether the medically frail population is increasing.

Tribal Consultation Process

DHS initiated consultation with Iowa's federally recognized Indian tribes, Indian health programs, and urban Indian health organizations on April 29, 2019. Consultation was conducted in accordance with the process outlined in Iowa's Medicaid State Plan, and consisted of an electronic notice directed to Indian Health Service/Tribal/Urban Indian Health (I/T/U) Tribal Leaders and Tribal Medical Directors identified by the Iowa Indian Health Services Liaison. No comments were received.

APPENDIX E1: Abbreviated Public Notice

NOTICE OF IOWA DEPARTMENT OF HUMAN SERVICES PUBLIC COMMENT PERIOD TO EXTEND THE 1115 IOWA WELLNESS DEMONSTRATION WAIVER

Notice is hereby given that the Iowa Department of Human Services (DHS) will hold public hearings on the renewal of the §1115 Iowa Wellness Plan Demonstration Waiver, which is set to expire December 31, 2019. DHS intends to request extension of this waiver for an additional five years pursuant to §1115(f) and §1915(h)(2) of the Social Security Act.

Hearings offer an opportunity for the public to provide written or verbal comments about the Iowa Wellness Plan Demonstration Waiver extension. All comments will be summarized and taken into consideration prior to submission to the Centers for Medicare and Medicaid Services (CMS). Hearings will be held at the following dates, times, and locations:

Tuesday, May 21, 2019
Hoover State Office Building
A-Level, Conference Room 7
1305 E. Walnut St.
Des Moines, IA 50319
1:30 – 2:30 p.m.
1-866-685-1580
Code: 000-999-0232

Wednesday, May 22, 2019
Coralville Public Library
Meeting Room A
1401 5th Street
Coralville, IA 52241
12:00 – 1:00 p.m.
1-866-685-1580
Code: 000-999-0232

The Iowa Wellness Plan was created to provide comprehensive health care coverage to low-income, uninsured Iowans ages 19 to 64. During the initial two waiver periods, the innovative design of the Iowa Wellness Plan has demonstrated success in meeting key State goals. The State seeks to continue its success with the program and requests an extension of all current federal waivers. The only modification requested is a technical change to the special terms and conditions (STCs) to align with current program operations for retroactive eligibility. Specifically, as implemented by DHS effective for applications received on or after July 1, 2018, in accordance with Iowa Senate File 2418, a period of up to three months of retroactive eligibility is provided for applicants who are residents of a nursing facility at the time of Medicaid application and are otherwise Medicaid-eligible.

A full public notice, waiver documents, and information about the Iowa Wellness Plan are available at: https://dhs.iowa.gov/public-notices/iowa-wellness-plan and non-electronic copies will be made available for review at DHS Field Offices.

Written comments may be addressed to Anna Ruggle, Iowa Medicaid Enterprise, 611 Fifth Avenue, Des Moines, IA 50309. Comments may also be sent to the attention of: DHS, Iowa Health and Wellness Plan at: aruggle@dhs.state.ia.us through June 10, 2019.

Submitted by:
Michael Randol, Medicaid Director
Iowa Medicaid Enterprise
Iowa Department of Human Services

APPENDIX E2: Public Notice

NOTICE OF IOWA DEPARTMENT OF HUMAN SERVICES PUBLIC COMMENT PERIOD TO EXTEND THE §1115 IOWA WELLNESS DEMONSTRATION WAIVER

Notice is hereby given that the Iowa Department of Human Services (DHS) will hold public hearings on the renewal of the §1115 Iowa Wellness Plan (IWP) Demonstration Waiver, which is set to expire December 31, 2019. DHS intends to request extension of this waiver for an additional five years pursuant to §1115(f) and §1915(h)(2) of the Social Security Act with no modifications to current program operations.

Hearings offer an opportunity for the public to provide written or verbal comments about the IWP Demonstration Waiver extension. All comments will be summarized and taken into consideration prior to submission to the Centers for Medicare and Medicaid Services (CMS). Hearings will be held at the following dates, times, and locations:

Tuesday, May 21, 2019
Hoover State Office Building
A-Level, Conference Room 7
1305 E. Walnut St.
Des Moines, IA 50319
1:30 – 2:30 p.m.
Conference Line Available:
Call 1-866-685-1580; Code 000-999-0232

Wednesday, May 22, 2019
Coralville Public Library
Meeting Room A
1401 5th Street
Coralville, IA 52241
12:00 – 1:00 p.m.
Conference Line Available:
Call 1-866-685-1580; Code 000-999-0232

This notice provides details about the Demonstration Waiver and serves to open the 30-day public comment period. The comment period closes June 10, 2019.

GOALS AND OBJECTIVES

In 2013, the Iowa Legislature passed with bi-partisan support the Iowa Health and Wellness Plan (IHAWP) to provide access to healthcare for uninsured, low-income Iowans, using a benefit design intended to address liabilities associated with simply expanding the number of members in traditional Medicaid coverage. The IHAWP design sought to improve outcomes, increase personal responsibility, and ultimately lower costs. Key goals of the program include:

- Improving enrollee health and wellness through the encouragement of healthy behaviors and use of preventive services.
- Increasing enrollee engagement and accountability in their health care.
- Increasing enrollee's access to dental care.

Since its inception, the IHAWP has expanded access to health care throughout Iowa. Trends in quality measures indicate this coverage has improved access to primary care and preventive services. The proposed extension of the IWP will enable the State to continue its efforts to provide access to health care to otherwise Medicaid ineligible Iowans.

DEMONSTRATION ELIGIBILITY

No changes are proposed to program eligibility. Under the waiver extension, the IWP will continue to target individuals who are eligible in the adult group under the State Plan.

Table 1: IWP Eligibility

Eligibility Group Name	Social Security Act and CFR Citations	Income Level
The Adult Group	§1902(a)(10)(A)(i)(VIII) 42 CFR §435.119	0 – 133% FPL

Iowa Medicaid enrollees aged 19 and older outlined in Table 2, who do not meet one of the following exclusions, will continue to be enrolled in the DWP portion of the Demonstration: (i) enrollment in the Program of All-Inclusive Care for the Elderly (PACE); (ii) enrollment in the Health Insurance Premium Payment Program (HIPP); (iii) presumptively eligible; (iv) nonqualified immigrants receiving time-limited coverage of certain emergency medical conditions; (v) persons eligible only for the Medicare Savings Program; (vi) medically needy; and (vii) during periods of retroactive eligibility.

Table 2: DWP Eligibility

Eligibility Group Name	Social Security Act and CFR Citations	Income Level	Age Requirement
The Adult Group	§1902(a)(10)(A)(i)(VIII) 42 CFR §435.119	0 – 133% FPL	19 and over
Parents and Other Caretaker Relatives	1902(a)(10)(A)(i)(I) 1931(b) and (d) 42 CFR 435.110	*Household Size* / *Income Limit* 1 / $447 2 / $716 3 / $872 4 / $1,033 5 / $1,177 6 / $1,330 7 / $1,481 8 / $1,633 9 / $1,784 10 / $1,950	19 and over
Transitional Medical Assistance	408(a)(11)(A) 1931(c)(2) 1925 1902(a)(52)	First 6 months: N/A Additional 6 months: 0-185% FPL	19 and over
Pregnant Women	1902(a)(10(A)(i)(III) and (IV) 1902(a)(10)(A)(ii)(I), (IV) and (IX) 1920 43 CFR 435.116	0-375% FPL	19 and over
Mandatory Aged, Blind and Disabled	42 CFR 435.120 through 42 CFR 435.138	SSI Limit	19 and over

Eligibility Group Name	Social Security Act and CFR Citations	Income Level	Age Requirement
Individuals			
Optional Eligibility for Individuals who Meet Income & Resource of Cash Assistance Programs	1902(a)(10)(A)(ii)(I) 42 CFR 435.210	SSI Limit	19 and over
Optional Eligibility for Individuals who would be Eligible for Cash Assistance if they Were not in Medical Institutions	1902(a)(10)(A)(ii)(IV) 42 CFR 435.211	SSI FBR	19 and over
Institutionalized Individuals	1902(a)(10)(A)(ii)(V)	300% SSI FBR	19 and over
Medicaid for Employed People with Disabilities	1902(a)(10)(A)(ii)(XIII)	250% FPL	19 and over
Former Foster Care Children up to Age 26	1902(a)(10)(A)(i)(IX) 42 CFR 435.150	N/A	19 and over
Independent Foster Care Adolescents	1902(a)(10)(A)(ii)(XVII)	254% FPL	19 and over
Reasonable Classifications of Children	42 CFR 435.222	N/A	19 and over
§1915(c) HCBS Physical Disability Waiver	1902(a)(10)(A)(ii)(VI) 42 CFR 435.217	300% SSI FBR	19 and over
§1915(c) HCBS Health and Disability Waiver	1902(a)(10)(A)(ii)(VI) 42 CFR 435.217	300% SSI FBR	19 and over
§1915(c) HCBS Elderly Waiver	1902(a)(10)(A)(ii)(VI) 42 CFR 435.217	300% SSI FBR	19 and over
§1915(c) HCBS Intellectual Disability Waiver	1902(a)(10)(A)(ii)(VI) 42 CFR 435.217	300% SSI FBR	19 and over
§1915(c) HCBS AIDS Waiver	1902(a)(10)(A)(ii)(VI) 42 CFR 435.217	300% SSI FBR	19 and over
§1915(c) HCBS Brain Injury Waiver	1902(a)(10)(A)(ii)(VI) 42 CFR 435.217	300% SSI FBR	19 and over
Breast & Cervical Cancer Treatment Program	1902(a)(10)(A)(ii)(XVIII) 42 CFR 435.213	N/A	19 and over

ENROLLMENT & FISCAL PROJECTIONS

Annual enrollment and aggregate annual expenditures are not expected to increase or decrease as a result of the extension of this Demonstration. The State is not seeking any expenditure authorities under this Demonstration and CMS has previously determined that this Demonstration is budget neutral.

BENEFITS

The IWP extension will not modify current covered benefits. IWP benefits are described in the Iowa Wellness Plan alternative benefit plan (ABP). Dental benefits also remain unchanged under this extension. During the first year of enrollment in the DWP, expansion adults receive all available dental benefits described in the ABP; all other eligibility groups receive all dental benefits described in the state plan during their first year of enrollment in the DWP. To maintain access to full dental benefits in their second year of enrollment without a premium obligation, DWP enrollees must complete the required healthy behaviors, which include completion of an oral health self-assessment and preventive dental exam, during their first year of enrollment. All enrollees under 21 years of age continue to be eligible for medically necessary services in accordance with federal early and periodic screening, diagnostic and treatment (EPSDT) requirements.

COST SHARING

Current IWP and DWP cost sharing will remain unchanged by this extension. All IWP members have no cost-sharing during their first year of enrollment. During the second year, enrollees at or above 50% of the federal poverty level (FPL), who do not complete required healthy behaviors (i.e., health risk assessment and annual exam) during their first year of enrollment will be required to pay a monthly premium during the subsequent enrollment year, subject to a 30-day healthy behavior grace period. Individuals below 50% of the FPL, medically frail and members in the Health Insurance Premium Payment (HIPP) population, and all individuals who self-attest to a financial hardship are exempt from the required premium payment.

Monthly premium amounts will not exceed $5 per month for nonexempt households from 50% up to 100% of FPL, and $10 per month for nonexempt households between 100% and 133% of FPL. Enrollees are allowed a 90-day premium grace period, and enrollees under 100% FPL cannot be disenrolled for nonpayment of a premium, nor can an individual be denied an opportunity to re-enroll due to nonpayment of a premium. Individuals over 100% may be disenrolled for nonpayment but they can reapply. After 90 days, unpaid premiums may be considered a collectible debt owed to the State. Finally, the State will impose a copayment for non-emergency use of the emergency room consistent with Iowa’s Medicaid State Plan and with all federal requirements.

DWP enrollees over 50% FPL who have not completed a DWP healthy behavior in their first year of program enrollment will be charged a monthly dental premium, not to exceed $3, beginning in their second year of enrollment. Annual completion of the required healthy behaviors will waive an enrollee’s premium for the following year. Therefore, members who continue to complete the required healthy behaviors will never be subject to a monthly premium.

Enrollees with a premium obligation who fail to make monthly DWP premium payments will receive basic dental services as outlined in the ABP and State Plan for the remainder of the benefit year. The following eligibility groups continue to be exempt from DWP premiums, and will not have their benefits reduced in their second year of enrollment: (i) pregnant women; (ii) individuals whose medical assistance for services furnished in an institution is reduced by amounts reflecting available income other than required for personal needs; (iii) 1915(c) waiver enrollees; (iv) individuals receiving hospice care; (v) Indians who are eligible to receive or have received an item or service furnished by an Indian health care provider or through referral under contract health services; (vi) breast and cervical cancer treatment program enrollees; and (vii) medically exempt enrollees.

DELIVERY SYSTEM

Managed care organizations continue to be responsible for delivering all IWP covered benefits, with the exception of dental benefits, which are carved out and delivered to enrollees through a prepaid ambulatory health plan (PAHP).

Enrollment of Demonstration participants in managed care and the program is mandatory, with the exception of certain populations described in the State's §1915(b) Iowa High Quality Healthcare Initiative Waiver, and Alaskan Natives and American Indians are enrolled voluntarily. Excepted populations continue to receive services through the fee-for-service delivery system outlined in Iowa's Medicaid State Plan.

WAIVER AUTHORITY

The State requests continuation of all currently approved federal waivers. The only modification requested is a technical change to the waiver of retroactive eligibility to align with current program operations. Specifically, as implemented by DHS effective for applications received on or after July 1, 2018, in accordance with Iowa Senate File 2418, a period of up to three months of retroactive eligibility is provided for applicants who are residents of a nursing facility at the time of Medicaid application and are otherwise Medicaid-eligible.

EXPENDITURE AUTHORITY

There are currently no expenditure authorities required to implement the IWP and DWP. No federal expenditure authorities are requested with this Demonstration extension.

EVALUATION

The State intends to study the following research questions and hypotheses during the waiver extension period. These have been developed in alignment with the recent CMS release of evaluation design guidance for eligibility and coverage §1115 waivers, where applicable to the Iowa Wellness Plan.

Table 3: Proposed IWP Evaluation Parameters

Hypothesis	**Research Question(s)**
Waiver Policy: Premiums Tied to Healthy Behavior Requirements	
Goal: Improve enrollee health and wellness through the encouragement of healthy behaviors and	

Hypothesis	Research Question(s)
use of preventive services.	
The proportion of IWP enrollees who complete a wellness exam will be greater than among traditional Medicaid enrollees who do not have premiums tied to completion of healthy behaviors.	What are the effects of the premium incentive on Wellness Plan enrollees?
Waiver Policy: Non-Eligibility Periods (Disenrollment for Premium Non-Payment)	
Goal: Increase enrollee engagement and accountability in their health care.	
Medicaid beneficiaries subject to non-eligibility periods for noncompliance with program requirements will have higher rates of compliance with those requirements than other beneficiaries not facing non-eligibility periods.	Are beneficiaries subject to non-eligibility periods for noncompliance with program requirements more likely to comply with those requirements than other Medicaid beneficiaries not subject to non-eligibility periods?
	What are common barriers to compliance with program requirements that have non-eligibility period consequences for noncompliance?
Among beneficiaries who enroll in Medicaid, those subject to non-eligibility periods will have more continuous enrollment than those not subject to non-eligibility periods.	What is the likelihood of enrollment continuity for those subject to non-eligibility periods compared to other Medicaid beneficiaries?
Through greater continuity of coverage, health outcomes will be better for those subject to non-eligibility periods than for other Medicaid beneficiaries.	Do beneficiaries who are subject to non-eligibility periods have better health outcomes than other beneficiaries?
Waiver Policy: Waiver of Retroactive Eligibility	
Goal: Encourages individuals to obtain and maintain health insurance coverage, even when healthy.	
Eliminating retroactive eligibility will increase the likelihood of enrollment and enrollment continuity.	Do eligible people subject to retroactive eligibility waivers enroll in Medicaid at the same rates as other eligible people who have access to retroactive eligibility?
	What is the likelihood of enrollment continuity for those subject to a retroactive eligibility waiver compared to other Medicaid beneficiaries who have access to retroactive eligibility?
	Do beneficiaries subject to retroactive eligibility waivers who disenroll from Medicaid have shorter enrollment gaps than other beneficiaries who have access to retroactive eligibility?
Eliminating retroactive eligibility will increase enrollment of eligible people when they are healthy relative to those eligible people who have the option of retroactive eligibility.	Do newly enrolled beneficiaries subject to the waiver of retroactive eligibility have higher self-assessed health status than other newly enrolled beneficiaries who have access to retroactive eligibility

Hypothesis	Research Question(s)
Through greater continuity of coverage, health outcomes will be better for those subject to retroactive eligibility waivers compared to other Medicaid beneficiaries who have access to retroactive eligibility.	Do beneficiaries subject to the retroactive eligibility waiver have better health outcomes than other beneficiaries who have access to retroactive eligibility?
Elimination or reduction of retroactive coverage eligibility will not have adverse financial impacts on consumers.	Does the retroactive eligibility waiver lead to changes in the incidence of beneficiary medical debt?

Additionally, during the new Demonstration period, Iowa will maintain the original evaluation design of the DWP which studies the research questions as outlined in the table below.

Table 4: Proposed DWP Evaluation Parameters

Research Question	Hypothesis
What are the effects of DWP 2.0 on member access to care?	DWP 2.0 members will have equal or greater access to dental care than either DWP 1.0 or Medicaid State Plan (MSP) members had prior to May 1, 2017.
	DWP 2.0 members will be more likely to receive preventive dental care than either DWP 1.0 or MSP members were prior to May 1, 2017.
	DWP 2.0 members will have equal or lower use of emergency department services for non-traumatic dental care than either DWP 1.0 or MSP members had prior to May 1, 2017.
	DWP 2.0 members will have equal or better quality of care than either DWP 1.0 or MSP members did prior to May 1, 2017.
	DWP 2.0 members will report equal or greater satisfaction with the dental care provided than DWP 1.0 or MSP members did prior to May 1, 2017.
	DWP 2.0 members will report better understanding of their benefits when compared to the DWP 1.0 tiered structure.
	The earned benefit structure will not be perceived by members as a barrier to care in comparison to DWP 1.0.
What are provider attitudes towards the DWP?	The DWP 2.0 benefit structure will not be perceived by dentists as a barrier to providing care.
	Over 50% of DWP 2.0 providers will remain in the plan for at least 3 years.
What are the effects of the benefit structure –	The benefit structure for DWP 2.0 members will increase regular use of recall dental exams over the study period.

Research Question	Hypothesis
including healthy behavior requirements, cost sharing, and reduced benefits – on DWP member outcomes?	The benefit structure will not be seen as a barrier to care by DWP 2.0 members.
	In year 2 of the DWP 2.0 and beyond, use of preventive dental care will be higher than in the first year of the program.
	DWP 2.0 policies will promote member compliance with healthy behavior activities.
What are the effects of DWP member outreach and referral services?	DWP 2.0 member outreach services will address dentists' concerns about missed appointments.
	DWP 2.0 member referral services will improve access to specialty care for DWP 2.0 members as compared to MSP members prior to May 1, 2017.
	DWP 2.0 member outreach will improve DWP 2.0 members' compliance with follow-up visits, including recall exams, as compared to DWP 1.0 and MSP members
	DWP 2.0 member outreach will improve members' access to a regular source of dental care.

SUBMISSION OF COMMENTS

This notice and all waiver documents are available online at: https://dhs.iowa.gov/public-notices/iowa-wellness-plan. To reach all stakeholders, non-electronic copies will also be made available for review at DHS Field Offices. A complete listing of DHS Field Offices is provided as an Attachment to this notice. Written comments may be addressed to Anna Ruggle, Department of Human Services, Iowa Medicaid Enterprise, 611 Fifth Avenue, Des Moines, IA 50309. Comments may also be sent to the attention of: DHS, Iowa Health and Wellness Plan at: aruggle@dhs.state.ia.us through June 10, 2019. After the comment period has ended, a summary of comments received will be made available at: https://dhs.iowa.gov/public-notices/iowa-wellness-plan.

Submitted by:
Michael Randol
Iowa Medicaid Enterprise
Iowa Department of Human Services

Attachment: DHS Field Office Locations

County	Building Name	Building Address	City	Zip
Benton	Benton County DHS	114 E 4th Street	Vinton	52349
Black Hawk	Black Hawk County DHS	1407 Independence Ave.	Waterloo	50704
Buchanan	Buchanan County DHS	1415 1st Street West	Independence	50644
Buena Vista	Buena Vista County DHS	311 E. 5th Street	Storm Lake	50588
Butler	Butler County DHS	713 Elm Street	Allison	50602
Carroll	Carroll County DHS	608 N Court Street, Ste. C	Carroll	51401
Cass	Cass County DHS	601 Walnut Street	Atlantic	50022
Cerro Gordo	Cerro Gordo County DHS	Mohawk Square, 22 N Georgia Ave, Ste. 1	Mason City	50401
Clarke	Clarke County DHS	109 S Main	Osceola	50213
Clay	Clay County DHS	1900 North Grand Ave. Ste. E-8	Spencer	51301
Clinton	Clinton County DHS	121 Sixth Ave S.	Clinton	52733
Dallas	Dallas County DHS	25747 N. Avenue, Suite A	Adel	50003
Des Moines	Des Moines County DHS	560 Division Street, Suite 200	Burlington	52601
Dickinson	Dickinson County DHS	Dickinson County Courthouse 1802 Hill Ave, Suite 2401	Spirit Lake	51360
Dubuque	Dubuque County DHS	410 Nesler Center, 799 Main Street	Dubuque	52004
Emmet	Emmet County DHS	220 S 1st Street	Estherville	51334
Fayette	Fayette County DHS	129 A North Vine	West Union	52175
Floyd	Floyd County DHS	1206 S Main Street	Charles City	50616
Hamilton	Hamilton County DHS	2300 Superior Street	Webster City	50595
Harrison	Harrison County DHS	204 E 6th St	Logan	51546
Henry	Henry County DHS	205 W Madison Street	Mt. Pleasant	52641
Jasper	Jasper County DHS	115 N 2nd Ave E. Suite H	Newton	50208
Jefferson	Jefferson County DHS	304 South Maple	Fairfield	52556
Johnson	Johnson County DHS	855 S. Dubuque Street	Iowa City	52240
Lee	Lee County DHS	933 Avenue H	Ft. Madison	52627
Lee	Lee County DHS	307 Bank Street	Keokuk	52632
Linn	Linn County DHS	411 3rd Street SE, Suite 600	Cedar Rapids	52401
Linn	Linn County DHS, Harambee House	404 17th Street Southeast	Cedar Rapids	52403
Mahaska	Mahaska County DHS	410 S 11th Street	Oskaloosa	52577
Marshall	Marshall County DHS	206 W State Street	Marshalltown	50158
Montgomery	Montgomery County DHS	1109 Highland Ave	Red Oak	51566
Muscatine	Muscatine County DHS	3210 Harmony Lane	Muscatine	52653

County	Building Name	Building Address	City	Zip
O’Brien	O'Brien County DHS	160 Second Street Se	Primghar	51245
Polk	Polk County DHS	Polk County River Place, 2309 Euclid Ave	Des Moines	50310
Polk	Polk County DHS- Carpenter Office	1900-1914 Carpenter	Des Moines	50314
Polk	Centralized Service Intake Unit	401 SW 7th St, Suite G	Des Moines	50309
Pottawattamie	Pottawattamie County DHS	417 E Kanesville Blvd.	Council Bluffs	51503
Pottawattamie	Income Maintenance Customer Call Center	300 W Broadway, Suite 110	Council Bluffs	51503
Scott	Scott County DHS	600 W. 4th St. 2nd & 3rd Floors	Davenport	52801
Sioux	Sioux County DHS	215 Central Ave. Se	Orange City	50141
Story	Story County DHS	126 S Kellogg Ave, Suite 101	Ames	50010
Union	Union County DHS (SVC)	304 N Pine St	Creston	50801
Union	Union County DHS	300 N Pine St	Creston	50801
Wapello	Wapello County DHS	120 E Main St	Ottumwa	52501
Warren	Warren County DHS	1005 South Jefferson Way	Indianola	50125
Webster	Webster County DHS	330 1st Ave. N	Fort Dodge	50501
Winneshiek	Winneshiek County DHS	2307 US Highway 52 South	Decorah	52101
Woodbury	Woodbury County DHS	Trosper-Hoyt Co Svc Bld., 822 Douglas St	Sioux City	51101

APPENDIX E3: Tribal Notice

NOTICE OF IOWA DEPARTMENT OF HUMAN SERVICES TRIBAL COMMENT PERIOD FOR IOWA WELLNESS PLAN EXTENSION

Notice is hereby given to all federally recognized tribes, Indian Health Programs and Urban Indian Organizations within the State of Iowa that the Iowa Department of Human Services (DHS) will be submitting a request to the Centers for Medicare and Medicaid Services (CMS) to extend the §1115 Iowa Wellness Plan Demonstration Waiver, which is set to expire December 31, 2019. DHS is proposing to extend this waiver for an additional five years pursuant to §1115(e) and §1915(h)(2) of the Social Security Act.

PROPOSAL

The Iowa Wellness Plan is a Medicaid program that was created to provide comprehensive health care coverage to low-income, uninsured Iowans ages 19 to 64. DHS is seeking to extend the Demonstration for another five years with no substantive changes. The only modification requested is a technical change to the special terms and conditions (STCs) to align with current program operations for retroactive eligibility. Specifically, as implemented by DHS effective for applications received on or after July 1, 2018, in accordance with Iowa Senate File 2418, a period of up to three months of retroactive eligibility is provided for applicants who are residents of a nursing facility at the time of Medicaid application and are otherwise Medicaid-eligible. Tribal notice was originally provided at the time of this programmatic change in July 2018.

TRIBAL IMPACT

American Indian and Alaskan Native (AI/AN) populations located in the State of Iowa will continue to receive services through the Iowa Wellness Plan and will be able to voluntarily enroll in the managed care delivery system. Dental benefits will continue to be delivered to Demonstration enrollees through a prepaid ambulatory health plan (PAHP). Additionally, AI/AN enrollees will continue to have coverage with no cost sharing or premium obligation. To address AI/AN members and providers who voluntarily elect to participate in managed care, DHS contracts with participating MCOs and PAHPs include protections for Indian health care providers participating in Medicaid as required pursuant to Section 5006(d) of the American Recovery and Reinvestment Act of 2009 (AARA).

SUBMISSION OF COMMENTS

A copy of the waiver application and relevant attachments are included with this notice. Written comments may be addressed to Alisa Horn, Department of Human Services, Iowa Medicaid Enterprise, 611 Fifth Avenue, Des Moines, IA 50309. Comments may also be sent via electronic mail to ahorn@dhs.state.ia.us. DHS would be happy to schedule a phone or in-person consultation to discuss the amendment in further detail. All comments must be received by May 29, 2019.

Submitted by:

Michael Randol, Medicaid Director
Iowa Medicaid Enterprise
Iowa Department of Human Services

INITIAL REVIEW DRAFT

SUBMITTED: April 2019

Healthy Behaviors Program Evaluation
Interim Summative Report

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Background

The Iowa Health and Wellness Plan (IHAWP) is Iowa's version of the Medicaid expansion, approved by the federal government under a Section 1115 Demonstration waiver. Enrollment into IHAWP began on January 1, 2014. The IHAWP replaced IowaCare, a limited coverage program for adults age 19-64 with incomes from 0-200% Federal Poverty Level (FPL) who were not categorically eligible for Medicaid, expanding health care service coverage while reducing the upper end of the eligibility spectrum from 200% to 138% FPL (133% with a 5% income disregard). Originally, the IHAWP included two separate plans: 1) the Wellness Plan (WP) and the Marketplace Choice Plan (MPC). The WP was a more traditional, Medicaid-like program for adults with incomes from 0-100% of the Federal Poverty Level (FPL) who were not eligible for Medicaid through a categorical program such as Family Medical Assistance Plan (FMAP) or Medicaid for Employed People with Disabilities (MEPD). In MPC, individuals with incomes from 101-138% FPL selected a Qualified Health Plan (QHP) from eligible private plans in Iowa's Health Insurance Marketplace, and Medicaid paid the premiums.

One feature of the IHAWP that is unique for a Medicaid plan is the healthy behaviors incentive program (HBP). IHAWP members can avoid paying a premium for their insurance after their first year of coverage by participating in the HBP. The HBP requires members to have a yearly medical or dental exam (a wellness visit) and complete a health risk assessment (HRA) in order to avoid paying a premium in the following year. If the member does not complete these requirements during their first year of coverage, they may be required to pay a monthly premium ($5 or $10, depending on income). Due to a lack of participating insurers in Iowa's Health Insurance Marketplace, MPC members were transitioned to the WP in 2015 and the 1115 waiver for the MPC program was not renewed. The transition to the three Medicaid Managed Care Organizations (MCOs) was implemented on April 1, 2016.

Introduction

This summative report on the Healthy Behaviors Program (HBP) provides an outline of the analyses and results that have been conducted as of April 1, 2019.

The Healthy Behaviors Program

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

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

Starting in 2015, a small monthly contribution by the member may be required depending on family income, although there are no copayments for health care services and prescriptions under the plan. Members with incomes between 51

– 100% FPL would contribute $5 per month, while members with incomes between 101 – 138% FPL would contribute $10 per month. Members with individual earnings less than 51 percent of the Federal Poverty Level ($6,191 per year for an individual, or $8,395 for a family of 2 in 2018) would not have monthly contributions. IHAWP members who completed the wellness exam and the HRA would not be responsible for a monthly contribution. Additionally, members could claim a financial hardship to avoid paying a contribution. This hardship must be claimed on a monthly basis. Communication efforts to inform members and providers about the healthy behaviors program included mailings to members, toolkits for providers, and a website.

Members earning over 50% of the FPL are given a 30-day grace period after the enrollment year to complete the healthy behaviors (wellness exam and HRA) in order to have the contribution waived. If members do not complete the behaviors after the grace period has ended, members would receive a billing statement and a request for a hardship exemption form. For members with incomes at or below 100% FPL, all unpaid contributions would be considered a debt owed to the State of Iowa, but would not result in termination from the program. If, at the time of reenrollment, the member did not reapply for or was no longer eligible for Medicaid coverage and had no claims for services after the last premium payment, the member's debt would be forgiven. For members with incomes between 101 – 138% FPL, unpaid contributions after 90 days would result in the termination of the member's enrollment status. The member's outstanding contributions would be considered a collectable debt and subject to recovery. A member whose Medicaid benefits were terminated for nonpayment of monthly contributions must reapply for Medicaid coverage. Iowa's established and federally approved Medicaid waiver policy allows the member to reapply at any time; however, the member's outstanding contribution payments will remain subject to recovery.

Wellness Exam

The wellness exam is an annual preventive visit (New Patient CPT Codes: 99385 18-39 years of age, 99386 40-64 years of age; Established Patient CPT Codes: 99395 18-39 years of age, 99396 40-64 years of age) from any plan-enrolled physician, Rural Health Clinic (RHC), Federally Qualified Health Center (FQHC) or Advanced Registered Nurse Practitioner (ARNP). The exams are part of the preventive services covered by the plans and therefore do not cost the member anything out-of-pocket. A 'sick visit' or chronic care visit could count towards the requirement of the preventive exam, if wellness visit components were included and the billing code modifier 25 was used. Starting in January of 2015, members could also complete a preventive dental exam to fulfill this requirement. The following dental codes were included: D0120 periodic oral evaluation, D0140 limited oral examination, D0150 comprehensive oral examination, and D0180 comprehensive periodontal exam.

Health Risk Assessment

A health risk assessment (HRA) is a survey tool that can be used by members and providers to evaluate a member's health. IME identified Assess My Health as one such tool, although providers could select their own tool if it asked similar questions. Assess My Health is an online form that takes members between 15 and 40 minutes to complete. HRA information could be used by providers to develop plans addressing member needs related to health risks. The HRA could be completed online at any location, including the health care provider's office. Clinics could contact patients to fill out the HRA over the phone, with the clinic inputting the data into the online system. After the transition to statewide managed care, each managed care organization (MCO) was able to use their own health risk assessment or screening, as the MCOs referred to them.

Provider Incentives

Providers also had incentives available to them, so that they could encourage and support their patients in completing the wellness exam and HRA. Providers should have been assisting members with the HRA before or during their wellness exam. For every Wellness Plan member who completes the HRA with the assistance of the provider, the provider would receive $25.00. The only HRA which qualified for this incentive was the Assess My Health tool. Provider incentives were not part of the contractual agreements with the MCOs.

Further Behavior Incentives

A program of incentives was to be developed to encourage behavior change among enrollees. To participate in this part of the program, the member must have completed the wellness exam and the HRA, unless they were below 50% of the FPL or were Medically Exempt status. This program was not implemented.

Factors influencing the evaluation of the Healthy Behaviors Program

The table below outlines factors that have influenced the evaluation of the program. It is important to understand these factors as they impact the evaluation. First, some evaluation activities were eliminated or altered to respond to these factors and second these factors provide the reader with a lens to interpret evaluation findings.

Table 1. Factors influencing the evaluation of the Healthy Behaviors Program

Planned implementation	Actual implementation
Wellness exam was defined as CPT codes 99385, 99386, 99395, and 99396 or a "sick visit" with a modifier code of 25.	Additionally, members could report having a wellness exam without documentation. Beginning in year 2 a preventive dental exam also fulfilled the requirement.
Members needed to complete the Assess My Health HRA tool. The data would be available to IME, providers, and members.	This information is not shared with the providers or the members. Each MCO has a different screening or risk assessment tool. This information is not shared with IME, the providers or the members.
A communication campaign would ensure members, providers, and clinic staff awareness and knowledge of the program.	There were limited communication efforts, which resulted in low levels of awareness and knowledge.
The Marketplace Choice plan would provide members with insurers from which to select.	The MPC members were converted to the Wellness Plan when both QHPs were no longer participating in the IHAWP.
Members were to be disenrolled for non-payment of contribution and not completing the HRA and wellness exam.	Systems were not in place to make disenrollment possible until the 4th quarter of the 2nd year.
Intended to contract with vendor was supposed to implement a program to incentivize members to complete other behaviors.	A Request for Proposal was issued, but no suitable vendor was found. Following the transition to statewide managed care, the MCOs offered "value added benefits," such as rewards programs that served the purpose of incentivizing members to complete behaviors.
Providers were to receive incentives to encourage patients to complete HBP.	MCOs were not contractually required to implement a provider incentive program related to completion of the HBP.
Members could complete HRA online with/out provider.	Members could report having completed an HRA without documentation. Some health systems helped members complete the HRA over the telephone.
Members were supposed to complete the wellness exam and the HRA to be eligible for the additional incentivized behaviors.	Any MCO member can participate in the MCO's rewards program.

Operationalization of Research Questions and Hypotheses

Understanding the effects of new programs on the access to health care, utilization of health care, and outcomes of health care is a complex undertaking requiring a variety of methods and analytical approaches. This evaluation incorporates population-based outcomes as well as individual assessments in an attempt to provide a balanced evaluation. The evaluation design has evolved to be responsive to changes in program implementation and data availability. The table below outlines all the originally proposed research questions, hypotheses, and measures (Table 2). We have indicated if these data will be presented in the final report. If the data will not be available for the final report, we have outlined reasons for deviating from the original proposal. A version of the table with the protocols, data sources, and analyses for each measure is provided in the appendix.

Table 2. A comparison of proposed research questions, hypotheses, and measures with data available for summative report

Hypothesis	Measures	Inclusion in final report	Reasons for modifying original plan
1. Which activities do enrollees complete?			
1.1: The proportion of Wellness Plan (WP) members and Marketplace Choice (MPC) members who complete a wellness exam is greater than the proportion of Medicaid State Plan (MSP) or IowaCare members who complete an exam.	Measure 1: Proportion of members who had a preventive care visit	We presented DHS data on the proportion of members with a "well visit" that qualified for the HBP. We examined the differences between IHAWP members based on income level and do not make comparisons between IHAWP members and MSP or IowaCare.	We also included data on the proportion of members who complete both HBP behaviors (well exam and HRA) and compare those proportions by income level. We had to move from examining the differences between WP/MPC to income levels, because the programs merged, and we do not make comparisons to MSP and IowaCare, because DHS does not track wellness exams or HRAs in those groups
1.2: The proportion of WP/MPC members who complete a Health Risk Assessment is greater than 50%.	Measure 2: Proportion of WP/MPC members completing HRA	We presented data on the proportion of members completing the HRA and compare the members by income level.	We had to move from examining the differences between WP/MPC to income levels, because the programs merged.

Hypothesis	Measures	Inclusion in final report	Reasons for modifying original plan
1.3: The proportion of WP/MPC members who are eligible to participate complete at least one behavior incentive is greater than 50%.	Measure 3: Whether a WP/MPC member completed a healthy behavior	We are currently not able to present these data because we do not have data on additional healthy behaviors. This part of the program was delayed in implementation. The MCO data related to value added/rewards behavior has not been provided to us.	While it is our understanding that the MCOs are now operating incentive programs, we do not have data on these. Thus, we examined the proportion of WP and MPC members who completed both activities (wellness exam and HRA).
1.4: Members (WP/MPC) are most likely to complete the behaviors that require the least amount of effort.	Measure 4: Respondent report of how easy it is for them to obtain a yearly physical exam	We provided this information.	
1.5: Members (WP/MPC) will be least likely to complete incentivized behaviors requiring sustained participation.	Measure 5: Completion of healthy behavior by perceived sustained effort	We are unable to complete this because we have no data on additional healthy behaviors.	We had self-report data from the member survey, but there were not enough people who have completed the behaviors to examine specific behaviors. The MCO programs also do not incentivize for the same behaviors, so comparisons are not possible.
1.6: Member (WP/MPC) will be most likely to complete incentivized behaviors with the largest real or perceived value.	Measure 6: Completion of healthy behavior by value of behavior Measure 7: Completion of healthy behavior by value of incentive	We are not able to assess perceived value on additional behaviors because we do not have information about specific behaviors. We do not have specific information about incentives available through the MCOs.	We collected data on perceived value of a well exam and an HRA and reported on these perceptions.

Hypothesis	Measures	Inclusion in final report	Reasons for modifying original plan
2. What personal characteristics are predictive of completing at least one behavior incentive, and the number (or extent) of behavior incentives completed?			
2.1: Members (WP/MPC) who have heard of the program from their health care provider are more likely to complete at least 1 behavior.	Measure 8: Reported completion of healthy behavior by source of information	We have reported on this.	
2.2: Members (WP/MPC) who are young, white, female, and/or live in metro areas are more likely to complete at least 1 behavior.	Measure 9: Completion of healthy behavior by demographic characteristics	We presented these data.	
2.3: Members (WP/MPC) with poorer health status are less likely to complete behaviors compared to members with better health status.	Measure 10: Health Status by completion of healthy behavior	We presented these data using #Rx, #ED visits and count of chronic conditions as measure of health status.	
2.4: Members who do not pay a contribution (WP members less than 50% FPL) are least likely to complete behaviors compared to those who pay a contribution.	Measure 11: Proportion of members who complete the healthy behaviors prior to the application of the premium payment Measure 12: Proportion of members who complete the healthy behaviors only after the application of the premium payment Measure 13: Proportion of members who are	We did not present these data on completion of the behaviors after application of the premium payment, because we are not aware of who is not required to pay the premium because of a hardship.	

Hypothesis	Measures	Inclusion in final report	Reasons for modifying original plan
	disenrolled due to the application of a premium payment as a result of not completing the healthy behaviors		
2.5: Members (WP/MPC) receiving care at federally qualified health centers, rural health clinics, and public hospitals will be more likely to participate in the incentive programs than enrollees receiving care in other settings.	Measure 14: Completion of healthy behavior by type of provider	Medicaid claims data received from IME are missing a significant amount of data in the provider type and provider specialty fields needed to identify site of care. Therefore, we did not conduct claims-based analyses to predict completion of wellness exams, HRAs, and both, and thus, do not present this outcome.	We reported data from the member telephone survey asking about the use of FQHCs.
3. Is engaging in behavior incentives associated with improved access to care and health outcomes?			
3.1: The program will improve WP/MPC members' access to health care.	Measure 15: Adults access to primary care 15A Percent of members who had an ambulatory care visit 15B Whether a member had an ambulatory or preventive care visit Measure 16: Access to and unmet need for urgent care Measure 17: Access to and unmet need for routine care	We presented measure 15A, 20A, 21A, and 23 as proposed and 15B, 20B, and 21B using a DID approach.	We did not report on measures 15B, 20B, or 21B using RDD because RDD is not an appropriate analysis based on the outcome and the data. We used the member survey to report measures 17, 18 and 24. However, we will not conduct quantitative analyses of these measures (beyond descriptive statistics), because of concerns about collinearity (i.e., participating in the HBP requires completion of the wellness exam which means by definition

Hypothesis	Measures	Inclusion in final report	Reasons for modifying original plan
	Measure 18: Getting timely appointments, care, and information		members will have access to primary care, have a preventive visit, etc.).
	Measure 19: Prescription medication, access to and unmet need for prescription medication		
	Measure 20: Comprehensive diabetes care: Hemoglobin A1c		
	20A Percent of members with type 1 or type 2 diabetes who had Hemoglobin A1c testing		
	20B Whether a member with type 1 or type 2 diabetes had Hemoglobin A1c testing		
	Measure 21: Comprehensive diabetes care: LDL-C screening		
	21A Percent of members with type 1 or type 2 diabetes who had LDL-C screening		
	21B Whether a member with type 1 or type 2 diabetes had LDL-C screening		
	Measure 22: Preventive care		

Hypothesis	Measures	Inclusion in final report	Reasons for modifying original plan
	Access to and unmet need for preventive care Measure 23 Ambulatory Care Measure 24 Regular source of care – Personal Doctor The percent who respond that they currently have a personal doctor		
3.2: Health outcomes of WP/MPC members will be positively impacted by completing the healthy behaviors.	Measure 25: Non-emergent ED use 25A Number of non-emergent ED visits per 1,000 member months 25B Whether member had a non-emergent ED visit Measure 26: Follow-up ED visits 26A Percent of members with ED visit within the first 30 days after index ED visit 26B Whether member had an ED visit within the first 30 days after index ED visit	We reported measures 25A, 26A, 26B, 30, 31, and 32 as proposed, and measure 25B using a DID approach.	We did not report on measure 25B using RDD because RDD is not an appropriate analysis based on the outcome and the data. We did not report on measures 27, 28A, 28B, 29A, or 29B due to a lack of admissions for these conditions.

Hypothesis	Measures	Inclusion in final report	Reasons for modifying original plan
	Measure 27: Admission rate for diabetes short-term complications, and asthma The number of discharges for short-term complications from diabetes or asthma per 100,000 Medicaid members Measure 28: Admission rate for diabetes short-term complications 28A Number of discharges for diabetes short-term complications per 100,000 Medicaid members 28B Whether member had an admission for diabetes short-term complications Measure 29: Admission rate for asthma 29A Number of discharges for asthma per 100,000 Medicaid members 29B Whether member had an admission for asthma Measure: 30 Inpatient utilization-general hospital/acute care		

Hypothesis	Measures	Inclusion in final report	Reasons for modifying original plan
	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 Measure 31: Plan "all cause" hospital readmissions For members age 19-64 years who were enrolled for at least on month during the measurement year, the number of acute inpatient stays during the measurement year that were followed by an acute readmission for any diagnosis within 30 days and the predicted probability of an acute readmission Measure 32: Rate of 30 day hospital readmissions 30 day readmissions reported in last 6 months		
4. What are the effects of the program on health care providers?			
4.1 Providers use the information from the Health Risk Assessment	Measure 33: Provider reported use of HRA	We were unable to present these data due to the very low awareness of the program.	In-depth interviews with clinic managers (the person in the practice most likely to know about the program)

Hypothesis	Measures	Inclusion in final report	Reasons for modifying original plan
	33A Percent of providers who report using HRA 33B How providers use the HRA		indicated very low levels of awareness and high levels of confusion. It was not possible to design a survey to ask responses about a program that providers were unaware of.
4.2 Providers are encouraging patients to participate in the behavior incentive program	Measure 34: Percent of providers reporting encouraging patients to participate Measure 35: Enrollees report providers encouraging them to participate Measure 35A Percent of enrollees who report provider encouraged participation Measure 35B Percent of enrollees who reported participation	We were unable to report all these data, because the provider survey was not possible. We reported on the enrollee survey about where they heard about the program.	
4.3 Providers ae receiving their additional reimbursement	Measure 36: Percent of providers reporting reimbursement	We did not report on these data because the provider survey was not possible.	
4.4 Providers are more likely to use the HRA with Wellness Plan members compared to Marketplace Choice Plan members	Measure 37: Provider reporting using HRA Measure 37A Percent of providers who use HRA with Wellness Plan and Market Choice Plan members Measure 37B Providers reporting on using HRA	We did not report on the percent of providers using the HRA because the lack of awareness made the survey impossible to field.	In-depth interviews indicate that the HRA were not being used by providers.

Hypothesis	Measures	Inclusion in final report	Reasons for modifying original plan
4.5 The HRA changes communication between the provider and patient	Measure 38: Providers reported changes in communication with patients	We did not report on these because a provider survey was not possible.	
4.6 The HRA changes provider treatment plans	Measure 39: Provider reported changes in treatment plans due to HRA	We did not report on these because a provider survey was not possible.	
4.7 There are barriers to providers using the HRA information	Measure 40: Provider reported barriers to using the HRA information.	We were unable to report on these data because we did not identify providers or practices that use the HRA information.	
5. What are the effects of HBI on Medicaid costs?			
5.1 Costs of the program do not exceed the savings	Measure 41: Compare PMPM costs for those who have and have not completed the healthy behaviors in the Iowa Health and Wellness Plan and those in the Medicaid State Plan	We do not report these data.	Due to the move to Medicaid managed care, the State determined that these analyses would no longer be conducted as part of this evaluation.
6. What are the implications of disenrollment?			
6.1 Disenrolled members do not understand the disenrollment process	Measure 42: Disenrolled member reported understanding disenrollment process	We reported on these data.	
6.2 Disenrolled members do not understand premiums.	Measure 43: Disenrolled members reported understanding premiums	We reported on these data.	
6.3 Disenrolled members do not understand the HBP	Measure 44: Disenrolled members do not understand the HBP	We reported on these data.	

Hypothesis	Measures	Inclusion in final report	Reasons for modifying original plan
6.4 Disenrolled members find it difficult to meet their health needs	Measure 45: Disenrolled member ability to meet health needs.	We reported on these data.	
6.5 Disenrolled members are unable to re-enroll due to administration issues	Measure 46: Disenrolled member reporting of challenges related to re-enrollment	We reported on these data.	
7. What are members' knowledge and perceptions of the HBP?			
7.1 Members (WP/MPC) will value incentives offered to complete the healthy behaviors.	Measure 47: Members assigned value of the program and behaviors	We reported on these data.	We were limited by the few enrollees who actually completed the behaviors.
7.2 Members (WP/MPC) will be most willing to complete behaviors that have lower costs/barriers compared to those with higher benefits and relevance.	Measure 48: Members assessment of costs, barriers and benefits to program participation. Measure 48A Members indicate cost Measure 48B Members indicate barriers Measure 48C Members indicate benefits	We reported on these data.	We were limited by the small number of program participants.
7.3 Members (WP/MPC) with a greater sense of locus of control will be more willing to participate.	Measure 49: Members' perceived locus of control	We reported on these data.	We were unable to use a full-validated scale to measure locus of control due to survey length and respondent burden. We used one question. Additionally, we have used this measure in the in-depth interviews and found high levels of locus of control, which might make it difficult to

Hypothesis	Measures	Inclusion in final report	Reasons for modifying original plan
			have the variation we need.
7.4 Members (WP/MPC) understand the logistics (for example—payment, payment options, requirements of the program, …) of the HBP	Measure 50: Members' knowledge of program requirement Measure 51: Members' knowledge of payment process	We reported on these data.	
7.5 Members (WP/MPC) understand the purpose of the HPB and how it is supposed to influence their behavior.	Measure 52: Members' knowledge of the purpose of HBP Measure 53: Members' understanding of how the program influences behavior.	We reported on these data	
7.6 Members (WP/MPC) do not report difficulties paying premiums related to payment form accepted by IME	Measure 54: Members' experience with premium payment mechanism	We reported on these data	
8. What are the experiences of the ACOs related to the HBP?			
8.1 ACOs experience barriers to reaching targets for wellness exams and HRA	Measure 55: Type and number of barriers to reaching targets for wellness exams and HRA	We did not have these data.	With the move to managed care, ACOs would not play a significant role in the program.
8.2 ACOs promote the HBP	Measure 56: Type and level of promotion	We did not have these data.	With the move to managed care, ACOs would not play a significant role in the program.

Hypothesis	Measures	Inclusion in final report	Reasons for modifying original plan
8.3 ACOs experience advantages and success from the HBP.	Measure 57: Advantages and successes reported from the HBP	We did not have these data.	With the move to managed care, ACOs would not play a significant role in the program.

Methods

The original evaluation proposal included 8 research questions encompassing 34 hypotheses operationalized by 69 measures. General descriptions of the methods used to analyze these questions are listed below. Technical descriptions of the methods used to date may be found in individual reports at http://ppc.uiowa.edu/publications/healthy-behaviors-incentive-program-evaluation.

Data Sources and data collection

Administrative data

The Iowa evaluation provides a unique opportunity to optimize several sources of data to assess the effects of innovative coverage options. The Public Policy Center 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. The database allows members to be followed for long periods of time over both consecutive enrollment months and periods before and after gaps in coverage. When the enrollment database was started in 1965, Iowa made a commitment to retain a member number for at least 3 years and to never reuse the same Medicaid ID number. This allows long term linkage of member information including enrollment, cost and utilization. We also maximize the use of outcome measures derived through administrative data manipulation using nationally recognized protocols from the National Quality Forum (NQF) and National Committee on Quality Assurance (NCQA) HEDIS.

Healthy behavior data

While some data on the completion of the wellness exam are available to the team through the Medicaid administrative claims database, the fact that members could call in to report receipt of a wellness exam and/or completion of an HRA led us to rely exclusively on data from IME to determine if a wellness exam was received and/or a Health Risk Assessment was completed. We do not have access to the MCO value added/rewards data, which would indicate if someone had participated in behaviors in addition to the wellness exam or HRA. The use of these data also means that we were unable to compare healthy behavior completion rates among members of IowaCare or the Medicaid State Plan.

Qualitative and quantitative consumer data

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

Qualitative data collection enables us to capture member and clinic experiences for an in-depth examination of program implementation. The interviews explored enrollees' knowledge, perception and experience with the healthy behavior incentive program. Enrollees were sent a recruitment letter asking them to participate in an in-depth telephone interview. Interviews were transcribed and coded to distill the information relevant to the evaluation.

Interviews were conducted with enrollees (n = 152), in 2015. We invited 468 enrollees to participate. The sample was stratified by gender, age, income, and race/ethnicity to ensure the data included the widest range of experiences. Clinic managers (n = 52) were interviewed in 2015. Clinic managers were selected to interview in place of providers because clinic managers were more likely to know about insurance, Medicaid and other programs. They were also more likely to

have received the communication from IME about the program. We interviewed members who were disenrolled during the first disenrollment period and members who had been more recently disenrolled. We invited all members who had been disenrolled 3 months prior and had a telephone number to participate in the interviews. Members (n = 37) who had been disenrolled in late 2015/early 2016 were interviewed. Members (n = 34) who had been disenrolled in early 2017 were interviewed. We did not conduct interviews with ACOs because of the transition to managed care. With many unknowns about the HBP during the transition, the data gathered would not have been useful to understanding the HBP.

Survey data

To inform the development of the survey items, qualitative data collection was conducted before each survey was designed. The qualitative data provided information about experiences, perceptions, barriers, and motivators needed in order to ensure the survey items and response categories reflect the enrollees' experiences. The surveys include CAHPS measures and supplemental items. The supplemental items address issues specific to the healthy behaviors. We assess enrollees' awareness of the program and its components, including their overall perceptions of the program. Barriers and motivators to completing the specific behaviors will be documented. We include several demographic and self-reported health items to be used as adjustment variables in the analyses.

2017 Disenrollment Survey

The 2017 IWP Disenrollment Survey was conducted between June and December of 2017. Surveys were mailed on a rolling monthly basis to members who were disenrolled from the IWP program for non-payment in the prior three months. For example, surveys mailed in June were sent to members who had been disenrolled on March 1.

The monthly samples were drawn from Medicaid enrollment data. Individuals who had participated in previous evaluations were excluded from the sample. Individuals who had been disenrolled for failure to pay the IWP premium were identified through discontinuance data provided monthly and matched back to enrollment data to provide names and mailing addresses. In some cases, surveys were sent to multiple members in one household. The monthly groups varied in size as the monthly number of disenrolled members changed (Table 3).

Table 3. Sample Size for 2017 Disenrollment Survey by Survey Month & Disenrollment Month

Survey Month (Disenrollment Month)	n
June (March)	130
July (April)	150
August (May)	2
September (June)	338
October (July)	229
Total	849

Survey packets were initially mailed to each group on the second Wednesday of the month. The packets included the survey and a cover letter, which described the survey, stated that participation was completely voluntary, and provided a phone number to ask questions or opt out of the study. Respondents were given the option to complete the survey on paper or online by entering a unique access code. To maximize response rates for the survey, both a premium and an incentive were used: each initial packet included a $2 bill, and respondents who returned a completed the survey were sent a $20 Wal-Mart gift card.

One week after the initial survey packets were mailed, a postcard reminder was sent. Four weeks after the initial mailing, a reminder survey packet was sent to those who had not returned a completed survey.

2017 Enrollee Survey

The 2017 Survey of IHWAP members was conducted between July and September 2017 using computer assisted telephone interviewing. The purpose of the survey was to document member awareness of the HBP, knowledge of the program, perceptions of the program, and experiences with completing the behaviors and paying premiums.

The sample was drawn from Medicaid enrollment data current as of July 2017. The stratified random sample of IHAWP members included individuals who had been in their current plan for at least the previous fourteen months, June 2016 to July 2017. Individuals who had participated in previous evaluations and individuals without valid telephone numbers were excluded from the sample. Only one person was selected per household to reduce the relatedness of the responses and respondent burden. The sample was first stratified by completion of healthy behaviors (completed none, completed HRA, completed wellness exam, and completed both), then by FPL (0-50%, 51-100%, and 101-133%) and finally by MCO. The final sample was comprised of 6,000 IHWAP members: 2,000 from each of the three MCOs with equal numbers of members in the stratification groups (completion healthy behaviors and FPL).

Letters introducing the study were mailed to potential respondents. The introductory letter described the evaluation, stated why the respondent was being invited to participate, and ensured the participants of the anonymity of their responses. The letter stated that participation was completely voluntary, that refusal would not lead to any penalty or lost benefits, and provided a telephone number to ask questions, update their contact information, or opt out of the study. In an effort to maximize response rates for the survey, both a premium and an incentive were used: each introductory letter included a $2 bill, and respondents who completed the survey when contacted over the telephone were sent a $10 Wal-Mart gift card.

Interviews were conducted by the Iowa Social Science Research Center at The University of Iowa. All interviewers were trained on the purpose of the evaluation, human subjects research protections, and the survey instrument. Following the training, telephone calls were made to each sampled IHAWP member, the evaluation was introduced, the confidentiality of all responses and voluntary nature of participation was explained, informed consent was obtained, and either the interview was conducted or an alternate time to complete the interview was arranged. The survey consisted of 66 questions and took approximately twenty minutes to complete.

There were 1,375 IHAWP members who responded to the survey. The AAPOR standard Response Rate 3 (an industry standard for best practices in calculating response rates for telephone data collection projects of this nature) was 32.3%.

2018 Enrollee Survey

The 2018 Survey of IWP members was conducted between September and October 2018 using computer-assisted telephone interviewing to document member awareness of the HBP, knowledge of program specifics, perceptions of the program, and experiences with completing the activities and/or paying premiums. The sample was drawn from members who had completed the 2017 survey of IWP members. Of the 1375 respondents to the 2017 survey, the research team identified 1102 individuals who maintained IWP enrollment in 2018, had complete information for both periods, and were otherwise eligible. Results from this type of sampling provides a unique look into program experiences over time for one group of members, it does not indicate the experiences of all members or provide for comparisons within the program across time generally.

Letters introducing the study were mailed to potential respondents. To maximize survey response rates, both a premium and an incentive were used: each introductory letter included a $2 bill, and respondents who completed the survey were sent a $10 Wal-Mart gift card.

Interviews were conducted by the Iowa Social Science Research Center at The University of Iowa. All interviewers were trained on the purpose of the evaluation, human subjects research protections, and the survey instrument. Following the training, telephone calls were made to each sampled IWP member, the evaluation was introduced, the confidentiality of all responses and voluntary nature of participation was explained, informed consent was obtained, and the interview was either conducted then or scheduled for an alternate time. The survey consisted of 48 questions and took approximately twenty minutes to complete.

There were 641 IWP members who responded to the survey and had complete interviews. There was one IWP member who completed partial interviews, 56 who refused or broke off the interview, 303 who could not be contacted or were unable to complete the interview for other reasons, 9 who were not eligible, and 92 who had problem telephone numbers. Based on this, the AAPOR standard Response Rate 3 (an industry standard for best practices in calculating response rates for telephone data collection projects of this nature) was 64%. For more information on how the response rate was calculated, see https://www.aapor.org/Standards-Ethics/Standard-Definitions-(1).aspx.

Linking of survey data to claims data

The team will continue to explore the possibilities of linking survey data with claims data.

Research Design

This evaluation employs multiple levels of analyses, using quantitative and qualitative data. First, where data permit, univariate and bivariate analyses are used to compare descriptive characteristics. Second, simple rate comparisons are computed for population-based outcomes, to demonstrate differences in trends between groups. Finally, for hypotheses related to utilization, we utilize more sophisticated analytic approaches including difference-in-differences estimation (DID). While Iowa is very fortunate to have more comparable data and comparison populations over time than many other states (e.g., IowaCare), there are still limitations to the comparability across populations due to income, categorical eligibility, and health status. Unfortunately, while we had proposed an analysis that leveraged two comparison groups— IowaCare and Medicaid State Plan members—we learned as we undertook the evaluation that critical data for these groups were either entirely unavailable or had exceedingly high levels of missingness. Therefore, we opted to focus exclusively on the IHAWP population, using them as their own controls when possible. Additionally, we analyze IHAWP members by income level. We do this, rather than comparing Wellness Plan and Marketplace Choice Plan (MCP) members, because over the course of our longitudinal evaluation, the MCP was ended and those individuals were merged into the Wellness Plan, however the income levels continued to remain an important part of the IHAWP program, with respect to the amount of potential premiums members owe.

Study Population: Iowa Wellness & Marketplace Choice Plans

The focus of this evaluation is the examination of outcomes among IHAWP members, stratified by income level.

Process measures

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

Means testing

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

Multivariate modelling

Measures from the Medicaid Adult Core Set, NCQA HEDIS, and annual CAHPS survey may be modelled using logistic regression and DID. While we originally proposed use of a regression discontinuity design (RDD), we lack a continuous variable that we could identify as assigning someone to treatment, which in this case is considered the completion of one or more healthy behaviors. As indicated in earlier reports, we have determined that they cannot be conducted. Many of our outcomes are population based, however through modification of the protocols they will also be measured as individual outcomes most often through a dichotomous variable indicating whether or not the member had a service (e.g., person with type 1 or type 2 diabetes receiving a Hemoglobin A1c) or experienced an outcome (e.g., asthma exacerbation).

Qualitative data

Interviews were transcribed and coded to distill the information relevant to the evaluation. The codebook was produced based on the research questions and hypotheses. Trained teams of coders established intercoder reliability before coding all transcripts.

Survey data

The survey data will be analyzed using descriptive and bivariate statistics.

Limitations

As with all evaluations, there are limitations to the interpretation of the results and the potential for bias. For example, the quantitative analyses are limited in three ways. First, the definition of our sample and the treatment variable, as well as the use of propensity score matching—while necessary to cleanly model the relationship between the Healthy Behaviors Program and our outcomes of interest using a quasi-experimental method—result in dropping a number of member-year observations. In turn, this raises the possibility that our results are not generalizable to other IHAWP members, to say nothing of Medicaid members writ large. Despite employing numerous analytic strategies to combat them, our regression models may be limited by unobserved factors that differ between individuals, which may bias our results. However, the direction and magnitude of any such bias cannot be well predicted. Related to this, we were unable to include the identified comparison groups (IowaCare and Medicaid State Plan) as originally intended, because data on these individuals' wellness exams and health risk assessments were not tracked by IME. However, we do include IowaCare members who transitioned to the IHAWP and HBP in our quasi-experimental approach to modeling HBP outcomes wherein members effectively serve as their own control group. Finally, administrative data are collected for billing and tracking purposes and may not always accurately reflect the service provided. For our other analyses, including survey data collection, which are based on self-reported information and the recall of the enrollee there is the potential for response bias. Non-response bias tests are conducted to determine if the characteristics of respondents differ significantly from non-respondents.

Summary of Results

We have summarized the results across the evaluation and the various evaluation data sources and analysis. More detail about the results and the methods can be found in the Appendix and the previous evaluation reports have all of the methods, analysis, and results in detail.

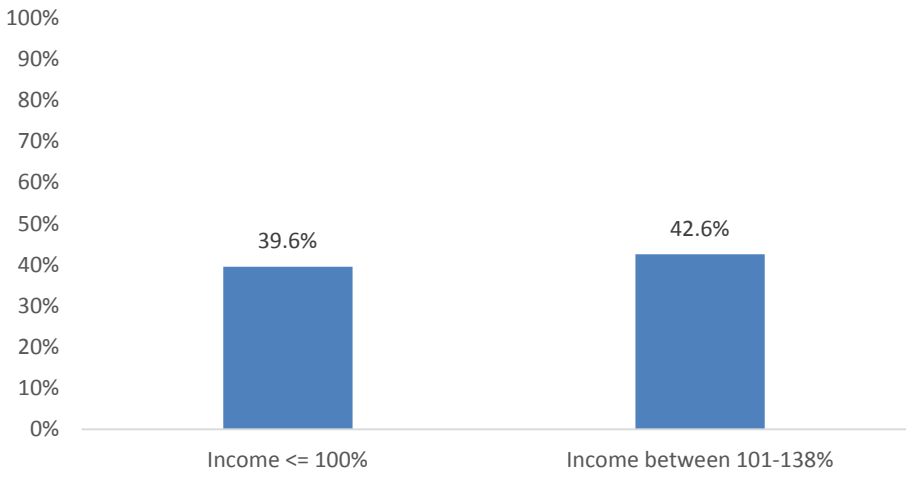
1. Which activities do enrollees complete?

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

Data Source: HBI Completion and Outcomes Report 2018

Across all years, Iowa Department of Human Services (DHS) data—including administrative data for medical well visits and members who self-report completion of an activity via telephone—indicate that 40% of lower-income members and 43% of higher-income members completed a wellness exam

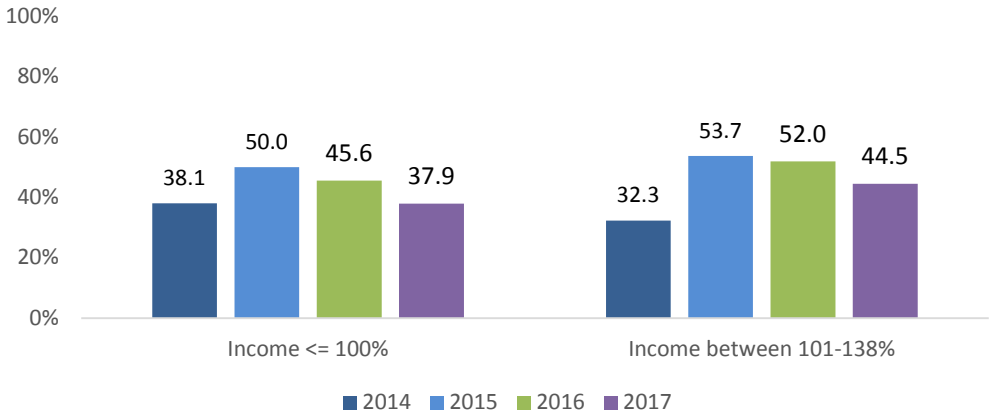
Figure 1. Wellness Exam Completion Rates Using DHS Data, 2014-2017



Note: Significantly different at p<0.001.

From 2014 to 2017, receipt of a wellness exam remained at 38% among lower-income members, but increased from 32% to 45% among higher-income members.

Figure 2. Members Enrolled for Full Calendar Year Who Received a Wellness Exam as Identified by DHS Data, by Income and Year 2014 – 2017



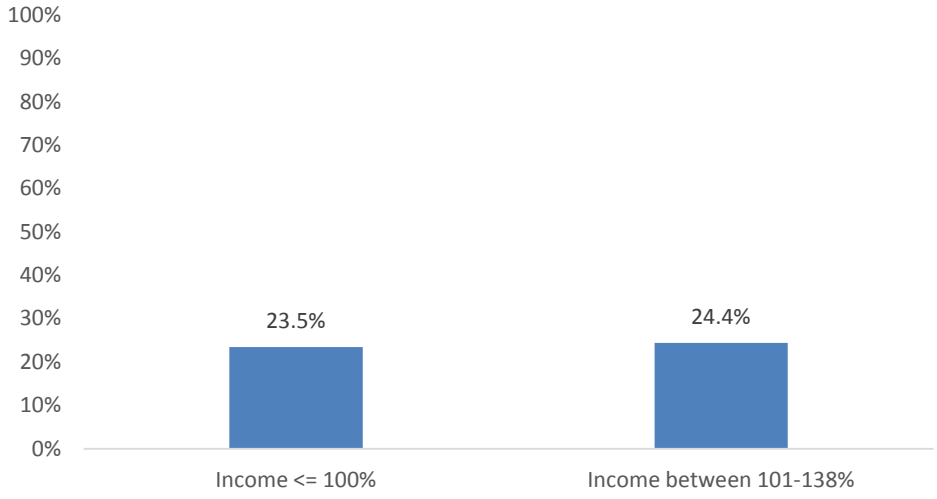
Note: Both the differences between programs within years and the differences between years within programs are statistically significant (p<0.001), with the exception of years 2014 and 2017 of the income below 100% group (p=1.00) and years 2015 and 2017 of the income between 101-138% group (p=0.854).

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

Data Source: HBI Completion and Outcomes Report 2018

Across all years, 24% of members (regardless of income level) completed an HRA.

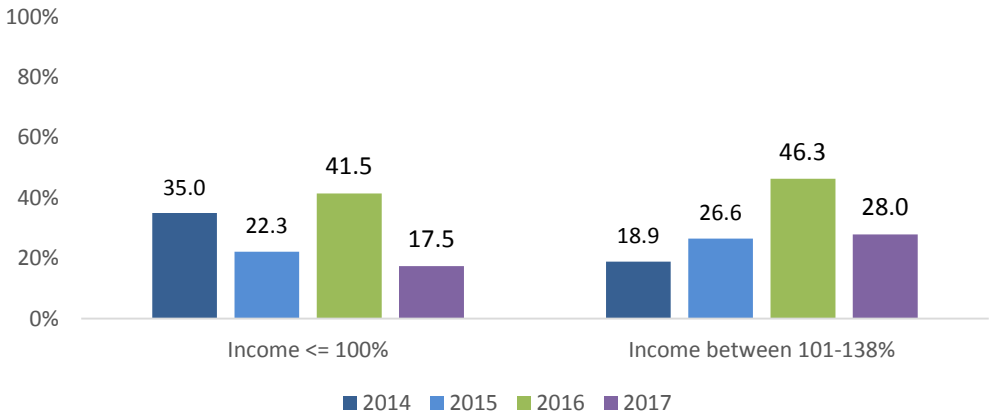
Figure 3. HRA Completion Rates Using DHS Data, 2014 – 2017



Note: Significantly different at p<0.001.

From 2014 to 2017, HRA completion rates decreased from 35% to 18% among lower-income members, but increased from 19% to 28% among higher-income members.

Figure 4. Members Enrolled for Full Calendar Year Who Received an HRA as Identified by DHS Data, by Income and Year 2014 – 2017



Note: Both the differences between programs within years and the differences between years within programs are statistically significant ($p<0.001$), with the exception of years 2015 and 2017 of the income between 101-138% group ($p=0.937$).

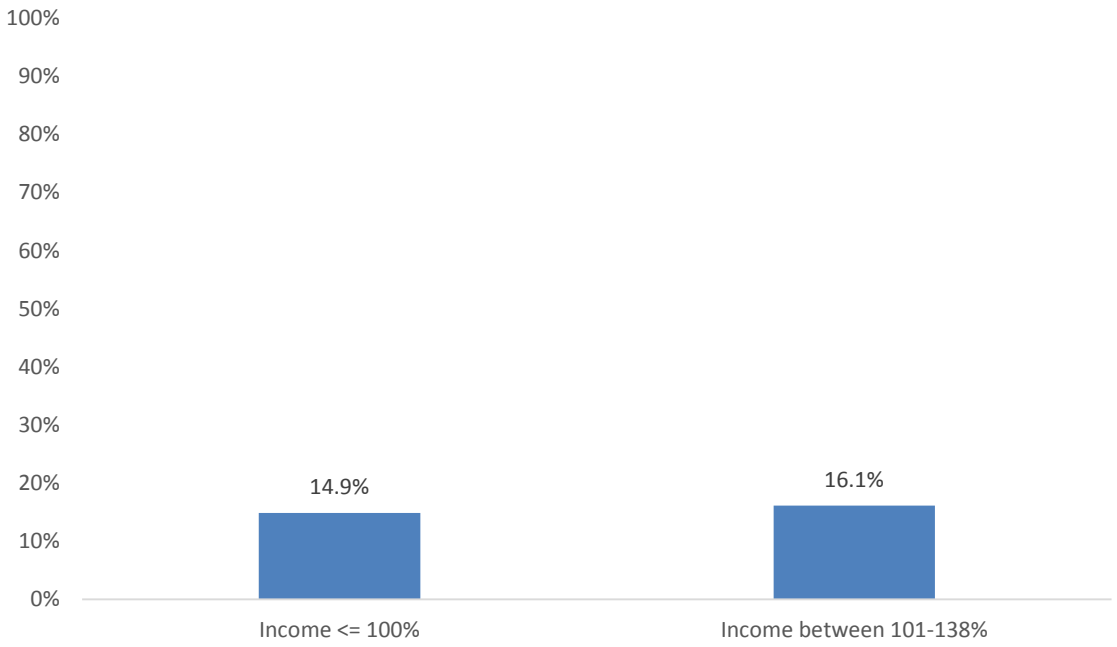
1.3: The proportion of WP/MPC members who are eligible to participate complete at least one behavior incentive is greater than 50%.

Data Source: HBI Completion and Outcomes Report 2018

We were unable to track the completion of additional behavior incentives, because this aspect of the program was not implemented initially. While it is our understanding that the MCOs are now operating incentive programs, we do not have data on these. Thus, we examined the proportion of WP and MPC members who completed both activities (wellness exam and HRA).

Across all years, approximately 15% of lower-income members and 16% of higher-income members completed both activities

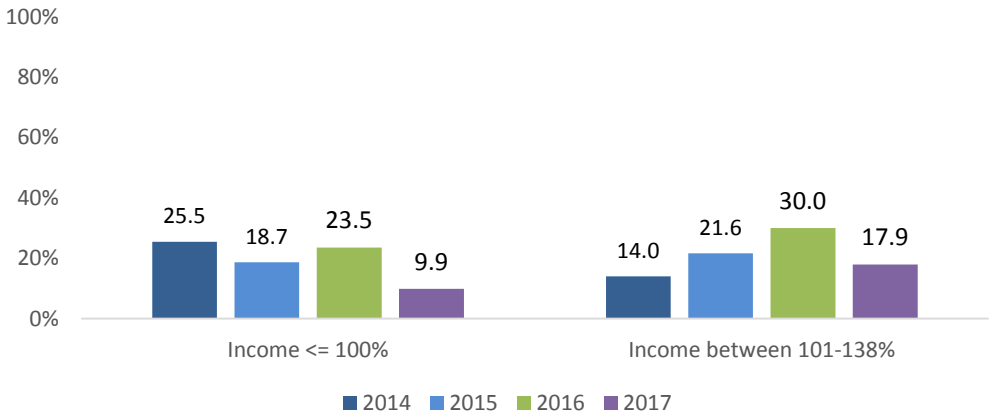
Figure 5. HRA and Wellness Exam Completion Rates Using DHS Data, 2014 – 2017



Note: Significantly different at p<0.001.

From 2014 to 2017, completion of both activities decreased from 26% to 10% among lower-income members, but increased from 14% to 18% among higher-income members.

Figure 6. Members Enrolled for Full Calendar Year Who Received an HRA and Wellness Exam as Identified by DHS Data, by Income and Year 2014 – 2017



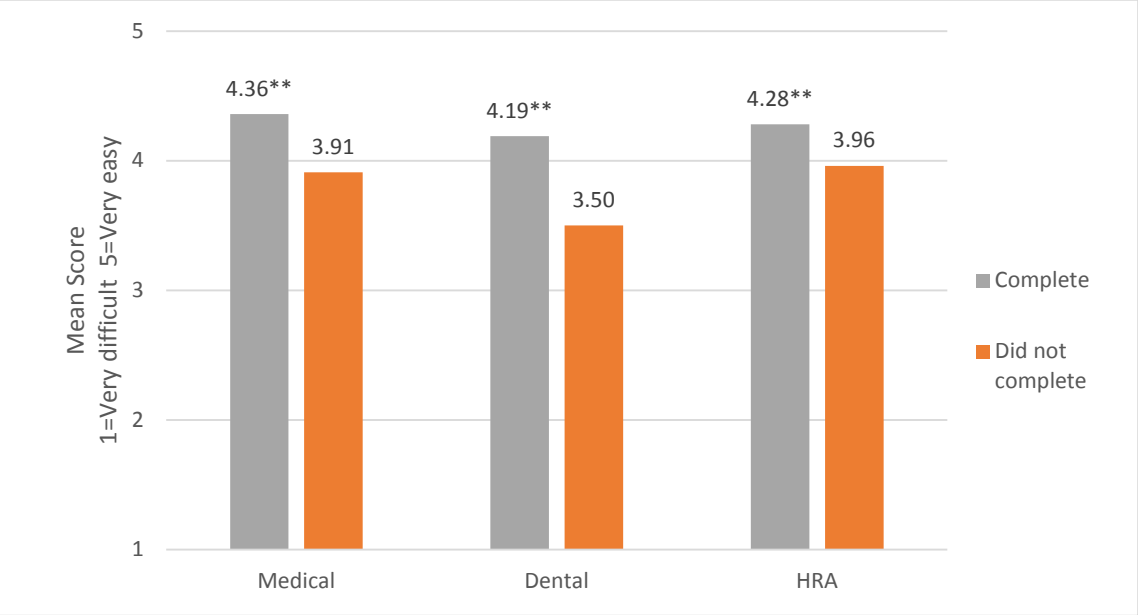
Note: Both the differences between programs within years and the differences between years within programs are statistically significant ($p<0.001$), while slightly less significant results were seen for years 2014 and 2017 of the income between 101-138% group ($p=0.001$) and years 2015 and 2017 of the income between 101-138% group ($p=0.01$).

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

Data Source: Enrollee Survey 2017

Respondents were asked how easy it would be for them to complete the behavior (Figure 7). Respondents who completed each individual behavior reported that it was easier to complete a wellness exam (t=7.96, p<0.001), a dental exam (t=11.52, p<0.001), and HRA (t=6.78, p<0.001) compared to those who did not complete the behavior (Figure 7).

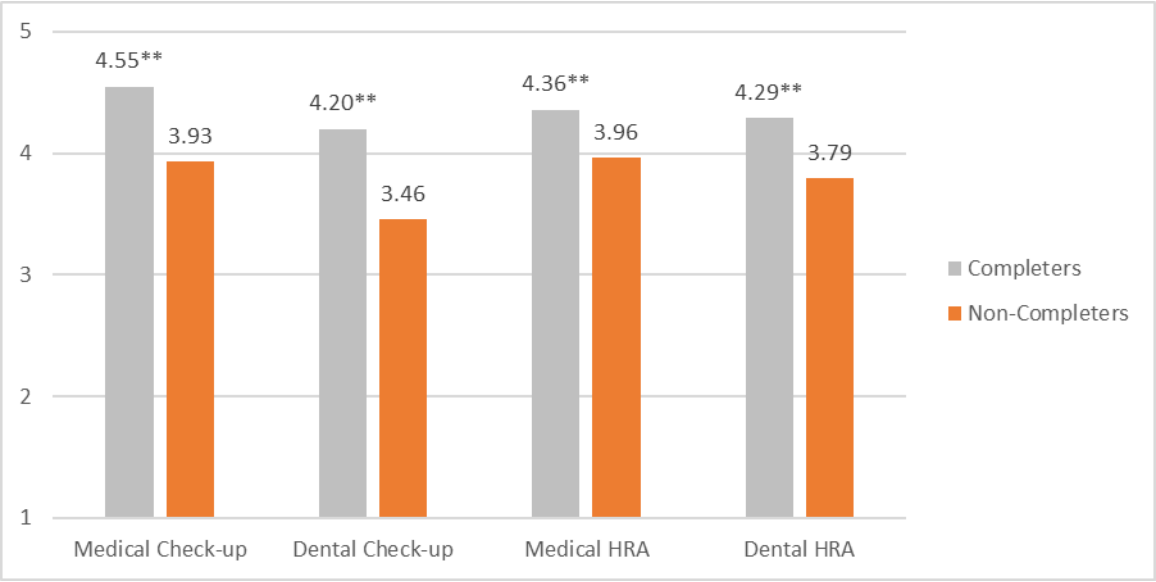
Figure 7. Respondents' perception of difficulty of completing a wellness exam, dental exam, and HRA for those who completed the behavior and those who did not complete the behavior



Data Source: Enrollee follow up survey 2018 of those surveyed in 2017

Respondents were asked how easy it would be for them to complete each behavior (Figure 8). Respondents who completed each individual behavior reported that it was easier to complete a wellness exam (t=5.22, p<0.001), a dental exam (t=7.50, p<0.001), a medical HRA (t=4.85, p<0.001), and an oral HRA (t=6.13, p<0.001) compared to those who did not complete the behavior (Figure 8).

Figure 8. Respondents' perception of difficulty of completing a wellness exam, dental exam, medical HRA, and an oral HRA for those who completed the behavior and those who did not complete the behavior



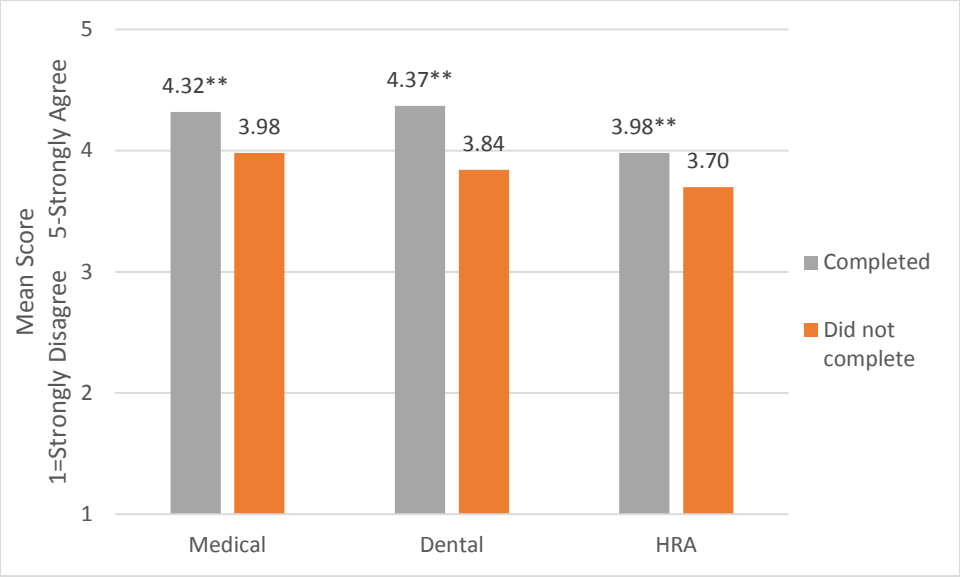
* indicates significant difference at p < 0.05
** indicates significant difference at p< 0.001

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

Data Source: Enrollee Survey 2017

Respondents who completed each individual behavior reported significantly higher scores for the benefit of completing a wellness exam (t=6.67, p<0.001), a dental exam (t=13.11, p<0.001), and an HRA (t=5.10, p<0.001) compared to those who did not complete the behavior (Figure 9).

Figure 9. Respondents' perception of how beneficial wellness exams, dental exams, and HRA are for those who completed the behavior and those who did not complete the behavior



* indicates significant difference at p < 0.05
** indicates significant difference at p< 0.001

There was a significant association between completing a wellness/dental exam and an HRA and whether the respondent would rather pay $10 a month or complete a wellness/dental exam and an HRA (χ^2=14.3381, p<0.001, Table 4). Regardless of whether a respondent has completed the behaviors, members reported preferring completing the behaviors over paying the $10 premium.

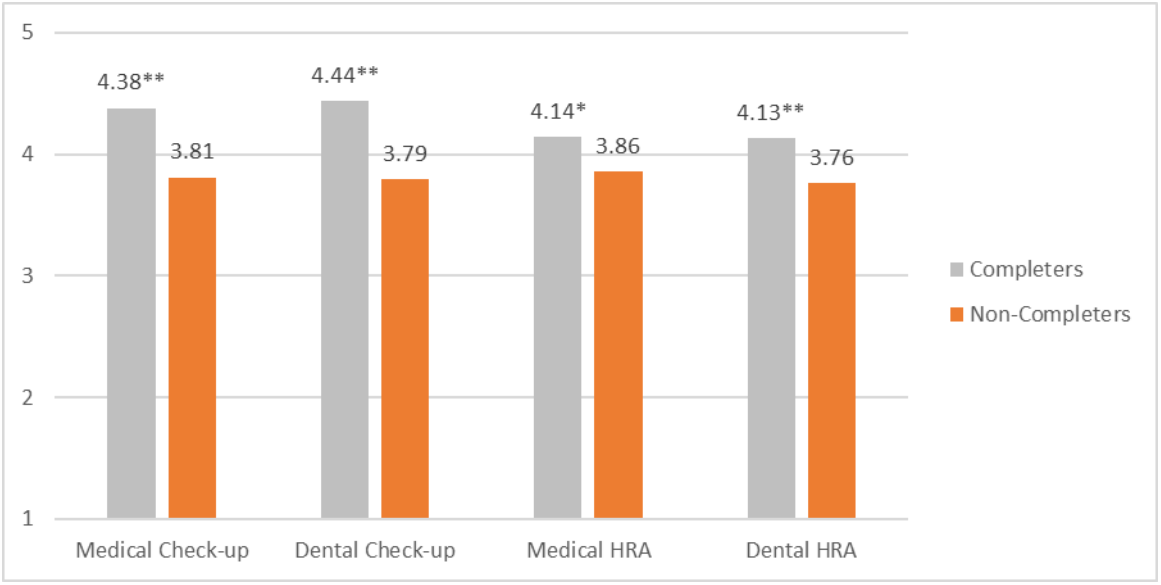
Table 4. If respondent would rather completed HBP requirements or pay $10 by whether complete wellness/dental exam and HRA

	Complete wellness/dental exam and HRA		
	Yes	No	Total
Would rather pay $10	58 (7.09%)	66 (13.41%)	124
Would rather complete wellness/dental exam and HRA	760 (92.91%)	426 (86.59%)	1186
Total	818 (100.00%)	492 (100.00%)	1310

Data Source: Enrollee follow up survey 2018 of those surveyed in 2017

Respondents who completed each individual behavior reported significantly higher scores for the benefit of completing a wellness exam (t=7.51, p<0.001), a dental exam (t=10.04, p<0.001), a medical HRA (t=3.28, p=0.001), and an oral HRA (t=4.99, p<0.001) compared to those who did not complete the behavior (Figure 10).

Figure 10. Respondents' perception of how beneficial wellness exams, dental exams, medical HRA, and oral HRA are for those who completed the behavior and those who did not complete the behavior



* indicates significant difference at p < 0.05
** indicates significant difference at p< 0.001

There was a significant association between completing a wellness/dental exam and a medical HRA and whether the respondent would rather pay $10 a month or complete a wellness/dental exam and an HRA (χ^2=16.87, p<0.001, Table 5). Regardless of whether they had completed the behaviors, respondents reported preferring completing the behaviors (89%) over paying the $10 premium (8%).

Table 5. If respondent would rather complete HBP requirements or pay $10 by whether completed wellness/dental exam and HRA

	Complete wellness/dental exam and HRA		
	Yes	No	Total
Would rather pay $10	21 (4.90%)	28 (14.50%)	49
Would rather complete wellness/dental exam and HRA	407 (95.10%)	165 (85.50%)	572
Total	428 (100.00%)	193 (100.00%)	621

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

Data Source: HBI Completion and Outcomes Report 2018

In general, the models find that the likelihood of completing both activities is higher among members who are older, female, white or unknown race, reside in an urban area, don't move during the year, have fewer ER visits, take more prescription drugs, and have more chronic conditions. The magnitude and direction of these results is generally consistent across both the lower-income and higher-income models, suggesting that the relationships we identify are not influenced by a person's income level. The likely reason some of the estimates in the higher-income group are not statistically significant is the smaller sample for that group of members. (HBI Completion and Outcomes Report 2018)

Table 6. Odds of Completing Both Activities by Income Groups

	Income ≤ 100%			Income between 101-138%		
	OR	95% CI		OR	95% CI	
Average Age	1.02***	1.02	1.02	1.02***	1.02	1.03
Male	0.64***	0.62	0.66	0.71***	0.68	0.75
Black	0.75***	0.72	0.79	0.73***	0.65	0.81
Hispanic	0.83***	0.78	0.89	0.85**	0.77	0.94
Other Race	0.85***	0.80	0.90	0.96	0.88	1.05
Unknown Race	1.05**	1.02	1.08	1.05	0.99	1.11
Metropolitan	1.12***	1.09	1.15	1.06*	1.01	1.11
Nonmetropolitan Urban	1.29***	1.23	1.37	1.06	0.96	1.17
Number of Moves	0.96***	0.95	0.97	1.00	0.98	1.02
Number of ER visits	0.90***	0.89	0.91	0.90***	0.88	0.92
Number of Rx drugs	1.10***	1.09	1.10	1.13***	1.11	1.14
Number of Chronic conditions	1.06***	1.05	1.07	1.04***	1.02	1.06
Constant	0.14***	0.13	0.15	0.06***	0.05	0.06

Note: Odds ratios for the cohort-specific fixed effects are not shown.

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

Data Source: Enrollee Survey 2017

There was a significant association between members reporting they heard about the HBP from their health care provider and completing an HRA ($\chi 2=4.985$, $p=0.026$, Table 7) and completing either a wellness exam/dental exam and completing the HRA ($\chi 2=7.752$, $p=0.0054$, Table 8). The vast majority of respondents did not hear about the program from their health care provider.

Table 7. Frequency of being aware from health care provider by whether complete HRA

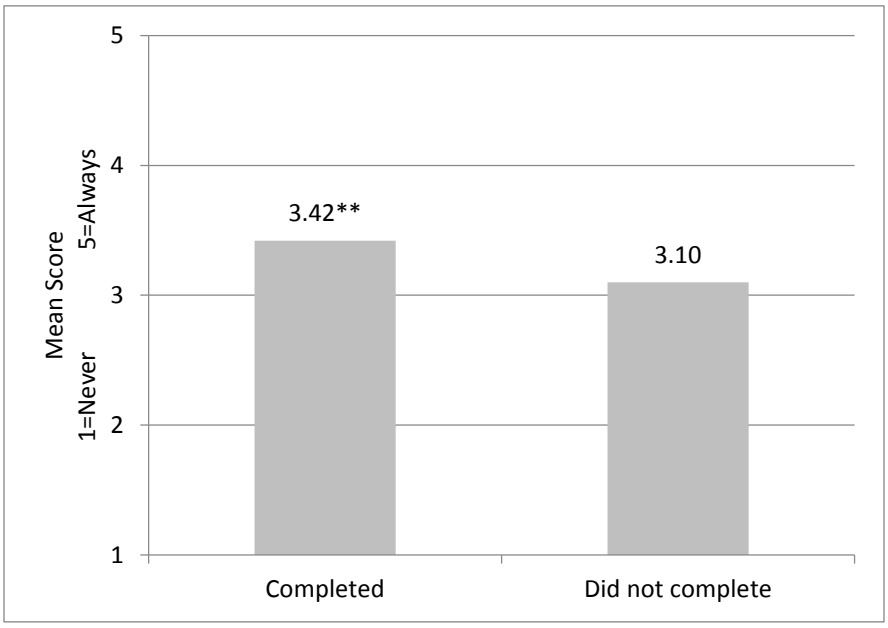
	Complete HRA		
	Yes	**No**	**Total**
Heard from provider	52 (5.84%)	9 (2.71%)	61
Did not hear from provider	839 (94.16%)	323 (97.29%)	1162
Total	891 (100.00%)	332 (100.00%)	1223

Table 8. Frequency of being aware from health care provider by whether complete wellness/dental exam and HRA

	Complete wellness or dental exam and HRA		
	Yes	**No**	**Total**
Heard from provider	51 (5.97%)	14 (2.69%)	65
Did not hear from provider	803 (94.03%)	507 (97.31%)	1310
Total	854 (100.00%)	521 (100.00%)	1375

Members who completed a wellness/dental exam and an HRA got an appointment as soon as they needed more often compared to those who did not (t=6.36, p<0.001) (Figure 11).

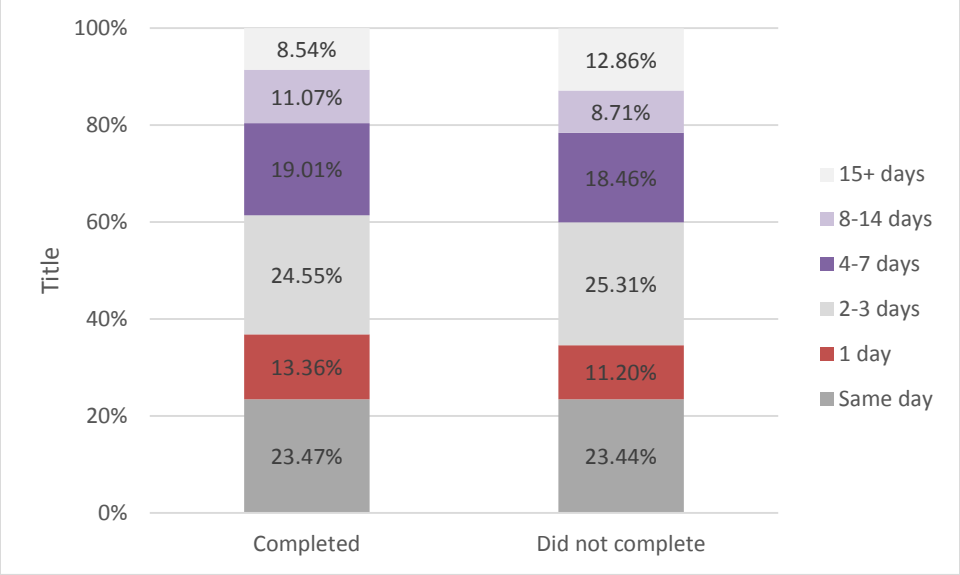
Figure 11. Respondents reporting receiving appointment for routine care as soon as they needed for those that completed the HBP behaviors and those that did not



* indicates significant difference at p < 0.05
** indicates significant difference at p< 0.001

There was no significant difference between members who have completed the wellness/dental exam and HRA and those who did not in the number of days they had to wait for an appointment for a check-up or routine care (Figure 12).

Figure 12. Members' report of the number of days they had to wait for a check-up or routine care appointment



Of the IHAWP members who responded to the survey, 1217 (88.51%) stated that they have a personal doctor when asked "A personal doctor is the one you would see if you need a check-up, want advice about a health problem, or get sick or hurt. Do you have a personal doctor?" There was a significant association between having a personal doctor and completing the healthy behaviors (χ^2=13.74, p=0.001, Table 9).

Table 9. Frequency of having a personal doctor by whether complete wellness/dental exam and HRA

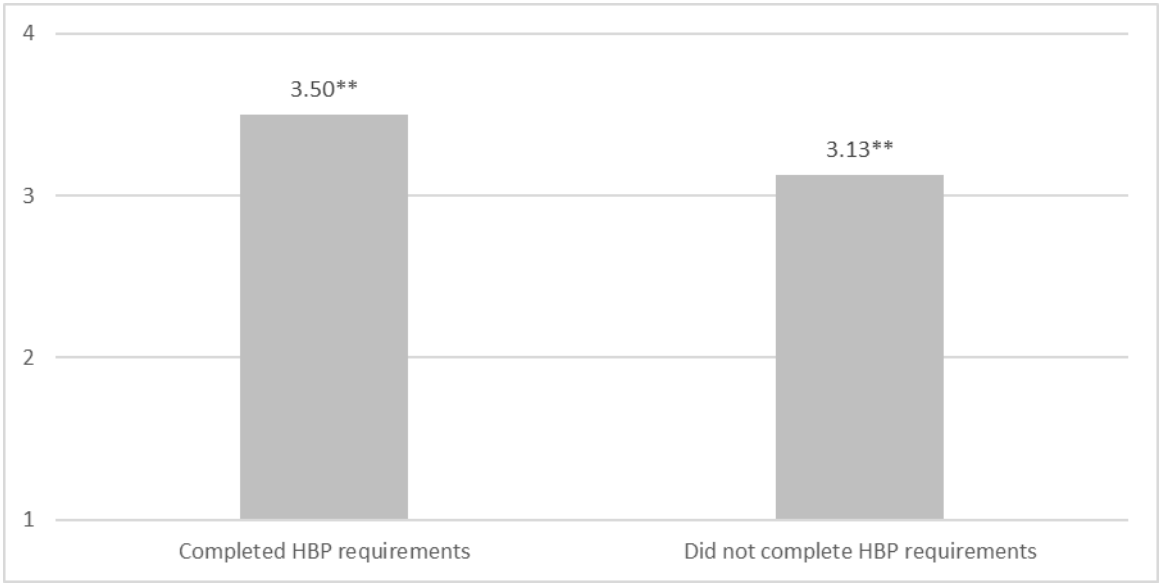
	Complete wellness/dental exam and HRA		
	Yes	**No**	**Total**
Has personal doctor	777 (91.20%)	440 (84.94%)	1217
Does not have personal doctor	75 (8.80%)	78 (15.06%)	153
Total	852 (100.00%)	518 (100.00%)	1370

Data Source: Enrollee follow up survey 2018 of those surveyed in 2017

There were no significant associations between respondents reporting they heard about the HBP from their health care provider and completing a wellness exam, dental exam, medical HRA, oral HRA, or completing either a wellness exam/dental exam and completing the HRA. The vast majority of respondents (93.8%) did not hear about the program from their health care provider

Respondents who completed a wellness/dental exam and an HRA got an appointment as soon as they needed more often compared to those who did not ($t=4.51$, $p<0.001$) (Figure 13).

Figure 13: Respondents reporting receiving appointment for routine care as soon as they needed for those that completed the HBP behaviors and those that did not



* indicates significant difference at $p < 0.05$
** indicates significant difference at $p< 0.001$

Of the IWP members who responded to the survey, 584 (91%) stated that they have a personal doctor when asked "A personal doctor is the one you would see if you need a check-up, want advice about a health problem, or get sick or hurt. Do you have a personal doctor?" There was a significant association between having a personal doctor and completing a medical exam ($\chi2=27.72$, $p<0.001$, Table 10), completing a medical HRA, ($\chi2=8.31$, $p=0.004$, Table 11), and the HBP program requirements ($\chi2=7.41$, $p=0.006$, Table 12). Having a personal doctor was not significantly associated with completing a dental exam or oral HRA.

Table 10. Frequency of having a personal doctor by whether complete wellness exam

	Complete medical exam		
	Yes	No	Total
Has personal doctor	512 (93.8%)	64 (76.2%)	576
Does not have personal doctor	34 (6.2%)	20 (23.8%)	54
Total	546 (100.00%)	84 (100.00%)	630

Table 11. Frequency of having a personal doctor by whether complete a medical HRA

	Complete HRA		
	Yes	No	Total
Has personal doctor	424 (93.2%)	94 (84.7%)	518
Does not have personal doctor	31 (6.8%)	17 (15.3%)	48
Total	455 (100.00%)	111 (100.00%)	566

Table 12. Frequency of having a personal doctor by whether complete HBP program requirements

	Complete medical/dental exam and HRA		
	Yes	No	Total
Has personal doctor	408 (93.6%)	176 (87.1%)	584
Does not have personal doctor	28 (6.4%)	26 (12.9%)	54
Total	436 (100.00%)	202 (100.00%)	638

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

Data Source: HBI Completion and Outcomes Report 2018

Members who are older, female, white, and/or live in metropolitan areas are more likely to complete both behaviors.

	Income ≤ 100%			Income between 101-138%		
	OR	**95% CI**		**OR**	**95% CI**	
Average Age	1.02***	1.02	1.02	1.02***	1.02	1.03
Male	0.64***	0.62	0.66	0.71***	0.68	0.75
Black	0.75***	0.72	0.79	0.73***	0.65	0.81
Hispanic	0.83***	0.78	0.89	0.85**	0.77	0.94
Other Race	0.85***	0.80	0.90	0.96	0.88	1.05
Unknown Race	1.05**	1.02	1.08	1.05	0.99	1.11
Metropolitan	1.12***	1.09	1.15	1.06*	1.01	1.11
Nonmetropolitan Urban	1.29***	1.23	1.37	1.06	0.96	1.17
Number of Moves	0.96***	0.95	0.97	1.00	0.98	1.02
Number of ER visits	0.90***	0.89	0.91	0.90***	0.88	0.92
Number of Rx drugs	1.10***	1.09	1.10	1.13***	1.11	1.14
Number of Chronic conditions	1.06***	1.05	1.07	1.04***	1.02	1.06
Constant	0.14***	0.13	0.15	0.06***	0.05	0.06

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

Data Source: HBI Completion and Outcomes Report 2018

Contrary to our hypothesis, we found that members with more chronic conditions (a proxy for poorer health status) were more likely to complete behaviors compared to members with fewer chronic conditions.

	Income ≤ 100%			Income between 101-138%		
	OR	**95% CI**		**OR**	**95% CI**	
Average Age	1.02***	1.02	1.02	1.02***	1.02	1.03
Male	0.64***	0.62	0.66	0.71***	0.68	0.75
Black	0.75***	0.72	0.79	0.73***	0.65	0.81
Hispanic	0.83***	0.78	0.89	0.85**	0.77	0.94
Other Race	0.85***	0.80	0.90	0.96	0.88	1.05
Unknown Race	1.05**	1.02	1.08	1.05	0.99	1.11
Metropolitan	1.12***	1.09	1.15	1.06*	1.01	1.11
Nonmetropolitan Urban	1.29***	1.23	1.37	1.06	0.96	1.17
Number of Moves	0.96***	0.95	0.97	1.00	0.98	1.02
Number of ER visits	0.90***	0.89	0.91	0.90***	0.88	0.92
Number of Rx drugs	1.10***	1.09	1.10	1.13***	1.11	1.14
Number of Chronic conditions	1.06***	1.05	1.07	1.04***	1.02	1.06
Constant	0.14***	0.13	0.15	0.06***	0.05	0.06

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

Data Source: Enrollee Survey 2017

Table 13. While you were enrolled in the Iowa Health and Wellness plan, did you receive care from any of the following clinics?

	Yes n (%)	No n (%)	Don't know/ not sure. n (%)	Refused n (%)
United Community Health Center	95 (6.91)	1236 (89.89)	44 (3.20)	0 (0.00)
Community Health Centers of Southeastern Iowa, Inc	54 (3.93)	1290 (93.82)	31 (2.25)	0 (0.00)
Primary Health Care, Inc	214 (15.56)	1114 (81.02)	47 (3.42)	0 (0.00)
Community Health Centers of Southern Iowa, Inc	34 (2.47)	1314 (95.56)	27 (1.96)	0 (0.00)
Community Health Center of Fort Dodge, Inc	22 (1.60)	1340 (97.45)	13 (0.95)	0 (0.00)
Greater Sioux Community Health Center	12 (0.87)	1350 (98.18)	13 (0.95)	0 (0.00)
Linn Community Care – now called Eastern Iowa Health Center	40 (2.91)	1318 (95.85)	17 (1.24)	0 (0.00)
Community Health Care, Inc	59 (4.29)	1282 (93.24)	34 (2.47)	0 (0.00)
All Care Health Center	25 (1.82)	1331 (96.80)	19 (1.38)	0 (0.00)
Crescent Community Health Center, Inc	31 (2.25)	1327 (96.51)	17 (1.24)	0 (0.00)
River Hills Community Health Center, Inc	40 (2.91)	1321 (96.07)	14 (1.02)	0 (0.00)
Siouxland Community Health Center	50 (3.64)	1311 (95.35)	14 (1.02)	0 (0.00)
People's Community Health Clinic, Inc	44 (3.20)	1316 (95.71)	15 (1.09)	0 (0.00)

Data Source: Enrollee follow up survey 2018 of those surveyed in 2017

We did not examine completion rates by site of care, given difficulties in assigning / attributing members to a site of care, and the fact that additional incentive programs were not implemented. However, we report data from member surveys about receipt of care at Federally Qualified Health Centers.

Table 14. While you were enrolled in the Iowa Health and Wellness plan, did you receive care from any of the following clinics? (n=641)

	Yes n(%)	No n(%)	Don't know/ Not sure n(%)	Refused n(%)
United Community Health Center	40 (6.2)	570 (88.9)	30 (4.7)	1 (0.2)
Community Health Centers of Southeastern Iowa, Inc	22 (3.4)	606 (94.5)	12 (1.9)	1 (0.2)
Primary Health Care, Inc	61 (9.5)	562 (87.7)	16 (2.5)	2 (0.3)
Community Health Centers of Southern Iowa, Inc	17 (2.7)	610 (95.2)	13 (2.0)	1 (0.2)
Community Health Center of Fort Dodge, Inc	7 (1.1)	630 (98.3)	3 (0.5)	1 (0.2)
Greater Sioux Community Health Center	1 (0.2)	633 (98.8)	6 (0.9)	1 (0.2)
Linn Community Care – now called Eastern Iowa Health Center	14 (2.2)	615 (95.9)	11 (1.7)	1 (0.2)
Community Health Care, Inc	27 (4.2)	598 (93.3)	14 (2.2)	2 (0.3)
All Care Health Center	10 (1.6)	621 (96.9)	8 (1.2)	2 (0.3)
Crescent Community Health Center, Inc	16 (2.5)	619 (96.6)	4 (0.6)	2 (0.3)
River Hills Community Health Center, Inc	27 (4.2)	609 (95.0)	3 (0.5)	2 (0.3)
Siouxland Community Health Center	16 (2.5)	620 (96.7)	3 (0.5)	2 (0.3)
People's Community Health Clinic, Inc	19 (3.0)	613 (95.6)	7 (1.1)	2 (0.3)

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

Data Source: HBI Completion and Outcomes Report 2018

Percent of persons having an ambulatory care visit significantly increased if they had completed either a wellness exam and/or an HRA. We assessed access to primary care using the percentage of members who had an ambulatory care visit. Figure 14 compares both lower-income and higher-income IHAWP members, by completion of a wellness exam and/or HRA. The percent of persons having an ambulatory care visit increased significantly when they completed a wellness exam and/or HRA. We suspect that we see these differences because completion of either of these healthy behaviors likely required or resulted from an ambulatory care visit. The results are very similar regardless of income level.

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

Data Source: HBI Completion and Outcomes Report 2018

Among lower-income and higher-income IHAWP members with diabetes, those who completed both healthy behaviors had higher rates of hemoglobin A1c testing in comparison to those who completed neither health benefit. However, this result was not statistically significant among the higher-income group.

In both lower-income and higher-income members completing both healthy behaviors showed higher rates of LDL-C Screening. However, this result was not statistically significant among the higher income group.

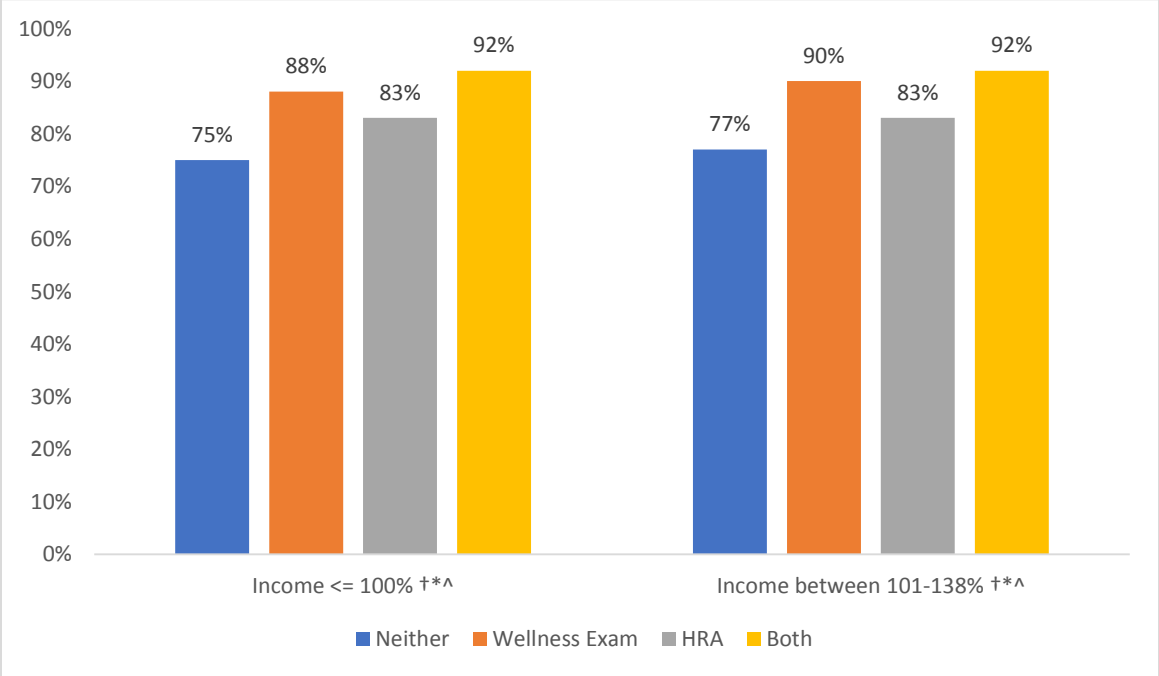
Table 15. Modeling Ambulatory/Preventive Care Visits as a Function of Healthy Behavior Completion

	Coefficient	95% CI	
Post Medicaid Expansion	0.048***	0.03	0.067
Treatment Group	0.169***	0.151	0.186
Post Medicaid Expansion*Treatment Group	-0.010	-0.037	0.016
Age	-0.001	-0.001	0.000
Male	-0.082***	-0.097	-0.067
Black	0.023	-0.006	-0.052
Hispanic	0.052**	0.013	0.091
Other Race	0.004	-0.038	-0.047
Unknown Race	-0.033***	-0.05	-0.015
Metropolitan	0.025**	0.009	0.042
Nonmetropolitan Rural	0.009	-0.032	0.049
Number of Relocations	-0.001	-0.007	0.006
Number of 24 Chronic Conditions	0.074***	0.07	0.078
Income between 51-100% of FPL	0.005	-0.017	0.027
Income between 101-138% of FPL	0.028	-0.003	0.058
Constant	0.695***	0.657	0.734

N = 10,202

* p<0.05, ** p<0.01, ***p<0.001

Figure 14: Percent of Members who had an Ambulatory Care Visit, by Income and Healthy Behavior Completion, 2015 - 2017



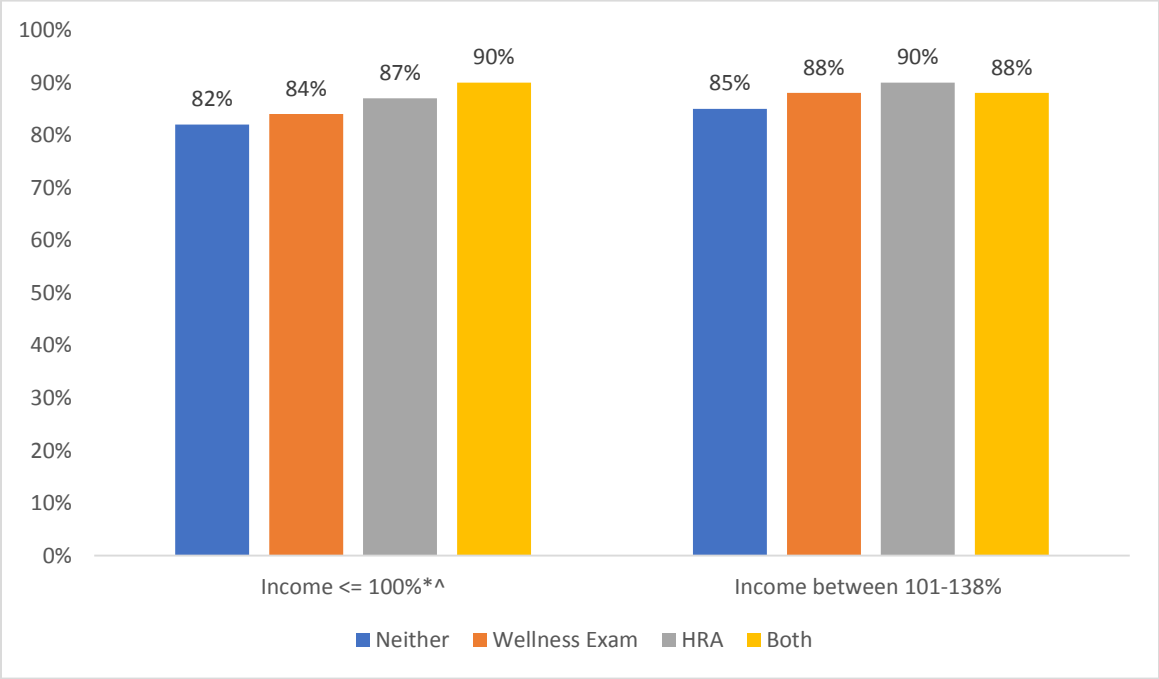
† Neither vs. wellness exam is significant at p<0.001
* Neither vs. heath risk assessment is significant at p<0.001
^ Neither vs. both (wellness exam and health risk assessment) is significant at p<0.001

Table 16. Modeling Hemoglobin A1c Testing in Diabetic Members as a Function of Healthy Behavior Completion

	Coefficient	95% CI	
Post Medicaid Expansion	0.046*	0.000	0.091
Treatment Group	0.095***	0.051	0.140
Post Medicaid Expansion*Treatment Group	-0.026	-0.100	0.047
Age	0.001	-0.001	0.003
Male	-0.027	-0.063	0.009
Black	-0.018	-0.095	0.060
Hispanic	0.094**	0.037	0.151
Other Race	0.083	-0.007	0.173
Unknown Race	0.031	-0.011	0.074
Metropolitan	0.013	-0.027	0.052
Nonmetropolitan Rural	-0.069	-0.190	0.053
Number of Relocations	0.000	-0.014	0.015
Number of 24 Chronic Conditions	0.014*	0.000	0.027
Income between 51-100% of FPL	0.035	-0.014	0.084
Income between 101-138% of FPL	-0.008	-0.086	0.069
Constant	0.708***	0.578	0.838

N = 1,424* p<0.05, ** p<0.01, ***p<0.001

Figure 15: Percent of Members with Diabetes Who had Hemoglobin A1c Testing, by Income and Healthy Behavior Completion



† Neither vs. wellness exam is significant at p<0.001

* Neither vs. heath risk assessment is significant at p<0.001

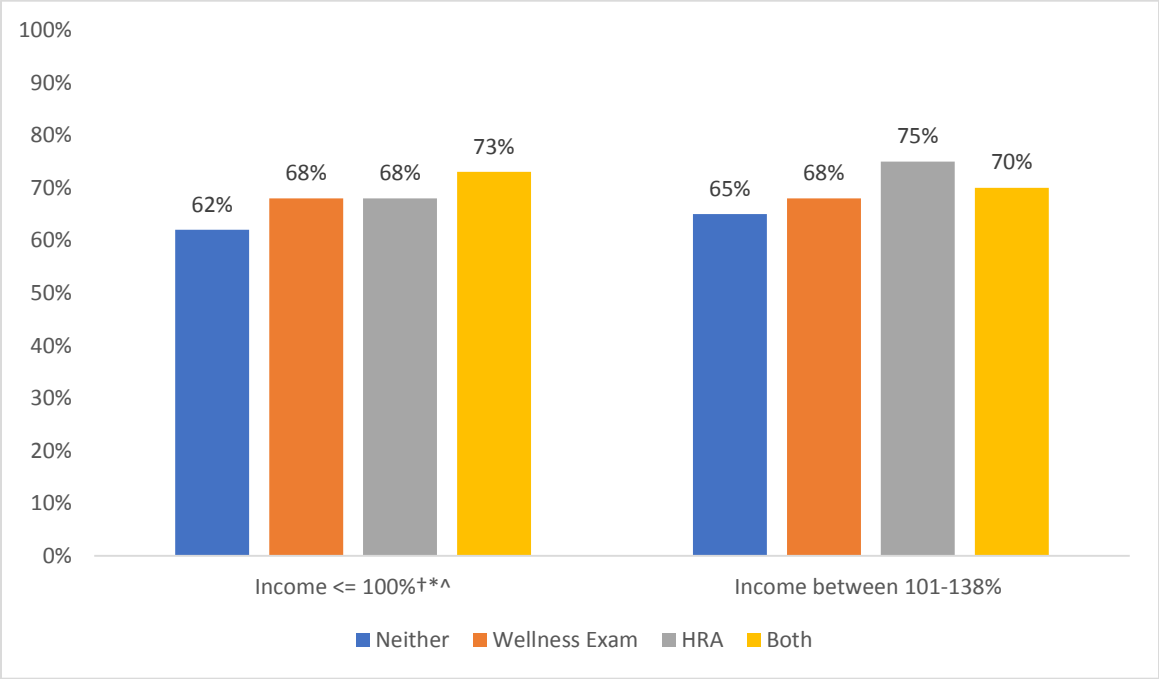
^ Neither vs. both (wellness exam and health risk assessment) is significant at p<0.001

Table 17. Modeling LDL-C screenings in Diabetic Members as a Function of Healthy Behavior Completion

	Coefficient	95% CI	
Post Medicaid Expansion	0.165***	0.104	0.226
Treatment Group	0.094**	0.024	0.164
Post Medicaid Expansion*Treatment Group	-0.066	-0.188	0.056
Age	0.005**	0.002	0.008
Male	-0.031	-0.081	0.020
Black	0.016	-0.084	0.115
Hispanic	0.067	-0.036	0.170
Other Race	0.101	-0.039	0.242
Unknown Race	0.009	-0.050	0.068
Metropolitan	0.096***	0.040	0.151
Nonmetropolitan Rural	-0.105	-0.249	0.039
Number of Relocations	0.023*	0.003	0.042
Number of 24 Chronic Conditions	0.014	-0.003	0.030
Income between 51-100% of FPL	0.108**	0.036	0.180
Income between 101-138% of FPL	-0.030	-0.140	0.081
Constant	0.146	-0.021	0.313

N = 1,424, * p<0.05, ** p<0.01, ***p<0.001

Figure 16. Percent of Members with Diabetes Who had an LDL-C screening, by Income and Healthy Behavior Completion



† Neither vs. wellness exam is significant at p<0.001

* Neither vs. heath risk assessment is significant at p<0.001

Data Source: Enrollee Survey 2017

Below are results from survey data to address H3.1. Of respondents, 88.51% reported having a personal doctor. When asked about being able to get an appointment for routine care, when they needed it 56.15% indicated "always" (Table 19). Only 5.24% reported having to wait 15-30 days for an appointment, while most indicated they could get an appointment sooner (Table 20).

Table 18. A personal doctor is the one you would see if you need a check-up, want advice about a health problem, or get sick or hurt. Do you have a personal doctor?

	n	percent
Yes	1217	88.51
No	153	11.13
Don't know/not sure	5	0.36
Refused	0	0.00

Table 19. In the last 6 months, how often did you get an appointment for a check-up or routine care at the doctor's office or clinic as soon as you needed? Would you say never, sometimes, usually, or always?

	n	percent
Never	78	5.67
Sometimes	209	15.20
Usually	281	20.44
Always	772	56.15
Don't know/not sure	30	2.18
Refused	5	0.36

Table 20. In the last 12 months, how many days did you usually have to wait for an appointment for a check-up or routine care?

	n	percent
Same day	308	22.40
1 day	165	12.00
2 to 3 days	326	23.71
4 to 7 days	247	17.96
8 to 14 days	134	9.75
15 to 30 days	72	5.24
More than 30 days	61	4.44
Don't know/not sure	56	4.07
Refused	6	0.44

Data Source: Enrollee follow up survey 2018 of those surveyed in 2017

For enrollees who had been in the program at least two years, 91.1% reported having a personal doctor and 59.6% said they could "always" get an appointment when needed.

Table 21. A personal doctor is the one you would see if you need a check-up, want advice about a health problem, or get sick or hurt. Do you have a personal doctor? (n=641)

	n	Percent
Yes	584	91.1
No	54	8.4
Don't know/not sure	3	0.5

Table 22. In the last 6 months, how often did you get an appointment for a check-up or routine care at the doctor's office or clinic as soon as you needed? Would you say never, sometimes, usually, or always? (n=641)

	n	Percent
Never	29	4.5
Sometimes	82	12.8
Usually	142	22.2
Always	382	59.6
Don't know/not sure	6	0.9

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

Data Source: HBI Completion and Outcomes Report 2018

When comparing members by completion of one or both healthy behaviors we found that that lower-income members who had an HRA or completed both activities had significantly lower rates of non-emergent ED visits. There was no association among higher-income members. We also found that the proportion of lower-income IHAWP members with a return ED visit was lower in the group that completed an HRA or both healthy behaviors in the prior year. The wellness exam alone was not statistically significant, nor were there any significant differences observed among higher-income members, regardless of their healthy behavior completion.

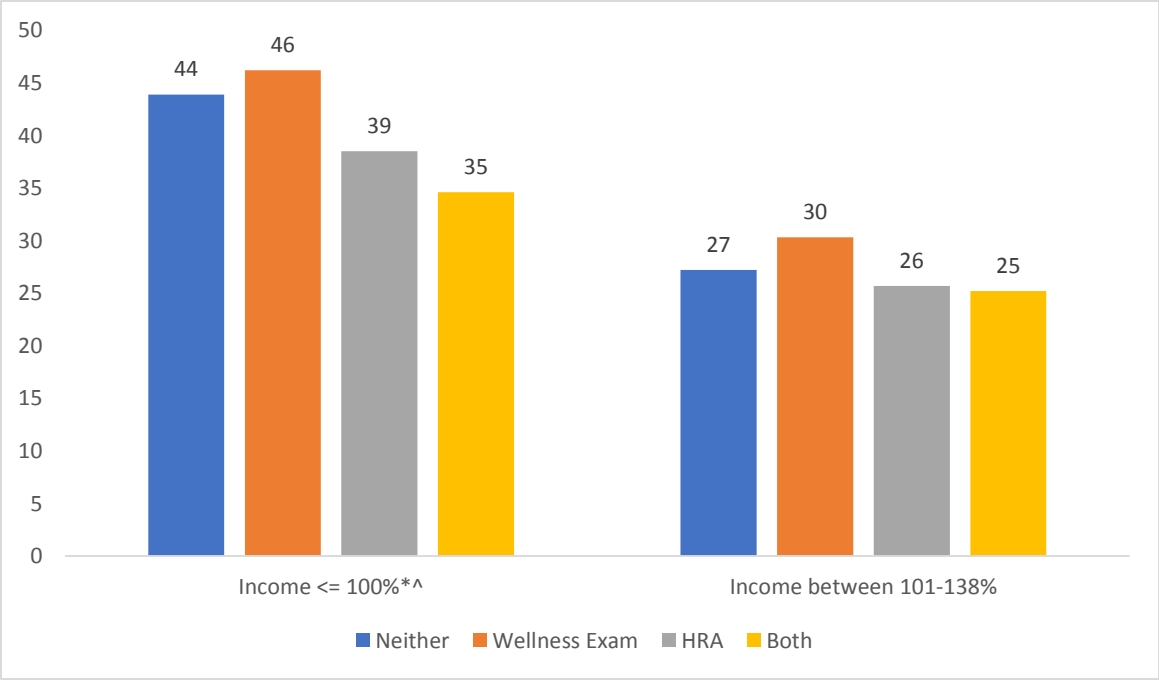
Table 23. Modeling Non-emergent ED Use as a Function of Healthy Behavior Completion

	Coefficient	95% CI	
Post Medicaid Expansion	0.019	-0.005	0.044
Treatment Group	-0.014	-0.048	0.019
Post Medicaid Expansion*Treatment Group	-0.028	-0.109	0.052
Age	-0.002***	-0.003	-0.001
Male	-0.027*	-0.048	-0.005
Black	0.015	-0.019	0.048
Hispanic	0.005	-0.062	0.071
Other Race	0.044	-0.002	0.090
Unknown Race	0.002	-0.024	0.029
Metropolitan	0.008	-0.015	0.032
Nonmetropolitan Rural	-0.011	-0.078	0.056
Number of Relocations	-0.000	-0.010	0.009
Number of 24 Chronic Conditions	-0.010**	-0.017	-0.004
Income between 51-100% of FPL	-0.002	-0.034	0.029
Income between 101-138% of FPL	0.025	-0.014	0.065
Constant	1.012***	0.965	1.059

N = 3,161

* p<0.05, ** p<0.01, ***p<0.001

Figure 17. Number of Non-Emergent ED Visits per 1000 Member Months, by Income and Healthy Behavior Completion



† Neither vs. wellness exam is significant at p<0.001

* Neither vs. heath risk assessment is significant at p<0.001

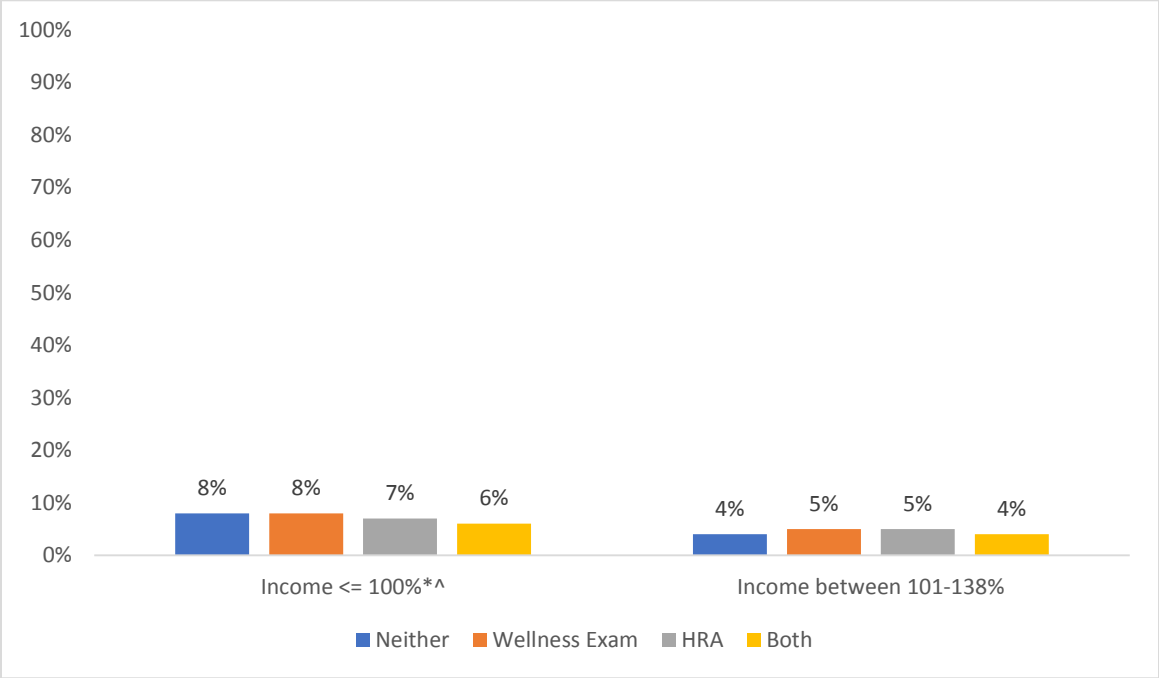
^ Neither vs. both (wellness exam and health risk assessment) is significant at p<0.001

Table 24. Modeling ED Visits 30 Days After Index ED Visit as a Function of Healthy Behavior Completion

	Coefficient	95% CI	
Post Medicaid Expansion	-0.003	-0.037	0.032
Treatment Group	-0.018	-0.061	0.026
Post Medicaid Expansion*Treatment Group	-0.006	-0.101	0.088
Age	-0.004***	-0.005	-0.002
Male	-0.031*	-0.062	-0.001
Black	0.000	-0.052	0.053
Hispanic	-0.012	-0.1	0.077
Other Race	-0.034	-0.118	0.050
Unknown Race	-0.049**	-0.083	-0.014
Metropolitan	0.019	-0.013	0.050
Nonmetropolitan Rural	-0.013	-0.096	0.069
Number of Relocations	-0.002	-0.015	0.010
Number of 24 Chronic Conditions	0.029***	0.019	0.038
Income between 51-100% of FPL	-0.049*	-0.091	-0.007
Income between 101-138% of FPL	-0.090**	-0.148	-0.032
Constant	0.387***	0.313	0.461

N = 3,161* p<0.05, ** p<0.01, ***p<0.001

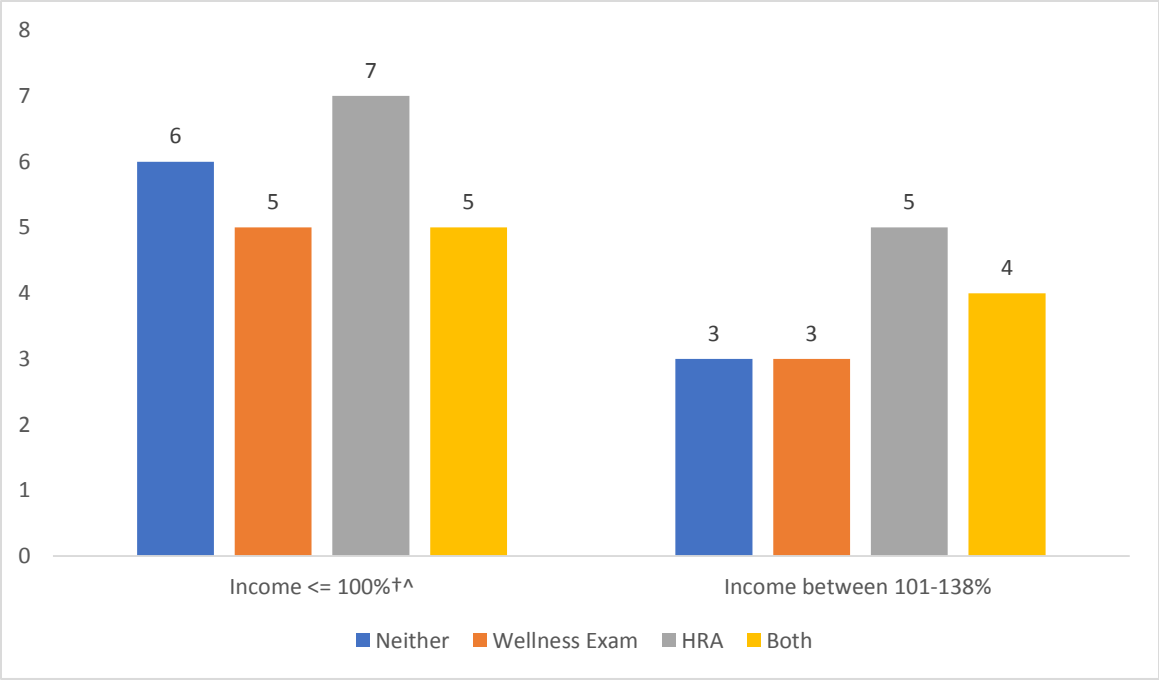
Figure 18. Percent of Members with an ED visit within first 30 days after index ED visit, by Income and Healthy Behavior Completion



* Neither vs. heath risk assessment is significant at p<0.001

^ Neither vs. both (wellness exam and health risk assessment) is significant at p<0.001

Figure 19. Average Number of Discharges per 1000 Member Months, by Income and Healthy Behavior Completion



† Neither vs. wellness exam is significant at p<0.001

* Neither vs. heath risk assessment is significant at p<0.001

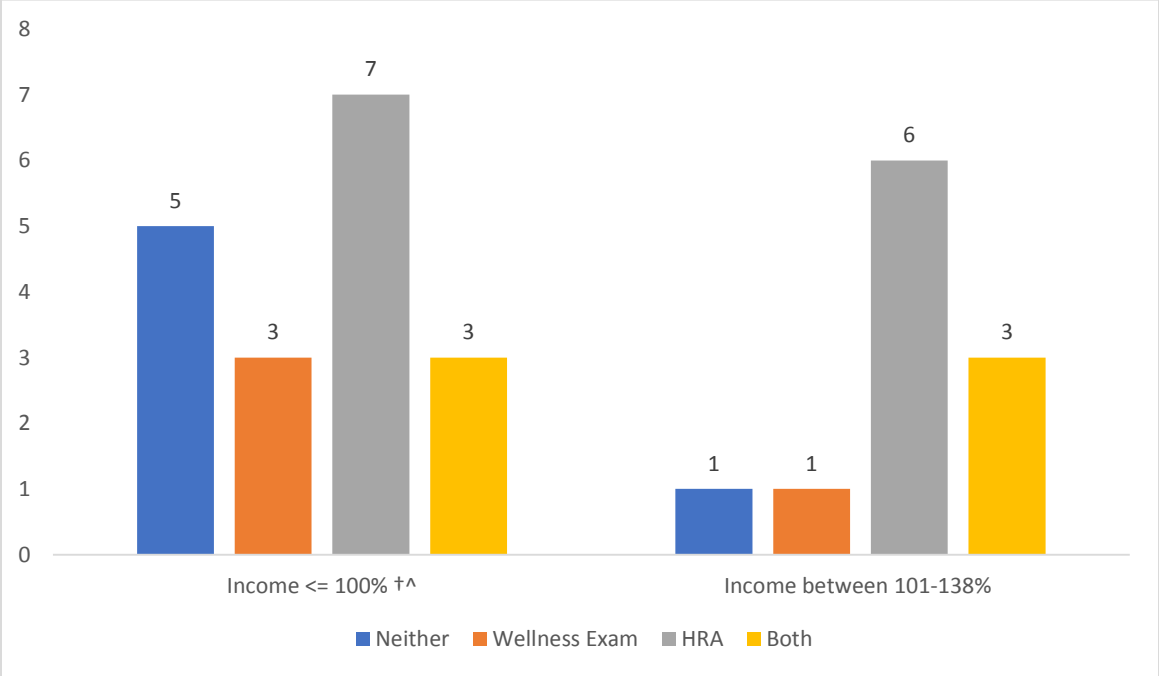
^ Neither vs. both (wellness exam and health risk assessment) is significant at p<0.001

Table 25. Modeling the Likelihood of Any Hospital Readmission as a Function of Healthy Behavior Completion

	Coefficient	95% CI	
Post Medicaid Expansion	0.009	-0.048	0.067
Treatment Group	0.013	-0.061	0.088
Post Medicaid Expansion*Treatment Group	0.130	-0.065	0.326
Age	-0.003	-0.006	0.000
Male	0.081***	0.035	0.128
Black	0.061	-0.048	0.169
Hispanic	-0.025	-0.145	0.096
Other Race	-0.069**	-0.117	-0.021
Unknown Race	0.016	-0.046	0.078
Metropolitan	-0.021	-0.074	0.032
Nonmetropolitan Rural	-0.097***	-0.154	-0.040
Number of Relocations	0.000	-0.02	0.021
Number of 24 Chronic Conditions	0.016*	0.002	0.031
Income between 51-100% of FPL	0.001	-0.078	0.080
Income between 101-138% of FPL	-0.039	-0.138	0.060
Constant	0.140	-0.012	0.293

N = 536* p<0.05, ** p<0.01, ***p<0.001

Figure 20. Average Annual Number of Hospital Readmissions per 1000 Members, by Income and Healthy Behavior Completion



† Neither vs. wellness exam is significant at p<0.001

* Neither vs. heath risk assessment is significant at p<0.001

^ Neither vs. both (wellness exam and health risk assessment) is significant at p<0.001

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

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

Respondents in both years indicated that the primary way they heard about the HBI program was through their MCO. The second most common ways for both years was hearing about HBI was receiving a letter from either DHS, IME, Medicaid, or Iowa Health Link.

Data Source: Enrollee Survey 2017

Table 26. How did you hear about the Healthy Behaviors Program?

	n	percent
I received a letter from my MCO (UnitedHealthCare, Amerigroup, AmeriHealth) telling me about the Healthy Behaviors Program	294	43.56
I received a letter from DHS/IME/Medicaid/Iowa Health Link telling me about the Healthy Behaviors Program	203	30.07
I received a phone call from my MCO	26	3.85
I received a call from the clinic I go to telling me about the Healthy Behaviors Program	9	1.33
My healthcare provider told me about the Healthy Behaviors Program while I was in the clinic	65	9.63
Family/Friend/Coworker	25	3.70
Letter/Brochure-unsure or other sources	36	5.33
Internet- unsure or other source	7	1.04
Received bill or disenrolled-inquired about HBP	6	0.89
Heard when completing HRA	3	0.44
Other	21	3.11
Don't know/not sure	42	6.22
Refused	0	0

Data Source: Enrollee follow up survey 2018 of those surveyed in 2017

Table 27. How did you hear about the Healthy Behaviors Program? (Select all that apply) (n=383)

	n	Percent
I received a letter from my MCO (UnitedHealthCare, AmeriGroup, AmeriHealth) telling me about the healthy behaviors program	155	40.5
I received a letter from DHS/IME/Medicaid/Iowa Health Link telling me about the healthy behaviors program	74	19.3
I received a phone call from my MCO	19	5.0
I received a call from the clinic i go to telling me about the healthy behaviors program	4	1.0
My healthcare provider told me about the healthy behaviors program while i was in the clinic	40	10.4
Family/friend/coworker	17	4.4
Letter/brochure-unsure or other sources	56	14.6
Internet	9	2.3
Received bill or disenrolled-inquired about HBO	7	1.8
Heard when completing HRA	4	1.0
From the evaluation by UI	11	2.9
TV, poster, fliers, or other advertisements	9	2.3
Other	15	3.9
Don't know/not sure	26	6.8

6. What are the implications of disenrollment?

Data Source: Healthy Behaviors Dis-enrollment Interviews Report 2017

In the interviews many members reported that losing their insurance had no impact on their health. Overwhelmingly, these individuals had not needed any kind of medical care since being disenrolled. However, several individuals also indicated that they could not access necessary health care services without their IHAWP coverage. The most common disenrollment consequences reported were financial hardship, an inability to get prescription medications, and an inability to get dental care.

Overall Experiences without Insurance

In analyzing the interviews collectively, many individuals indicated that losing their insurance had no impact on their health. Overwhelmingly, these individuals had not needed any kind of medical care since being disenrolled. However, several individuals also indicated that they could not access necessary health care services without their IHAWP coverage. The most common disenrollment consequences reported were financial hardship, an inability to get prescription medications, and an inability to get dental care.

Financial Hardship

One reoccurring theme in these interviews was financial hardship. Though more than half of interviewees (n=22) were employed full-time, a number of people reported that losing their health insurance had created a financial burden for them and that they would not be able to afford adequate healthcare without IHAWP coverage. When asked if the

disenrolled member tried to use any services, the person responded, “No. Because I, I just simply can’t afford to be billed at, billed for it.” [508] Another member provided more detail by stating,

“Once I get my, um, my check, it’s pretty well gone before I get it because of bills and stuff that I have to pay. And I’m trying to get some of my doctor bills and stuff paid. … So I haven’t been able to get my prescriptions like I should.” [575]

Prescription Medication

A number of individuals reported that they either took fewer doses or stopped taking necessary prescription medications because of their disenrollment. Concerns about the cost of prescriptions without IHAWP coverage were common. Although the disenrollment period was short for some, a number of individuals reported needing medication on a daily basis and that going even a few weeks without health insurance could have a profound health impact. Cost of the medications was one problem outlined by a member, “…some of them are like, even 50 to 100 dollars because they’re so expensive. And sometimes I don’t have the money to get ‘em.” [575] Another respondent indicated that returning to the doctor without insurance to get a prescription refilled was a problem. The person said, “Well I’ve had a water pill, but I mean, I can’t go back to the doctor and get a prescription again because I don’t have insurance.” [621]

Dental Care

Access to dental care was another concern that came up repeatedly in interviews. Many interviewees expressed concern that they could not access dental care without the IHAWP. After weight and high blood pressure, dental issues were the most commonly cited health concerns among interview respondents. One member explained the need for dental care and the challenges the lapse in coverage created,

“…And I have bad teeth and I need my wisdom teeth out. And I’m diabetic so I have periodontia. And they won’t do anything, they won’t do any coverage for af-, ‘til you’re in it for a complete year. Now that I have that lapse now I’m, uh, I’m not covered for getting my wisdom teeth out for another year. They are sitting in my face rotting. Um. And right now with Iowa City I have a, like an 80 dollar previous bill so they won’t even make me an appointment.” [508]

The lack of coverage also directly resulted in dental need that was unmet according to one respondent, “During, um, my, um, disenrollment I actually got an abscess in a tooth, um, which is, like, huge infection and my face swelled up. (laughing) And, um, my, my dentist actually informed me with my upcoming appointment that I was disenrolled before I even got the letter. Somehow they knew. I don’t know if they check before your appointment or what it is. But, um, they told me that they could not see me. Um, and that’s considered a, a medical emergency actually. (laughing) Um, when you get those abscesses.” [552]

Despite bringing up several of the same concerns, the disenrollment experience was clearly different when comparing those that successfully got back on the IHAWP, those that successfully got other insurance, and for those who had no insurance.

Experiences

Successfully Re-Enrolled

When asked about their experiences, those that had successfully re-enrolled in the IHAWP after their initial disenrollment reported general annoyance but minimal negative consequences. The majority of these individuals reported that re-enrollment was straightforward. One respondent who was successfully re-enrolled stated,

"Um, what I did is I just went down to the Department of Human Services and asked for their advice on how to re-enroll. They had me fill out the paper packet and provide them with my financial information...so they're actually really nice down there. Surprisingly. You know, that's kinda hard to come by at DHS offices, but they're really nice and they were very helpful…I am, I am enrolled again now." [508] Other respondents re-enrolled via the telephone and online. Some interview respondents who had successfully re-enrolled in the program expressed that disenrollment had consequences, but these were minimal and were resolved quickly. For those that were able to re-enroll, the most common problem reported during the disenrollment period was lack of coverage of prescription drugs. This was explained by one respondent, "... there's medicine I always take daily. And then when I was about to run out of, and so I hurried up and got that sent in. To re-enroll. But I didn't actually run out until the day, almost like the day I (was like), got my insurance back. (laughing)" [641]

Another member described, "I took my pills less and everything, until I knew what was gonna happen. So I wasn't doin' things right. Um, 'cuz I'm, yeah, my pills are very expensive." [696] The individuals in this group who did report a negative health impact suffered from serious pre-existing health conditions. For example, one interviewee described suffering from lupus and mentioned that losing her insurance had not only caused her to take her medication incorrectly but also drastically increased her stress levels.

Successfully Enrolled in Other Insurance

The experiences of those that enrolled in different insurance programs were much more varied in comparison with those that were able to re-enroll in the IHAWP. The enrollment process was relatively simple for some, but frustrating and confusing for others. Individuals in this group indicated that they enrolled through work or that they utilized community resources. A respondent who recently started a new job said,

" I took on their benefits. I was able to afford their benefits. Even though I, I'm sure I still qualify. But. I wanted to have better coverage. And. I didn't wanna be looked down upon either." [671]

Using a resource in the community one respondent reported,

"They tried to sign me up to, (with) a program that would kinda cover me for a while, bein' I'm 61, and I'll be 62 in January. I also went to, through United Way with women, which would help with the medicine. And would save me a PAP smear, mammogram, stuff like that. So I was able to, kind of, do something, cover, get my medicine covered, and some other small female things." [519]

Some individuals in this group reported considerable barriers to enrolling in a new insurance program. Common challenges included financial hardship and difficulty finding a plan with adequate coverage.

Most individuals who successfully enrolled in a different insurance program did not report that disenrollment had affected their ability to get healthcare. However, a few individuals reported difficulties paying for specialty care or

prescription medications with their new insurance. One respondent needed to have a CT scan, but the new insurance policy would not cover it [516]. Co-pays on prescriptions was a hardship described by one disenrolled member, "I have a copay that I have to pay on them. But some of them are like, even 50 to 100 dollars because they're so expensive. And sometimes I don't have the money to get 'em." [575]

Did Not Get Insurance

Those that were unable to re-enroll in the IHAWP or unable to enroll in another insurance plan reported more challenges, confusion, and frustration related to the disenrollment process compared to other interviewees who had successfully gained insurance. For example,

"Interviewer: Ok. Have you contacted DHS yet? Subject: Yes, I left a message on my caseworker. Voice mail, at least twice.

Interviewer: And have they gotten back to you? Subject: No." [503]

Other members reported not knowing what to do or what their options were. Interviewees who had been unable to get any type of insurance coverage more frequently reported that disenrollment had influenced their health or their ability to seek medical care compared to those who had been able to get insurance. One respondent described how the lack of coverage prevented the respondent from seeking care for a sprain and missing dental and eye appointments [505] Others did not continue taking medications.

Data Source: Disenrollment Survey Report 2018

From the survey of disenrolled members, 49% of respondents had no health insurance 3 months after disenrollment. Half of the respondents reported that they did not seek health care when they needed it, while 40% delayed preventive care, 38% delayed dental care, and 35% delayed having prescriptions filled.

Almost a third of survey respondents reported that their health had gotten worse since disenrollment, and 80% of disenrolled respondents reported that they spent at least some time without health insurance. While they had no insurance over half reported a delay in seeking care when it was needed, 40% reported delaying preventive care, and 38% reported delaying dental care.

Table 28. Current health insurance status* (n=237)

Status	n	percent
I am reenrolled in IHWAP	34	14.3
I am trying to reenroll in IHWAP	24	10.1
I am looking for health insurance	18	7.6
I have purchased health insurance privately	8	3.4
I am waiting to get health insurance from my employer	10	4.2
I have health insurance from my employer	21	8.9
I am on Medicaid/Title 19	15	6.3
I am on Medicare	8	3.4
I have no health insurance	108	45.6
***Respondents were able to select multiple responses**		

Table 29. While you had no health insurance coverage, did you do any of the following? (Check all that apply)

	Frequency	percent
I delayed getting prescriptions filled	77	35.5
I tried to stretch my medicine so it would last longer	59	27.1
I stopped taking prescribed medications	69	31.2
I did not seek health care when I needed it	119	52.7
I delayed getting check-ups or other preventive care	91	40.8
I delayed getting dental care	85	38.6
I paid more money for health care, dental care or prescriptions than I would have if I had insurance	47	21.9

6.1 Disenrolled members do not understand the disenrollment process.

Data Source: Healthy Behaviors Dis-enrollment Interviews Report 2017

From the disenrolled members who participated in the qualitative interviews confusion and misunderstandings were documented. The survey of disenrolled members indicated that about 50% believe they were disenrolled because they did not pay their premiums. This would be in agreement with the disenrollment reason provided by DHS. About 16% believed they were disenrolled because they made too much money and almost 12% did not know why they were disenrolled. A quarter of the respondents did not know they were going to be disenrolled before it happened.

The first set of interview questions addressed the IHAWP disenrollment process. First, respondents were asked if they remembered receiving a letter informing them they were disenrolled. If interview respondents did not remember the letter, they were asked, “Did you know that you had been disenrolled?” and “How did you find out?” All but two individuals were aware of their disenrollment from the IHAWP. Of the two that were unaware of their disenrollment, one did not believe that she had ever lost her insurance coverage, while the other had acquired another type of health insurance. Most interviewees remembered receiving the disenrollment letter from the IHAWP and reported learning of their disenrollment upon receiving the letter. However, a number of respondents described learning that they had been disenrolled at the doctor’s office, emergency room or dental office. As one disenrolled member indicated, “Well what happened was, I found out through the emergency room actually. I went to the emergency room because I was sick, I had a tonsil infection. And she said it came up on her computer that, uh, I’m no longer with my health care insurance.” [503]

Interviewees were asked to answer the question, “Can you tell me why you think you were disenrolled?” The majority of interviewees (n=24) knew that they had been disenrolled from the IHAWP because of missed premium payments. However, three respondents stated that they had been disenrolled because they were making too much money, three subjects said that they had been disenrolled because they had failed to fill out the necessary paperwork on time, and seven did not know why they had been disenrolled. One member explained that due to living arrangements mail was not consistent, “So basically, I went a couple months without payin’ the contribution, and it

went too long, and because of that it, I got disenrolled. And I, um, and I, (inaudible) on, and it went on so I, I think it went, uh, 90 days, days without paying it and I didn't know." [615] When interview respondents were asked, "Did you know in advance that you were going to be disenrolled?" three interviewees explained that they had known in advance, and one interviewee expressed a vague awareness that she might be disenrolled. For the remaining 33 interviewees, disenrollment came as a surprise. For example, one member said, "I had no idea that if you didn't pay that within a certain amount of time that they would, uh, kick you off." [667]

Many interview respondents expressed frustration or confusion about the disenrollment process. Interviewees did not feel as if they received enough notice before their disenrollment and perceived a general lack of available information. One interviewee suggested, "I would like, you know, phone calls instead of, like, letters all the time. Because, you know, mail gets shoved to the side. At least phone calls, if they left a message saying, hey, touch base with us, you know, we sent out a letter. You know, that way it kinda doubles up." [641] Largely, interview respondents felt that they did not have the resources or tools to find reliable information about the disenrollment. Respondents reported wanting more notice, "I think that there needs to be some notice. Besides just, hey! You're being done in March, and there's no notice." [654] The following quote illustrates a common issue. "That was the thing that was really frustrating to me, because I didn't have a premium payment, and then, all the sudden, here I am getting letters. And it was like, I was back three months already. When I got this letter sayin', oh by the way we're, we're making you pay a premium now. Which, I got no, you know, heads up sayin', oh, you know, by the way in the next month this is what we're considerin' doin'…all the sudden I get this letter in the mail and it shows, you know, a premium for three months back. I'm like, whoa! Wait a minute." [671] Another member indicated, "I haven't heard one thing from them. The only thing that I've heard is that, the two things that I've heard is the letter saying you're disenrolled. And then what, that in order to do this you have to reapply. And then when I reapplied, saying nope! Sorry, you're not covered." [654]

Members also reported trouble with accessing help to understand the process, I call customer service DHS, then they send me to a different person, then. They send me to a different person (laughing). They just need one person. Like, is in charge of my case. Instead of going around the merry-go-round. That's just crazy. And nobody has the answers." [633] Interview respondents reported confusion related to their disenrollment. Three individuals believed they had fulfilled the requirements of the HBI program, three individuals indicated that they did not owe money because they had selected the financial hardship option, and one individual believed that she had not missed any payments. One of the members who believed they had completed the HBI requirements said, "I did my yearly health and wellness risk assessment with [the doctor], um, as soon as I got put, put on it. And that would've been in June of last year. So I, I guess if that would've been the case then I shouldn't have been, even been able to be disconnected (disenrolled) until June of this year." [516] One member related their story and the frustration they felt about being told they were behind in payments, "I called DHS and they told me that, uh, after three months behind, they kick you off. And I said, I was never three months behind. And I had got a letter sayin' that I was three months behind, and I called 'em and said, no, that's not the issue. And then I called DHS back and they said that, um, they only go offa what those other people tell them, and they told them I'm three months behind. They have no way of seein' it, they said. It was all a bunch of crock" [696]

Data Source: HBI Disenrollment Survey Report 2018

At the time respondents received the survey they were generally aware that they were disenrolled (84%), but only about 25% knew that they would be disenrolled before it happened. About 50% believed that they were disenrolled because they did not pay their premiums, 15% believed it was because they made too much money, and about 12% reported that they did not know why they were disenrolled.

Table 30. Disenrollment Experience – Awareness, Timing of Notification & Actions Taken

Characteristic	n	percent
Aware of Disenrollment (n=229)		
Yes	192	83.8
No	37	16.2
Knew before it was going to happen (n=203)		
Yes	50	24.6
No	152	74.9
Actions taken before disenrollment, if disenrollment was known in advance* (n=237)		
I filled prescription before I was disenrolled	13	5.5
I went to see a health care provider before I was disenrolled	3	1.3
I did not do anything to prepare for being disenrolled	65	27.4
Other	15	6.3
***Respondents were able to select multiple responses**		

Table 31. Mode of Discovery of Disenrollment & Perceived Reason for Disenrollment

Characteristic	n	percent
Discovery of disenrollment (n=203)		
I received a letter telling me I was disenrolled	156	76.8
I was told when I went to get health care	19	9.4
I was told when I went to get dental care	4	2.0
I was told when I went to get a prescription filled	17	8.4
Other	7	3.4
Perceived reason for disenrollment* (n=237)		
I did not pay premiums/contributions	116	48.9
I made too much money	35	14.8
I did not pay co-pays	16	6.8
I did not return proper paperwork	18	7.6
I do not know	28	11.8
Other	37	15.6
***Respondents were able to select multiple responses**		

6.2 Disenrolled members do not understand premiums.

Data Source: HBI Disenrollment Survey Report 2018

Only 48% of the respondents reported knowing that they owed a premium while enrolled in IHAWP. Over 90% said there were months they did not pay premiums. When asked why they did not pay 46% indicated that they did not have the money and 38% said they did not know they needed to pay. Only 40% reported knowing that they could claim "financial hardship" if they could not pay.

Just over half (52%) of respondents reported that they were unaware that they owed a monthly premium and 91% indicated that there were months when they did not pay. Top cited reasons for lack of payment included not having the money (44%), not knowing that they needed to pay (35%), forgetting to pay (18%), and not understanding the invoices

or bills that they received (10%). Only 41% of respondents were aware of the financial hardship option for those unable to pay. At the time of the survey, 69% of respondents had not paid their premiums, and of those respondents, 60% were concerned about their debt being sent to collections.

Table 32. Premium Payment – Awareness, Ability to Pay, Reason for Lack of Payment, Awareness of Financial Hardship, Debt Status & Concern About Debt

Characteristic	n	Percent
Awareness of premium owed while on IWP (n=230)		
Yes	110	47.8
No	120	52.2
"Were there months when you did not pay your premiums?" (n=230)		
Yes	209	90.9
No	21	9.1
Reason for not paying monthly premiums* (n=237)		
I did not have the money	105	44.3
I did not know I needed to pay	84	35.4
I forgot to pay	42	17.7
I did not receive invoices or bills telling me to pay	28	11.8
I did not understand the invoices or bills I received	20	8.4
I did not know how to pay or who to pay	13	5.5
Other	34	14.3
Awareness of the "financial hardship" option if unable to pay (n=233)		
Yes	95	40.8
No	138	59.2
Respondent reported that they have paid their premiums to the State of Iowa (n=228)		
Yes	35	15.4
No	158	69.3
I do not owe a debt to the state	35	15.4
Concern over debt being sent to collections (n=165)		
Yes	99	60.0
No	66	40.0
***Respondents were able to select multiple responses**		

6.3 Disenrolled members do not understand the HBP.

Data Source: Healthy Behaviors Dis-enrollment Interviews Report 2017

Only seven interviewees reported being aware of the HBI program before they were disenrolled. Only two individuals correctly described both components of the HBI program, the other five were only vaguely familiar with it. More people were familiar with the wellness exam than with the health risk assessment. One respondent described how both behaviors were completed,

"Interviewer: Ok. Um. Are you, or did you get any information about getting a wellness checkup? Subject: I think I did. And I think I did it over, um, I think I did the health assessment online as well. I know I did. Interviewer: Ok. So did you

get the wellness exam as well? Subject: I'm sure I did. I went to [the doctor]. I go to the doctor so much, honey, I don't know." [696]

Respondents reported some knowledge of pieces of the program, for example,

"Interviewer: Ok. Who. How did you know about it? Subject: I got a letter, said if you don't go get your wellness check, you have to pay ridiculous amount of, of somethin', (some) (inaudible)…Yeah, something negative and bad will happen to your coverage, so go get one. I said ok! Well, I did and they said you're perfectly healthy. I said I know!" [597]

Another indicated that the wellness exam did not seem needed,

"I did a health assessment on the computer... I didn't get a checkup. 'Cuz that's, like, ...I didn't wanna go to the doctors 'cuz it gives me anxiety because, like, sick people go to the doctor, and if I'm healthy I don't have to expose myself to sickness. That's why I don't go. (laughing) Unless I'm sick." [639]

A number of individuals learned about the HBI program during the re-enrollment process. Out of the 16 interviewees that successfully re-enrolled, six reported learning about the HBI program after they had been initially disenrolled. A typical situation was described by one respondent, "Interviewer: Ok. So you mentioned that you paid, uh, contributions. Um, were you aware that there's a program through your health plan that will waive your contribution if you get an annual checkup or wellness exam and complete a health risk assessment? Subject: At the point, no. But I do now." [557] Another reported, "Um, I, beforehand I had not (inaudible) anything about it. Um. So I had not gotten any information on that part. Um, after I was appealing it, they explained the whole process that I wouldn't even have to pay the contribution if I did the. Um, those two things." [615]

Twenty-six interview respondents explicitly expressed that they would have liked to participate in the HBI program had they been aware of it. For example, one respondent said, "No, I never heard about it [HBI]. I would've liked that!" [610] Only two individuals indicated that they might not want to participate in the HBI program. One expressed general apathy towards the program, and the other explained that going to the doctor gave her too much anxiety.

Data Source: HBI Disenrollment Survey Report 2018

Survey respondents indicated that they had little knowledge of the Healthy Behaviors Program with only 27% reporting that they had heard about it.

Table 33. Awareness of Healthy Behavior Program

Characteristic	n	percent
Heard about the Healthy Behaviors Program (n=231)		
Yes	63	27.3
No	168	75.7

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

Data Source: HBI Disenrollment Survey Report 2018

Without health insurance, disenrolled members reported that they did not seek health care they needed (53%), delayed preventive care (41%), delayed dental care (39%), stopped taking prescription medication (31%), and stretched medication so it would last longer (27%).

Table 34. Gaps in Health Care Coverage & Actions Taken During That Time

Characteristic	n	percent
Respondent experienced any period of time without health insurance (n=234)		
Yes	192	82.1
No	42	17.9
Actions taken while having no health insurance coverage* (n=237)		
I delayed getting prescriptions filled	77	35.5
I tried to stretch my medicine so it would last longer	59	27.1
I stopped taking prescribed medications	69	31.2
I did not seek health care when I needed it	119	52.7
I delayed getting check-ups or other preventative care	91	40.8
I delayed getting dental care	85	38.6
I paid more money for health care, dental care or prescriptions than I would have if I had insurance	47	21.9
***Respondents were able to select multiple responses**		

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

Data Source: HBI Disenrollment Interviews Report 2017

From those that were interviewed, almost all described the re-enrollment process as negative.

Re-Enrollment Process

Interview respondents were asked “What has happened since you were disenrolled?” Almost all interviewees described the disenrollment process as a negative experience. Of the 32 interviewees who took immediate action, 27 attempted to re-enroll in the IHAWP and five attempted to enroll in an alternate plan. The remaining two interviewees took no action. Of the two individuals that indicated they had not yet tried to re-enroll in a health insurance plan, one had plans to re-enroll in the IHAWP, and one was not aware that re-enrollment was an option, as indicated here, “Um, I’ve just been goin’ without insurance. Hopin’ I don’t get injured…. Interviewer: Have you tried to get re-enrolled?

Subject: No. I wasn’t aware that I could.” [656]

Many individuals were able to re-enroll online, on the phone, or in person without any difficulty and reported that losing their insurance for a short period had no major impact on them. However, some individuals were denied coverage when they tried to re-enroll, and some individuals described that the disenrollment had affected their health or their ability to receive medical care. On several occasions, respondents attempted to appeal their status but ended up reapplying

instead. Nobody reported successfully appealing their disenrollment. One member explained why appealing was not workable,

"I explained to them what, exactly what happened and. Although they seemed to agree with me that, um, it wasn't fair with the mail, um, not being consistent and not clear, laid out that, that I definitely had a case but the, uh, final decision was apparently just to disenroll me and help me re-en-, re-enroll." [615] Another member agreed, "Oh let's see. (laughing) …Uh, it was actually a better strategy to withdraw that appeal than it was to appeal. Which. I suppose under some sort of Newtonian law that makes sense, but." [505]

Of the 32 individuals that reported taking action to obtain health insurance, 16 successfully reenrolled in the IHAWP, seven successfully enrolled in another insurance plan, and nine did not have any form of health insurance at the time of the interview. These three groups of interviewees had distinctive experiences. However, there were a few overarching themes across all three groups.

Did Not Get Insurance

Those that were unable to re-enroll in the IHAWP or unable to enroll in another insurance plan reported more challenges, confusion, and frustration related to the disenrollment process compared to other interviewees who had successfully gained insurance. For example,

> "Interviewer: Ok. Have you contacted DHS yet? Subject: Yes, I left a message on my caseworker's voicemail, at least twice.
>
> Interviewer: And have they gotten back to you? Subject: No." [503]
>
> Other members reported not knowing what to do or what their options were.

Data Source: HBI Disenrollment Survey Report 2018

According to disenrolled members who responded to the survey, 24% were able to re-enroll in IHAWP. Of those that re-enrolled in any insurance program, over 50% found it very easy or easy.

Table 35. Able to Reenroll & Level of Ease Associated with Reenrollment in IWP

Characteristic	n	Percent
Able to reenroll in IWP (n=225)		
Yes	55	24.4
No	170	75.6
Ease of reenrollment (n=66)		
Very easy	13	19.1
Easy	30	44.1
Difficult	18	26.5
Very difficult	7	10.3

7. What are members' knowledge and perceptions of the HBP?

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

Data Source: Enrollee Survey 2017

Respondents overwhelmingly chose to complete a wellness/dental exam and the HRA (90.53%) rather than pay $10 dollars per month (9.47%) (Figure 21). Respondents who completed each individual behavior reported significantly higher scores for the importance of completing a wellness exam ($t=10.60$, $p<0.001$), a dental exam ($t=14.65$, $p<0.001$), and a health risk assessment ($t=7.19$, $p<0.001$) compared to those who did not complete the behavior (Figure 22).

Figure 21. Respondents' preference for completing a wellness/dental exam and HRA or to paying $10 per month premium

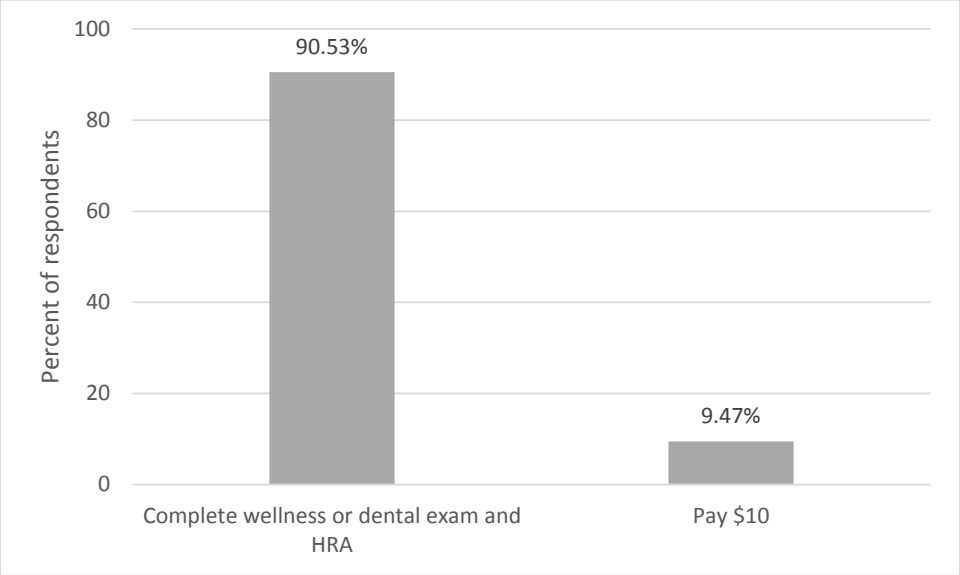
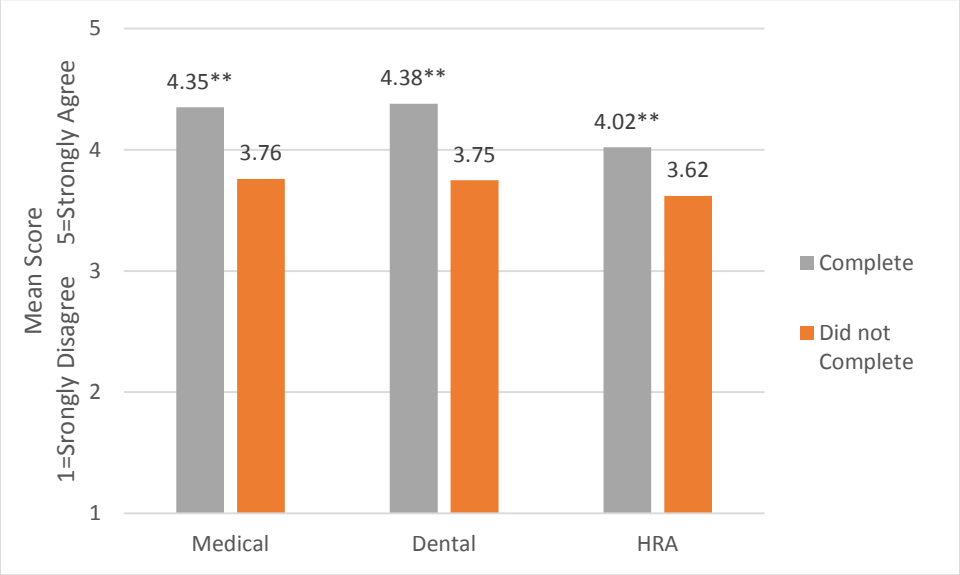


Figure 22. Respondents' perception of the importance of completing each behavior by completion of behavior status

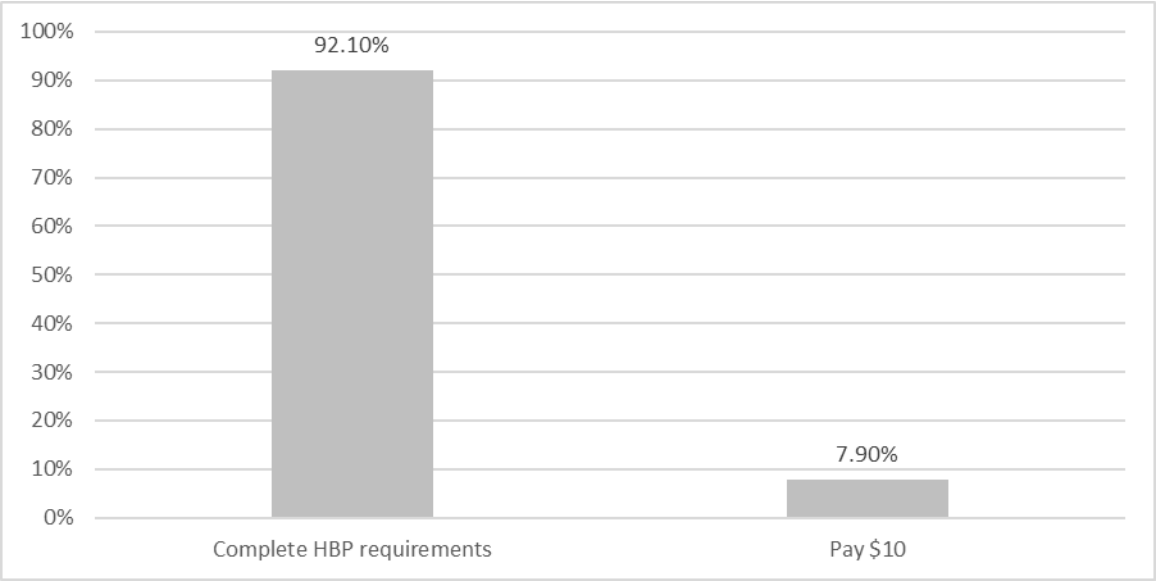


* indicates significant difference at $p < 0.05$
** indicates significant difference at $p < 0.001$

Data Source: Enrollee follow up survey 2018 of those surveyed in 2017

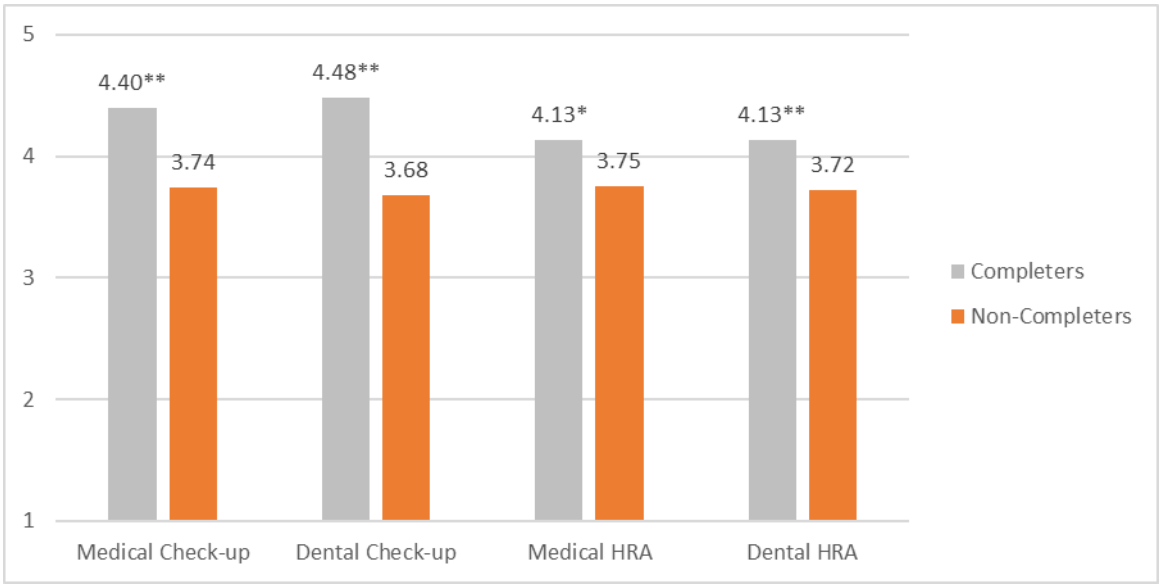
Respondents overwhelmingly chose to complete a wellness/dental exam and the HRA (92%) rather than pay $10 per month (8%). Respondents who completed each behavior reported significantly higher scores for the importance of completing the behavior than those who did not complete the behavior.

Figure 23. Respondents' preference for completing a wellness/dental exam and HRA or to paying $10 per month premium



Respondents who completed each individual behavior reported significantly higher scores for the importance of completing a wellness exam ($t=6.47$, $p<0.001$), a dental exam ($t=11.28$, $p<0.001$), a medical health risk assessment ($t=4.29$, $p<0.001$), and an oral health risk assessment ($t=5.17$, $p<0.001$) compared to those who did not complete the behavior (Figure 24).

Figure 24. Respondents' perception of the importance of completing each behavior by completion of behavior status



* indicates significant difference at $p < 0.05$
** indicates significant difference at $p< 0.001$

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

Data Source: Enrollee Survey 2017

Respondents to the member survey reported completing a wellness exam (83.49%), a dental exam (60.15%), and an HRA (64.84%), with 62.11% reporting having completed a wellness/dental exam and an HRA. The barriers to completing these behaviors are difficult to quantify as some barriers are more challenging to overcome than others. The most common barrier for not completing a wellness exam was not believing one was needed (27.18%). For dental exams, having dentures or having no or few teeth was the most frequently cited barrier (18.67%). The most frequently cited barrier for completing the HRA was not being aware it was required (42.77%)

Table 36 provides a summary of the barriers to obtaining a wellness exam reported by respondents who reported not completing an exam.

Table 36. Barriers to obtaining a wellness exam*

	n	percent
I don't believe I need a medical check-up	56	27.18
I can't get time off from work	29	14.08
It wasn't a priority, no reason, I just haven't, or I forgot	26	12.62
I was busy	25	12.14
I haven't yet but intend to or it is scheduled	14	6.80
I only go if i need to	13	6.31
It is hard to get an appointment for a medical check-up from my doctor	11	5.34
I am not sure where to go to get a medical check-up	10	4.85
I don't currently have a doctor	7	3.40
Getting transportation to my doctor's office is hard	7	3.40
I don't like getting a medical check-up	5	2.43
I can't get child care	5	2.43
I don't like my current doctor	4	1.94
Issues or confusion with insurance	3	1.46
Not time for an appointment	3	1.46
I didn't know I was supposed to	3	1.46

*Respondents were able to select multiple responses

Table 37 provides a summary of the barriers to obtaining a dental exam reported by respondents who said they did not have a dental exam.

Table 37. Barriers to obtaining a dental exam*

	n	percent
I have dentures, no teeth, or few teeth	84	18.67
I don't believe I need a dental check-up	61	13.56
I am not sure where to go to get a dental check-up	53	11.78
I don't currently have a dentist	49	10.89
I was busy	48	10.67
It's not a priority, no reason, I just haven't, I forgot, or I did not schedule one	48	10.67
I don't like getting a dental check-up	46	10.22
I can't get time off from work	44	9.76
Local provider does not take insurance/no local provider	38	8.44
It is hard to get an appointment for a dental check-up from my dentist	28	6.22
Getting transportation to my dentist's office is hard	22	4.89
I do not believe I have dental insurance/ I did not know until recently	20	4.44
I didn't get a card/other insurance issues	15	3.33
I don't like my current dentist	13	2.89
Financial reasons	10	2.22
I haven't yet but intend to/is scheduled	8	1.78
I can't get child care	5	1.11
I didn't know I was supposed to	4	0.89

*Respondents were able to select multiple responses

Table 38 provides a summary of the barriers to completing a HRA reported by respondents, who reported not completing an HRA.

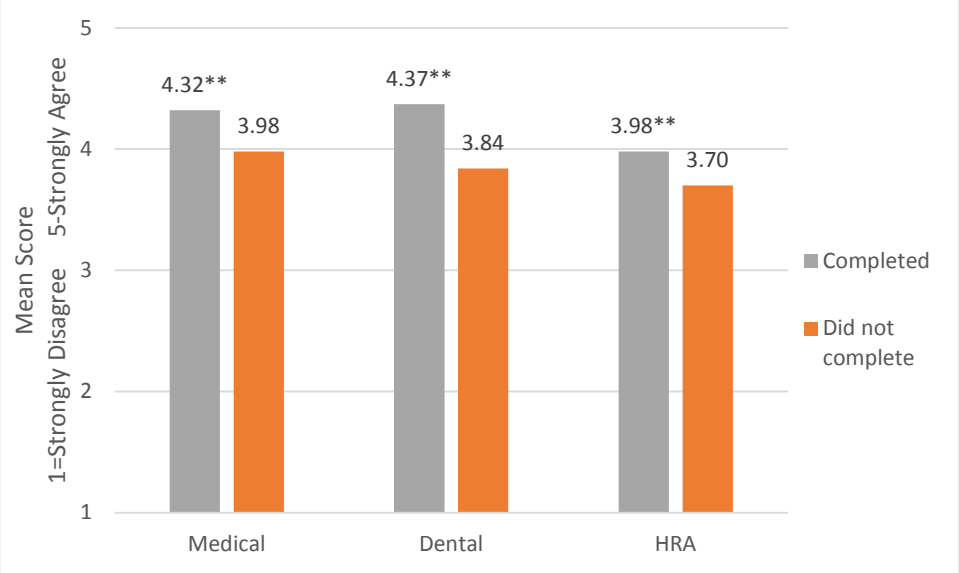
Table 38. Barriers to completing an HRA*

	n	percent
I wasn't aware I was supposed to complete the health risk assessment	142	42.77
I forgot	31	9.34
I did not think it was important	28	8.43
I was busy	25	7.53
It was not a priority, no reasons, or I just haven't	21	6.33
The health risk assessment was too long to complete	11	3.31
I lost the letter	10	3.01
I feel healthy/it is not necessary	10	3.01
I was not provided enough information	7	2.11
I don't like providing information	5	1.51
I do not have internet access	4	1.20
The health risk assessment was about information my health care provider already has	4	1.20
I do not know how to use the internet	3	0.90
I haven't yet but intend to	3	0.90
I didn't know how to use my pin to log in	2	0.60
I'd rather pay	2	0.60
I didn't know how to turn it into the clinic	1	0.30
I don't think I need one	1	0.30

*Respondents were able to select multiple responses

Members who completed each health behavior reported higher benefits compared to those who did not for completing a wellness exam (t=6.67, p<0.001), completing a dental exam (t=13.11, p<0.001), completing a HRA (t=5.10, p<0.001) (Figure 25). Respondents who completed a behavior reported higher benefits compared to those did not complete the behavior. This relationship was true across all three behaviors.

Figure 25. Respondents' perception of how beneficial wellness exams, dental exams, and HRA are for those who completed the behavior and those who did not complete the behavior



* indicates significant difference at p < 0.05
** indicates significant difference at p< 0.001

Data Source: Enrollee follow up survey 2018 of those surveyed in 2017

In the most recent survey (2018), members reported completing a wellness exam (85.6%), a dental exam (73.5%), a medical HRA (71.5%), an oral HRA (35.1%), with 67.9% reporting that they completed both a wellness or dental exam and an HRA. The barriers to completing these behaviors are difficulty to quantify as some barriers are more challenging to overcome than others .The most common barrier for not completing a wellness exam was being too busy (35.7%). For a dental exam the most common barrier was having no teeth or dentures (26.8%). The most common barrier to completing a medical HRA was not being aware one was needed (35.1%) and the most common barrier to completing an oral HRA was also not being aware that it was needed (37.5%)

Table 39. Awareness of HBI and Completion of Behaviors

	2018		2017	
	n	percent	n	percent
Awareness of HBI	383	59.8	336	52.4
Complete wellness exam	549	85.6	559	87.2
Complete dental exam	407	63.5	401	62.6
Complete medical HRA	458	71.5	441	68.8
Complete oral HRA	225	35.1	N/A	N/A
Complete wellness or dental exam and HRA	435	67.9	426	66.5

Table 40 provides a summary of the barriers to obtaining a wellness exam reported by respondents who reported not completing an exam.

Table 40. Barriers to obtaining a wellness exam* (n=84)

	n	Percent
I am too busy	30	35.7
I don't believe i need a medical check-up	20	23.8
Intend to soon or appointment scheduled	12	14.3
I can't get time off from work	5	6
Getting transportation to my doctor's office is hard	4	4.8
I am not sure where to go to get a medical check-up	3	3.6
I don't currently have a doctor	3	3.6
It is hard to get an appointment for a medical checkup from my doctor	2	2.4
I don't like my current doctor	1	1.2
I don't like getting a medical check-up	1	1.2
Other	24	28.6
***Respondents were able to select multiple responses**		

Table 41 provides a summary of the barriers to obtaining a dental exam reported by respondents who reported not completing a dental exam.

Table 41. Barriers to obtaining a dental exam* (n=231)

	n	percent
No teeth or have dentures	62	26.8
Local providers do not take coverage or no local providers	45	19.5
I am too busy	41	17.7
Don't like going to the dentist	23	10.0
I don't believe i need a dental check-up	19	8.2
I don't currently have a dentist	17	7.4
Getting transportation to my dentist's office is hard	13	5.6
I don't like getting a dental check-up	11	4.8
I am not sure where to go to get a dental check-up	10	4.3
It is hard to get an appointment for a dental check-up from my dentist	10	4.3
Intend to soon or appointment scheduled	10	4.3
I don't like my current dentist	7	3.0
Financial situations	7	3.0
I did not know i had dental insurance	6	2.6
I can't get time off from work	5	2.2
I can't get child care	3	1.3
Other	22	9.5
Don't know/not sure	2	0.9
***Respondents were able to select multiple responses**		

Table 42 provides a summary of the barriers to completing a medical HRA reported by respondents who reported not completing a medical HRA.

Table 42. Barriers to completing a medical HRA* (n=111)

	n	percent
I wasn't aware I was supposed to complete the HRA	39	35.1
I am too busy	19	17.1
Don't think I need one	10	9.0
I forgot	10	9.0
I did not think it was important	6	5.4
I do not have internet access	2	1.8
I lost the letter	1	0.9
I didn't know how to use my pin to log in	1	0.9
The HRA was too long to complete	1	0.9
Other	42	37.8
Don't know/not sure	4	3.6
***Respondents were able to select multiple responses**		

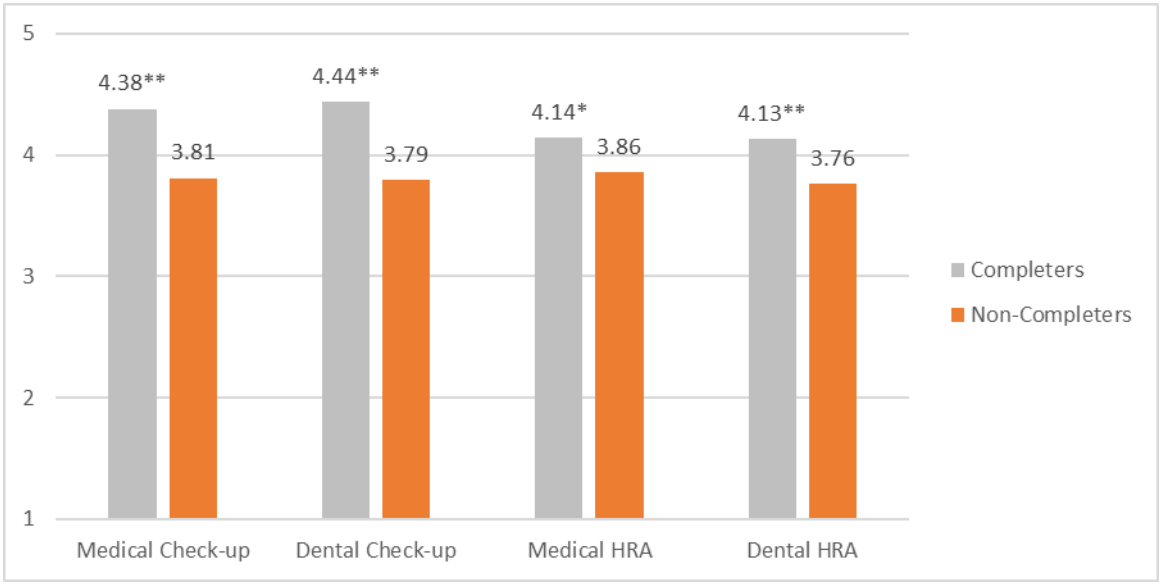
Table 43 provides a summary of the barriers to completing an oral HRA reported by respondents who reported not completing an oral HRA.

Table 43. Barriers to completing an oral HRA* (n=304)

	n	percent
I wasn't aware I was supposed to complete the oral health self-assessment	114	37.5
I haven't been to a dentist	43	14.1
I am too busy	30	9.9
Dentures/ no teeth	28	9.2
Don't think I need one	20	6.6
I don't have a dentist	19	6.3
Never received one	16	5.3
I forgot	15	4.9
I do not have dental coverage	13	4.3
I didn't know how to turn it	10	3.3
I did not think it was important	9	3.0
Dentists don't take insurance	8	2.6
I don't like dentists	6	2.0
I do not have internet access	2	0.7
I do not know how to use the internet	1	0.3
Other	39	12.8
Don't know/not sure	5	1.6
***Respondents were able to select multiple responses**		

Respondents who completed each individual behavior reported significantly higher scores for the benefit of completing a wellness exam (t=7.51, p<0.001), a dental exam (t=10.04, p<0.001), a medical HRA (t=3.28, p=0.001), and an oral HRA (t=4.99, p<0.001) compared to those who did not complete the behavior (Figure 26). This relationship was true across all four behaviors.

Figure 26. Respondents' perception of how beneficial wellness exams, dental exams, medical HRA, and oral HRA are for those who completed the behavior and those who did not complete the behavior



* indicates significant difference at p < 0.05
** indicates significant difference at p< 0.001

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

Data Source: Enrollee Survey 2017

There was no significant difference (t=1.20, p=0.230) in average scores for locus of control between members who completed the healthy behaviors (M=8.11, SD=1.96) and those who did not (M=7.98, SD=2.13).

Data Source: Enrollee follow up survey 2018 of those surveyed in 2017
There was no significant difference (t=1.24, p=0.215) in average scores for locus of control between respondents who completed the healthy behaviors (M=8.18, SD=1.80) and those who did not (M=7.99, SD=1.90).

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

Data Source: Enrollee Survey 2017

Only 678 respondents (49.31%) stated that they were aware of the monthly premium that they may have to pay if they did not complete the healthy behaviors. When asked why they did not pay their premium payments, respondents

reported that they did not receive invoices or bills (40.00%), almost 20% reported they did not have the money to pay and just over 25% did not believe they owed premiums.

Table 44. Reasons why respondents did not pay monthly premiums*

	n	percent
I did not know I needed to pay	92	9.34
I did not have the money	194	19.70
I forgot to pay	48	4.87
I did not know how to pay or who to pay	5	0.51
I did not receive invoices or bills telling me to pay	394	40.00
I did not understand the invoices or bills i received	11	1.12
I don't have premiums	263	26.70
I had a hardship waiver	5	0.51
I had issues with the methods to pay	12	1.22
Other	23	2.34
Don't know/not sure	10	1.02
Refused	0	0.00

*Respondents were able to select multiple responses

Data Source: Enrollee follow up survey 2018 of those surveyed in 2017

Only 386 respondents (60%) stated that they were aware of the monthly premium that they may have to pay if they did not complete the healthy behaviors. When asked why they did not pay their premium payments, those respondents who had not reported that they did not have the money to pay (48%), had a hardship waiver (16%) or did not receive invoices or bills (15%).

Table 45. Reasons why respondents did not pay monthly premiums* (n=304)

	n	percent
I did not have the money	92	48.4
I had a hardship waiver	30	15.8
I did not receive invoices or bills telling me to pay	29	15.3
I don't have premiums	21	11.1
I did not know I needed to pay	17	8.9
I forgot to pay	12	6.3
I had issues with the methods to pay	11	5.8
I did not know how to pay or who to pay	4	2.1
I did not understand the invoices or bills I received	3	1.6
Other	18	9.5
Don't know/not sure	2	1.1
***Respondents were able to select multiple responses**		

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

Data Source: Health Behaviors Incentive Program Evaluation, 2016

Interview data from members indicates there was some level of understanding that the wellness exam and HRA could help identify health problems early.

To assess measure 52, interviewees were probed Why do you think your health plan is encouraging people to get check-ups/annual exams? What about health risk assessments? Interviewees enrolled in both Marketplace Choice plans and the Iowa Wellness plan identified preventive care, identifying current and future healthcare issues, general health promotion, encouraging annual checkups, and lowering healthcare costs in the long term as reasons health plans are encouraging individuals to participate the HBI program. Preventative care and lowering healthcare costs were the most common responses among all interviewees.

Quotes from Marketplace Choice members:

• I think it's important to get annual exams. I mean, there's underlying health issues that a lot of people don't realize they have. That need to be addressed. And. So. I think that's very important to have an annual exam. I think it makes 'em think more in depthly about their health. And, you know, why they should or shouldn't have health insurance. And, 'cuz they ask, it asks good questions about you and makes ya think about it. [3001]

Quotes from Iowa Wellness Plan members:

• Well, maybe they, it's to head off any problems, you know. Catching things early. And, you know, for your own betterment and. [1079]

• Well I imagine it's because of the increase in illnesses like diabetes and cancer. Now, I don't know if we're seeing it more often or if before people just didn't notice. So I'm guessing that now they want people to be able to detect all of that sooner and to be able to get treatment sooner, to be able to fight it off. [2002]

• Well I think if we stay on top of things, then that keeps health costs down. [3101]

• Just to make sure they're healthy, and that they're not covering things that could be prevented. [4103]

• One, because preventative care, you know, is one, life-saving. It's money-saving. And, you know, people need to be aware and, you know, take (very) care for themselves. [3010]

• To avoid any major problems like, for example the mammogram that prevents your or they do an early (detention) of cancer, so. [3066]

To assess measure 53, Interviewees were asked What do you think the benefits are to getting regular check-ups? and What do you think are the benefits from completing this assessment? Interviewees enrolled in Marketplace Choice stated that participating in the program made them consider health and lifestyle decisions that they may not have previously. Interviewees enrolled in the Wellness Plan also mentioned that participation lead them to consider health and lifestyle decision with some specifically mentioning diet and exercise as examples of area that could be improved. A common sentiment among the responses was that participation raised awareness and stimulated action towards

healthier decision and lifestyle. Many interviewees from both the Marketplace Choice and Iowa Wellness Plan did not comment on any change in their behavior or how enrollment in the program influenced did or could influence their behavior.

Quotes from Marketplace Choice members:

• Just to be healthy and stay healthy...You know, and if they, and then if there's, something is wrong, you know, they're gonna let me know I'm sure and I could rectify the situation. [1016]

• Well, that way I know what's going on with my health. And I can get help from my doctor, you know, if something is wrong...I wanna stay healthy. I don't like being sick, it's just not like me to be sick. I haven't been sick in seven or eight years. [1016]

• Where there's stuff that sometimes you don't think of as a daily basic of your health and stuff so sometimes I think it would be good to learn. Or, to understand other stuff, so. I think it's a benefit and plus if they're willing to pay the premium for the year, that's even better too! [4002]

Quotes from Iowa Wellness Plan members:

• You could use whatever you said was like a way to improve your opinion on your own health and actually take action on that. And actually improve your health (laughing) instead of just thinking about it.[3053]

• Well, some of the benefits is that you really have to get on top of your health. Like if you have a problem with your heart or high blood pressure, it could be your weight, you know. If you have any diabetes and then your, they look for it, you know, the blood glucose. And stuff like that. It's pretty important. [1106]

• Basically, you know, you go in and you talk to your doctors. They tell you what you should and shouldn't be doin', what you should and shouldn't be eatin'...You know, things like that.

• It has. I don't know, it made me stop and think about my lifestyles. (laughing). [1007]

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

Data Source: Enrollee Survey 2017

About one third of respondents, 462, had received an invoice for a monthly premium. Of those respondents, 298 (64.50%) stated that they were able to pay their premium. The majority of respondents, 71.61%, reported months where they did not pay their premiums. See Table 45 for reasons why respondents stated they did not pay the monthly premium. About 50% of respondents reported that they knew they could claim a financial hardship if they were not able to pay the bill and would not have to pay the premium. Survey respondents overwhelmingly did not owe a debt to the states (44.00%) or had paid their premiums (41.75%), but 119 (8.65%) of the respondents stated that they have not yet paid the State of Iowa for the unpaid premiums (Table 46). Of those who had not paid the State of Iowa, 46 (38.02%) stated they are concerned about the debt being sent to collectors (Table 47).

Table 46. Have you paid the State of Iowa for your premiums of $5 or $10 a month?

	n	percent
Yes	574	41.75
No	119	8.65
I do not owe a debt to the state	605	44.00
Don't know/not sure	75	5.45
Refused	2	0.15

Table 47. Are you concerned about your debt being sent to collections?

	n	percent
Yes	46	38.02
No	72	59.50
Don't know/not sure	1	0.83
Refused	2	1.65

Data Source: Enrollee follow up survey 2018 of those surveyed in 2017

About two fifths of respondents, 251, had received an invoice for a monthly premium. Of those respondents, 171 (68%) stated that they were able to pay their premium. Approximately a third of respondents, 30%, reported months where they did not pay their premiums. See Table 45 for reasons why respondents stated they did not pay the monthly premium. About 60% of respondents reported that they knew they could claim a financial hardship if they were not able to pay the bill and would not have to pay the premium.

INITIAL REVIEW DRAFT

SUBMITTED: April 2019

Iowa Health and Wellness Plan Evaluation Interim Summative Report

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Executive Summary

Below are the research questions and associated hypotheses for the evaluation of the Iowa Wellness Plan with a summary of the results for comparisons with income eligible Medicaid members.

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

Hypothesis 1.1

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

Most measures within the hypothesis indicated that IWP members had equal access to primary care and specialty services.

Hypothesis 1.2

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

Preventive care measures show that IWP members did have equal or greater access to preventive services. The only exception to this finding was in cervical cancer screening where rates were higher for women who were income eligible for Medicaid.

Hypothesis 1.3

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

Results indicate that IWP members had a lower need for mental and behavioral health services as well as a lower unmet need for these services.

Hypothesis 1.4

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

Though IWP member access to care seems equal to Medicaid member access to care, utilization of the ED for non-emergent care is lower.

Hypothesis 1.5

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

IWP members do have lower barriers to care from transportation than Medicaid members despite the fact that they had a higher unmet need for transportation to health care.

Hypothesis 1.6

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

This hypothesis was not tested due to the low numbers of members 19-20 years of age. Many Medicaid members are able to remain in the Medicaid program during transition to adulthood at 21.

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

Hypothesis 2.1

Iowa Wellness Plan members will experience equal or less churning

Originally, IWP resulted in approximately 40,000 people losing coverage through the elimination of the IowaCare program, however for those who remained in IWP access to services and providers was expanded. Once the program stabilized the amount of churning was comparable between IWP and Medicaid.

Hypothesis 2.2

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

Some IWP members did churn into the Medicaid program, presumably due to a decrease in income. However, we were unable to follow members who lost eligibility over time. More information regarding access to care following disenrollment is contained in the HBI report.

Survey questions did address continuity of care when changing plans. Approximately half of the members who identified as having a personal doctor or nurse were able to retain a continuous relationship with that provider when changing plans and approximately 15% were able to gain a personal doctor or nurse when changing plans.

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

Hypothesis 3.1

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

Though most administrative measures related to quality of care were removed due to small numbers, the survey results indicated that IWP members were more likely to receive a flu shot than Medicaid members.

Hypothesis 3.2

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

IWP members experienced higher rates of hospitalization than Medicaid members, however, this must be interpreted with care, as we are unable to risk adjust the IWP population. This population is older and more likely to be chronically ill than the population of income eligible Medicaid members.

Hypothesis 3.3

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

IWP members generally reported equal or higher levels of satisfaction with care than Medicaid members.

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

Hypothesis 4.1

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

PMPM costs for IWP members were at or below the costs for Medicaid State Plan members during the previous waiver period. However, cost was not evaluated during the most recent waiver period as IWP and Medicaid State Plan members were covered by capitation, making the state's cost for their care comparable.

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

Hypothesis 5.1

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

The role of premium incentive impacting ability to receive health care was not addressed within the evaluation, however, less than ½ of members were aware of the premium incentive and less than 30% were worried a great deal about paying a premium. Additionally, the need for paying a premium was not mentioned as one of the top reasons for not obtaining a medical or dental exam.

Hypothesis 5.2

The majority of IWP members will complete the healthy behaviors and therefore not have to pay a premium incentive or be disenrolled.

A majority of IWP members were not disenrolled, though the reasons for this are unclear as definition, completion and documentation of the healthy behaviors has changed over time.

Hypothesis 5.3

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

Though the impact of the copayment on access to care was not assessed, less than 35% of IWP members were aware of the ED copayment requirement and less than ½ felt it would be very easy to know what constitutes an emergency condition.

Hypothesis 5.4

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

The utilization of annual exam increased over the 4 years of the IWP program.

Hypothesis 5.5

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

The increase in smoking cessation services was not addressed.

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

Hypothesis 6.1

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

Iowa Wellness Plan members did have equal or greater access to an adequate provider network as compared to those in the Iowa Medicaid State Plan.

Background

There were originally two components to the Iowa Health and Wellness Plan (IHAWP), a bipartisan solution to expand health care to low-income adult Iowans not categorically eligible for Medicaid: Wellness Plan (WP), a program operated by the Iowa Department of Human Services that provided health coverage for uninsured Iowans from 0-100% of the Federal Poverty Level (FPL) and Marketplace Choice (MPC), a premium support program for Iowans from 101-133% FPL. More information regarding the formulation and implementation of IHAWP can be found online at http://dhs.iowa.gov/ime/about/initiatives/iowa-health-and-wellness-plan.

IHAWP was modified in significant ways in the first two years (**Table 1**), affecting the program design, the network of providers from whom members could receive services, and potentially the outcomes evaluated in this report. The first major change occurred when CoOportunity Health withdrew as a Qualified Health Plan (QHP) option for MPC members at the end of November 2014.[1] Approximately 9,700 CoOportunity Health members were automatically transitioned to Medicaid providers on December 1, 2014 through MediPASS (primary care case management [PCCM] program), Meridian (HMO), or traditional Medicaid (fee-for-service [FFS] payment mechanism); however, they retained their designation as MPC members. IHAWP members who were not in CoOportunity Health remained in Coventry, the other QHP. However, Coventry was not willing to cover MPC members transitioning from CoOportunity Health.

Effective January 1, 2016 MPC members were rolled into WP and the Iowa Health and Wellness Plan (IHAWP) became Iowa Wellness Plan (IWP) covering Iowans not categorically eligible for Medicaid with incomes from 0-133% FPL through one program.

Beginning April 1, 2016, Iowa implemented mandatory managed care service delivery. The majority of Medicaid members, including IHAWP members, were enrolled with one of three managed care organizations (MCOs). Due to a three-month implementation delay, IHAWP members enrolled with a QHP were placed into the traditional Medicaid FFS program effective December 31, 2015, until the Medicaid Managed Care Organizations (MCOs) were able to begin accepting members on April 1, 2016.

Members were enrolled with one of three MCOs: Amerigroup Iowa, Inc.; AmeriHealth Caritas, Inc.; or UnitedHealthcare Plan of the River Valley, Inc. This report provides the outcome results for the two years in which statewide managed care was implemented. However, due to the late start members were only in the MCO model for nine months during CY 2016. The results for previous years are contained in a number of reports and articles that can be accessed at http://ppc.uiowa.edu/health/study/evaluation-iowas-medicaid-expansion-iowa-health-and-wellness-plan.

[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.

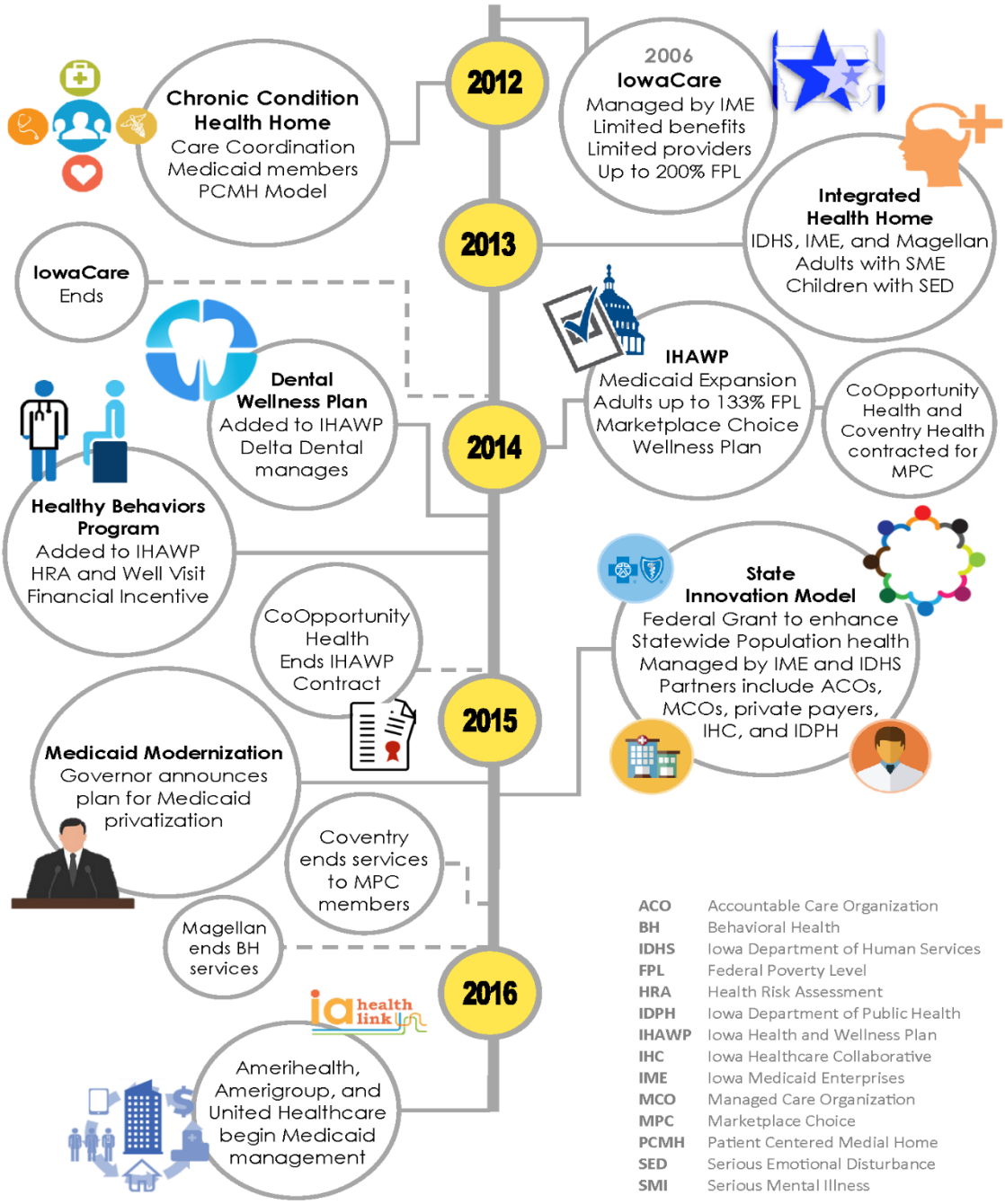
Table 1. IHAWP timeline

Date	Change
January 2014	First IHAWP members enrolled
May 2014	MPC members enrolled in Dental Wellness Plan with Delta Dental of Iowa
July 2014	MPC members enrolled in the Healthy Behaviors Incentive Program
November 2014	MPC members in CoOportunity transitioned to MediPASS (PCCM program), Meridian (HMO), or Coventry (QHP)
November 2015	MPC members in Coventry transitioned to MediPASS or Fee-for-service (MPC component dormant)
April 2016	MPC members transitioned to one of three MCOs - AmeriGroup Iowa, AmeriHealth Caritas, or UnitedHealthcare Plan of the River Valley
November 2017	AmeriHealth Caritas exists Medicaid program

Other activities in Iowa

Other activities occurring in Iowa's health care system during the implementation and first three years of IWP may have affected some of the outcomes in this report (**Figure 1**). For example, Iowa completed the first three years of a four-year State Innovation Model project implementing statewide system changes designed to increase the proportion of providers in value-based purchasing (VBP) contracts, increase members covered by VBP contracts, enhance health information technology (HIT) to provide alerts regarding emergency department use, and improve population health through targeted model projects and statewide health strategies. Along with the introduction of MCOs, these activities implemented statewide make it more difficult to isolate IWP-induced changes in utilization or health outcomes.

Figure 1. Iowa health system changes



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).

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.

MSP – Medicaid State Plan

MSP 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. MSP members enrolled due to disability determination are not included in these results.

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.

People with incomes 0-100% FPL were enrolled in Wellness Plan
People with incomes 101-133% FPL were enrolled into Marketplace Choice
People whose income was from 134-200% 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 2**) 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. 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 2. Map of IowaCare Medical Home Regions

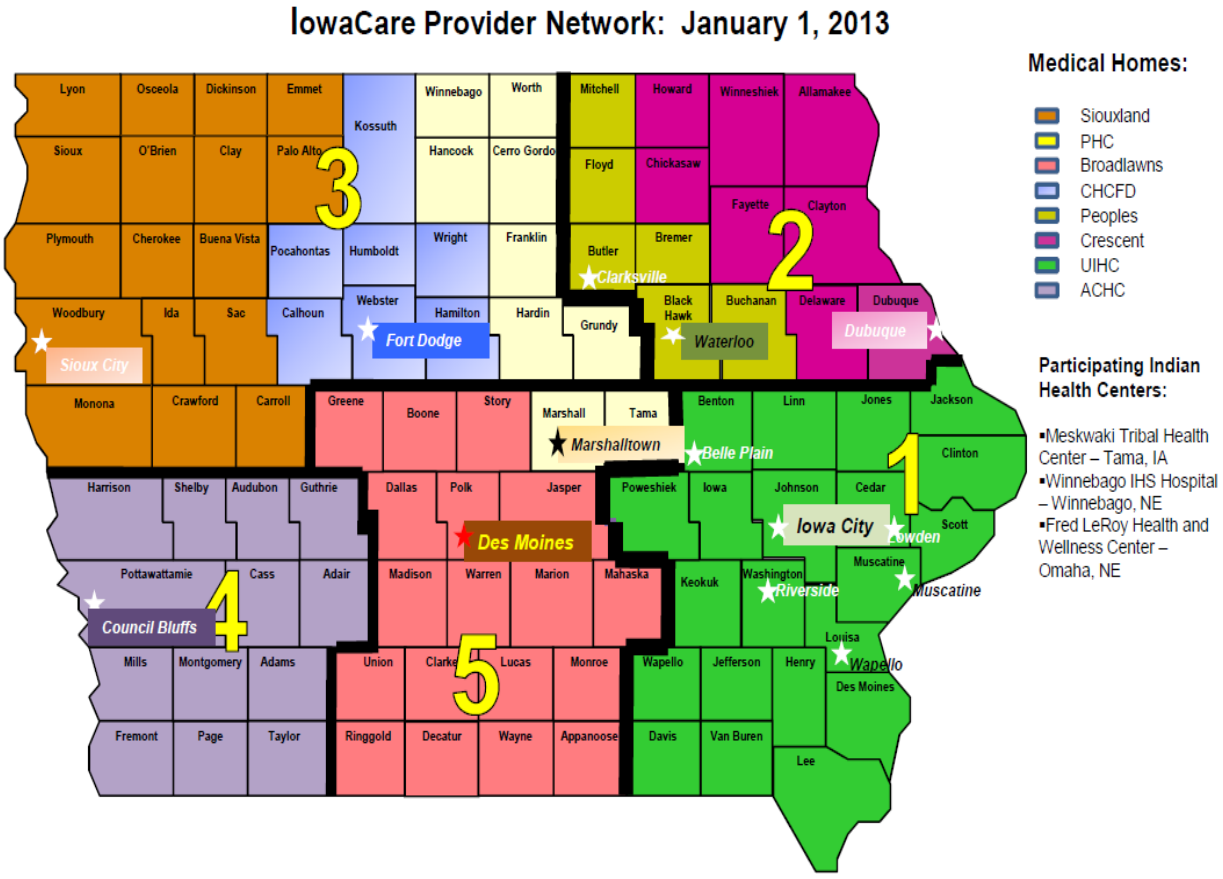


Table 2 provides comparisons of IWP members from CY 2014 – CY 2017. The characteristics of IWP members remained stable over the three years following implementation. IWP members were equally likely to be male or female and most likely to be white, between 22 and 30 years of age, and live in a metropolitan area.

Table 2. Demographic characteristics of IWP members CY 2014 - 2017

	CY 2017 N (%)	CY 2016 N (%)	CY 2015 N (%)	CY 2014 N (%)
Gender				
Female	117,991 (53%)	105,606 (51%)	102,598 (52%)	78,421 (51%)
Male	102,372 (47%)	99,413 (49%)	95,086 (48%)	74,966 (49%)
Race				
White	140,324 (64%)	134,327 (66%)	129,637 (66%)	99,487 (65%)
Black	18,844 (9%)	17,337 (9%)	15,932 (8%)	11,908 (8%)
American Indian	3,473 (2%)	3,145 (2%)	2,609 (1%)	2,017 (1%)
Asian	5,226 (2%)	4,687 (2%)	4,323 (2%)	3,066 (2%)
Hispanic	10,156 (5%)	9,182 (5%)	8,122 (4%)	5,548 (4%)
Pacific Islander	1,102 (<1%)	1,075 (<1%)	1,243 (1%)	819 (1%)
Multiple—Hispanic	2,904 (1%)	2,643 (1%)	2,330 (1%)	1,502 (1%)
Multiple—Other	2,188 (1%)	2,064 (1%)	1,810 (1%)	1,179 (1%)
Undeclared	36,146 (16%)	30,559 (15%)	31,678 (16%)	27,861 (18%)
Age				
18-21 years	18,205 (8%)	20,666 (10%)	19,325 (10%)	11,599 (8%)
22-30 years	62,203 (28%)	56,234 (27%)	53,039 (27%)	38,997 (25%)
31-40 years	53,260 (24%)	47,067 (23%)	44,720 (23%)	33,722 (22%)
41-50 years	38,780 (18%)	36,281 (18%)	35,588 (18%)	30,503 (20%)
51 and over	47,915 (22%)	44,769 (22%)	45,012 (23%)	38,566 (25%)
County rural/urban status				
Metropolitan	132,548 (60%)	121,398 (60%)	119,368 (60%)	93,551 (61%)
Non-metropolitan, urban	77,167 (35%)	69,809 (34%)	68,988 (35%)	52,977 (35%)
Non-metropolitan, rural	10,648 (5%)	9,705 (5%)	9,328 (5%)	6,859 (4%)
Total	**220,363**	**205,019**	**197,684**	**153,387**

Limitations to the study

For CY 2016 we provided a special note of caution in regard to comparisons over time. Though we provided some trend data, the change in data source and management may have led to variance in how claims were coded for billing and the quality of the data for analysis. However, results for CY 2017 were similar to the results for CY 2016, providing validation for the veracity of the CY 2016 results.

From CY 2016 forward we were able to include many more IWP members for measures requiring at least 11 months of eligibility for the measurement year and each of the two years prior to the measurement year (primarily breast cancer and cervical cancer screening). This is the second measurement year that members could have been eligible for IWP across three years. For example, the numbers of women receiving a breast cancer screening increased considerably from 1,855 to 4,430 though as a proportion of the eligible members the rate only increased from 60% to 62% in CY 2016.

As mentioned, the IowaCare program did not provide prescription drug coverage. This limits our ability to use the IowaCare data in measures that require data on medication use. In addition, members who were or became dually enrolled in Medicaid and Medicare are removed from the analysis, since accurate claims data were not available.

Previous results

Reports containing previous analyses and results can be found at

- IHAWP evaluation - http://ppc.uiowa.edu/health/study/evaluation-iowas-medicaid-expansion-iowa-health-and-wellness-plan
- Healthy Behavior Program - http://ppc.uiowa.edu/publications/healthy-behaviors-incentive-program-evaluation
- Provider network adequacy - http://ppc.uiowa.edu/publications/evaluation-provider-adequacy-iowa-health-and-wellness-plan-during-first-year

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), and Medicaid State Plan (MSP). Surveys with members of the WP, MPC, and MSP, were fielded post-implementation of the IHAWP (in October of 2014 and are included to provide results for hypotheses that were no longer deemed critical during the most recent waiver period. Surveys fielded in spring 2017 provided most of the information utilized to evaluate hypotheses. Detailed survey methodology, including the survey instruments, responses to each item in the surveys, and summarized results can be found at the Public Policy Center website.

Analytic methods

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 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. There are some 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 Iowa Wellness Plan on member access to care?*

Hypothesis 1.1

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

Measure 1 Access to primary care

Percent of members who had an ambulatory care visit

Definition

This measure protocol derives from HEDIS 2018. It provides the proportion of adults 20-64 years of age that were eligible for at least 11 months during the measurement year and 11 months during the year prior to the measurement year that had at least 1 preventive or ambulatory care visit during the measurement year.

Results

Table 3 indicates that FMAP adults were more likely to have a preventive/ambulatory visit throughout the study period, however, the proportion of IWP adults with a visit increased over this time. For adults 20-44 years of age in CY 2017, the proportion of FMAP adults with a visit was 89%, down 1% from CY 2016 but still above CY 2015 levels. During this same time, the proportion of IWP adults with a visit was 84%, down 2% from CY 2015 but up 8% from CY 2014. For adults 45-64 years of age, the proportion of FMAP adults with a visit dropped from 90% to 89%, while the proportion of IWP adults remained stable at 90% during that same time. In CY 2016, IWP adults 45-64 were as likely to have had a visit as the FMAP group. (See Figure 3 and Figure 4).

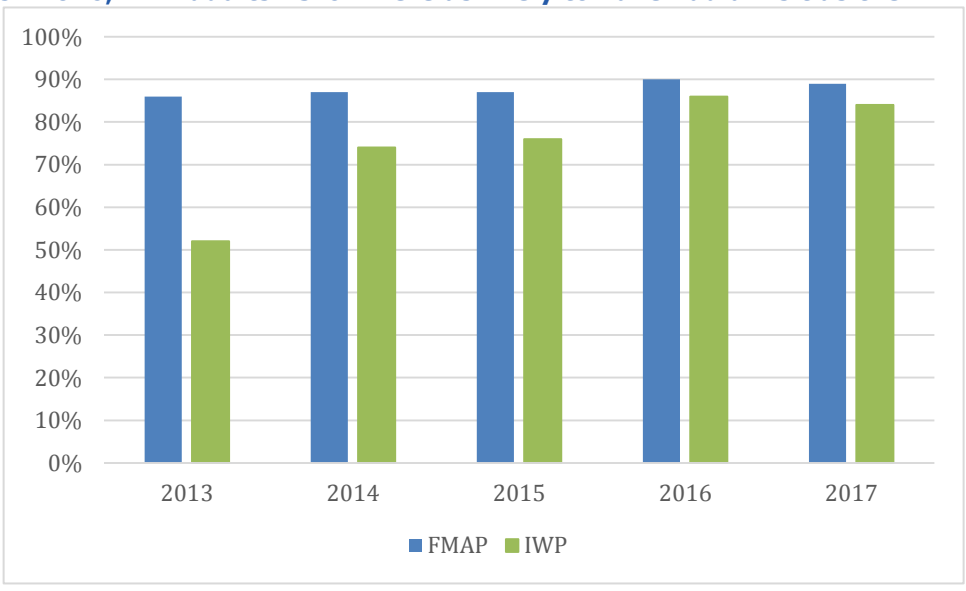


Table 3. Adults' access to preventive/ambulatory health services by program and age CY 2013 – CY 2017

Age	FMAP 2013	IC→IWP 2013	FMAP 2014	IWP 2014	FMAP 2015	IWP 2015	FMAP 2016	IWP 2016	FMAP 2017	IWP 2017
20-44 yrs	14,706	8,876	16,556	16,633	17,065	27,629	14,624	27,339	14,961	32,926
	86%	52%	87%	74%	87%	76%	90%	86%	89%	84%
45-64 yrs	1,494	9,016	2,049	14,428	2,386	20,287	2,309	23,832	2,323	25,238
	85%	66%	86%	83%	88%	84%	90%	90%	89%	90%
Total	16,200	17,892	18,606	31,061	19,451	47,916	16,933	51,271	17,329	58,474
	86%	59%	87%	78%	87%	79%	90%	88%	89%	86%

Figure 3. Access to preventive/ambulatory health services for adults 20-44 years of age by program and year, CY 2013-CY 2017

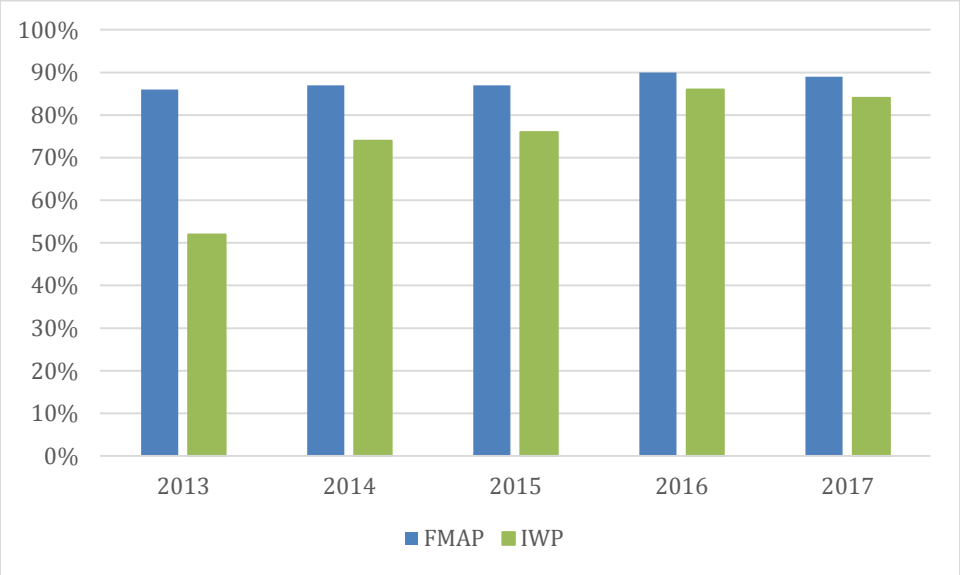
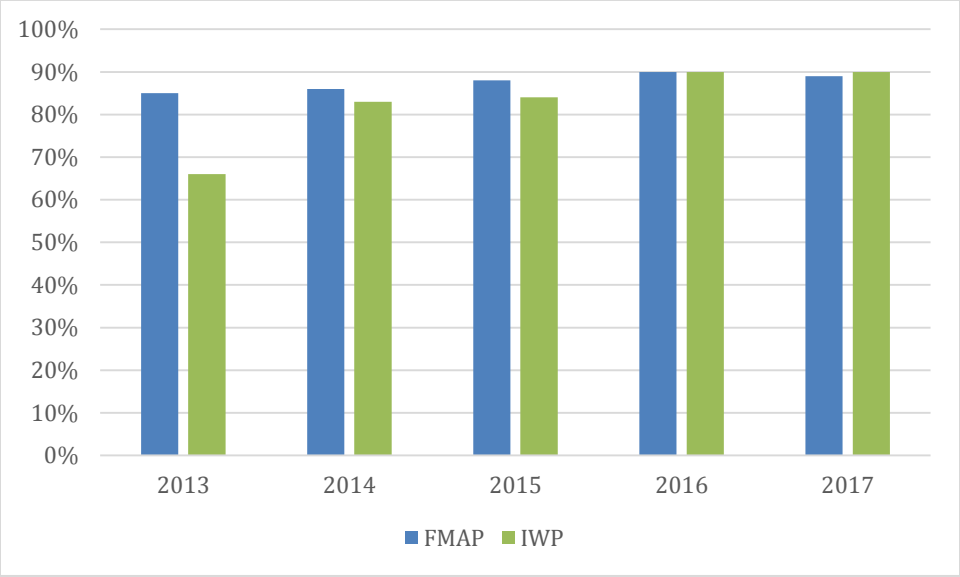


Figure 4. Access to preventive/ambulatory health services for adults 45-64 years of age by program and year, CY 2013-CY 2017



Whether a member had an ambulatory or preventive care visit

The DID framework is combined with multiple modeling frameworks to assess the robustness of the parameter estimation. Normal and logistic generalized estimating equation (GEE) models which account for within-individual correlation are fit. Additionally, a normal regression with individual random effects, a conditional logistic regression matching on individual is fit to further assess robustness. Equation (1) below expresses the normal GEE DID model and equation (2) the logistic GEE DID model:

$$Y_{it} = \mu + \gamma_{\text{FMAP}} + \gamma_{\text{SSI}} + \gamma_{\text{WP}} + \gamma_{\text{MPC}} + \text{T}_\text{t} + \gamma\text{T}_{\text{MPC}*\text{post}} + \gamma\text{T}_{\text{Wp}*\text{post}} + \mathbf{X}'_{\text{it}}\boldsymbol{\beta} + \varepsilon_{it} \qquad (1)$$

$$logit(Y_{it}) = \mu + \gamma_{\text{FMAP}} + \gamma_{\text{SSI}} + \gamma_{\text{WP}} + \gamma_{\text{MPC}} + \text{T}_\text{t} + \gamma\text{T}_{\text{MPC}*\text{post}} + \gamma\text{T}_{\text{WP}*\text{post}} + \mathbf{X}'_{\text{it}}\boldsymbol{\beta} \qquad (2)$$

where Y_{it} is an indicator for member *i* receiving a wellness visit in time period *t*, the γ terms are the program effects, T_t indicates the time period, $\gamma\text{T}_{\text{MPC}*\text{post}}$ is the MPC specific DID estimate, $\gamma\text{T}_{\text{WP}*\text{post}}$ the WP specific DID estimate, $\mathbf{X}'_{\text{it}}\boldsymbol{\beta}$ captures all other predictors controlled for, and ε_{it} the random error. The additional predictors controlled for include sex, race, UIC, age indicators, FPL indicators, months in a MHH indicators, months in a IHH indicators, had delivery, and chronic illnesses. Variations of all models were fit using only a subset of additional predictors, excluding having a delivery and chronic illnesses. Additionally, variations of all models are fit with the DID estimate for MPC and WP pooled into a single DID estimate; this is achieved by replacing $\gamma\text{T}_{\text{MPC}*\text{post}} + \gamma\text{T}_{\text{Wp}*\text{post}}$ with $\gamma\text{T}_{(\text{MPC or WP})*\text{post}}$ in equations (1) and (2).

Due to the nature of the models the GEE approach can estimate effects that are unchanging over time, such as sex and chronic illness status. Both the normal regression with individual random effects and conditional logistic regression matching on individual cannot estimate these. The robustness check solely focused on the DID parameter estimation.

Four different types of Models were fit as a robustness check.

1. Linear: OLS with person effects and robust standard errors
2. Linear: Generalized Estimating Equations (GEE)
3. Logistic: Conditional logistic regression with robust standard errors
4. Logistic: Generalized Estimating Equations (GEE)

Each model was fit using the full set and a reduced set of predictors.

1. Subset of predictors: sex, race, UIC, age, FPL, MHH, IHH, program, post indicator, DID estimates
2. All predictors: Subset of predictors + pregnancy, illness indicators

Each combination of the 4 model types and 2 sets of predictors were first fit with a separate DID estimator for WP/MPC and then fit with a pooled DID estimator for WP/MPC.

Results

Regardless of the model, DID estimator(s) always indicated that the likelihood of getting a wellness visit increased for those in WP or MPC over time, with a larger increase for WP than MPC (**Figure 5**). Regardless of model type and predictors used regression estimates are nearly identical across linear models and very similar across logistic models (**Table 4** and **Table 5**).

Figure 5. Proportion of members with a well adult visit by program

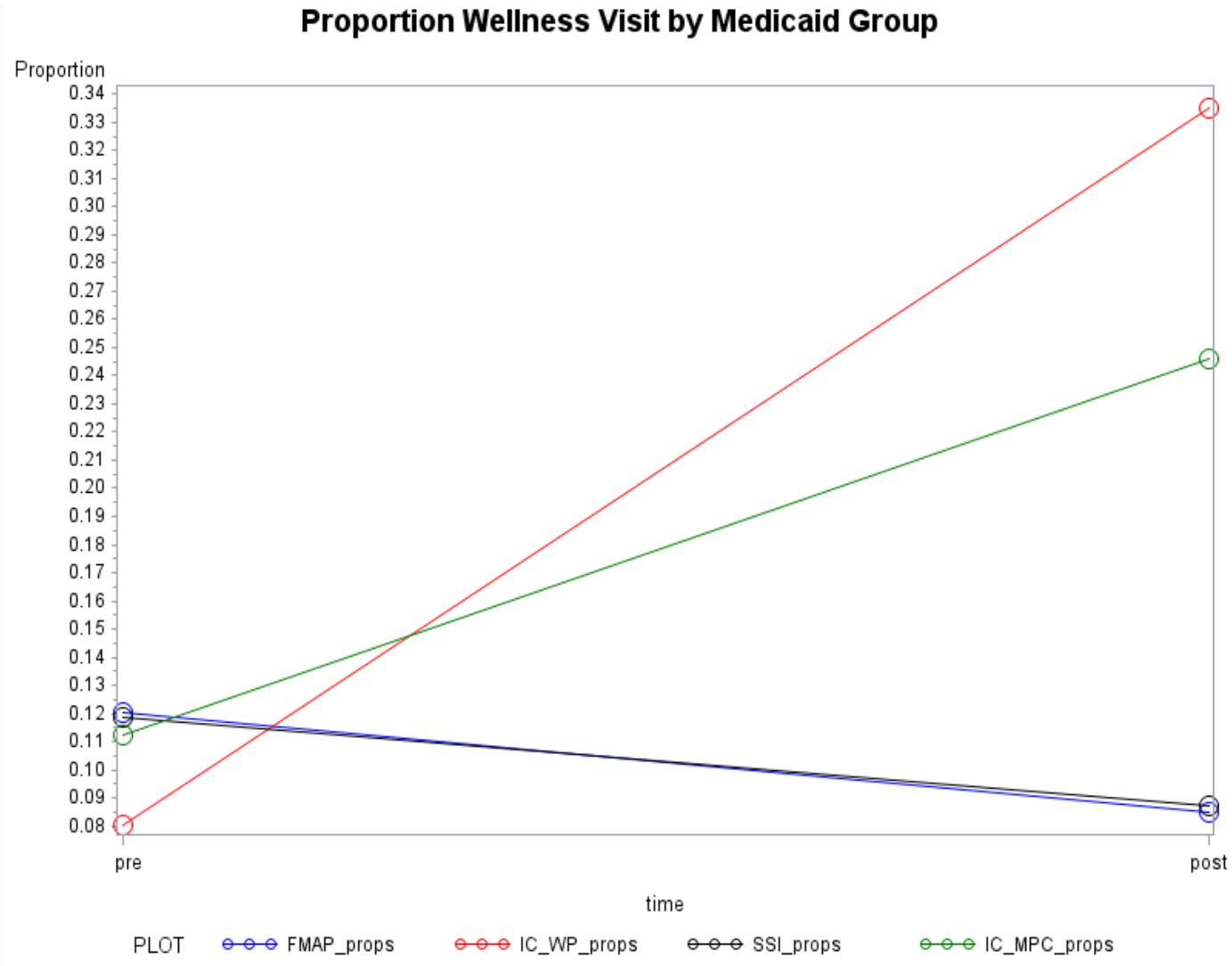


Table 4. Regression estimates for the full model across all model types

Response	Linear	Linear	Linear	Linear	Logistic	Logistic	Logistic	Logistic
Predictors	Subset	Subset	All	All	Subset	Subset	All	All
DID Estimate	Separated	Pooled	Separated	Pooled	Separated	Pooled	Separated	Pooled
Parameter	Beta	Beta	Beta	Beta	Beta	Beta	Beta	Beta
Intercept	0.0544***	0.0554***	0.0176***	0.0186***	-2.5889***	-2.5807***	-2.9796***	-2.9704***
Had delivery	-	-	-0.0465***	-0.0467***	-	-	-0.5487***	-0.5508***
Chronic Illnesses								
Attention Deficit Disorder	-	-	0.0115	0.0115	-	-	0.1168*	0.1172*
Acute Myocardial Infarction	-	-	-0.0329**	-0.0329**	-	-	-0.3203**	-0.3217**
Anxiety	-	-	-0.0049	-0.0049	-	-	-0.0352	-0.0358
Asthma	-	-	-0.0007	-0.0007	-	-	0.0025	0.0024
Coronary Artery Disease	-	-	-0.0079*	-0.0079*	-	-	-0.0622	-0.0618
COPD Emphysema	-	-	-0.0148***	-0.0149***	-	-	-0.1188**	-0.1192**
Cerebrovascular Event	-	-	-0.0146*	-0.0145*	-	-	-0.1209*	-0.1203*
Developmental Disorder	-	-	0.0485**	0.0483*	-	-	0.4053**	0.404**
Dementia	-	-	-0.0358	-0.0358	-	-	-0.3706	-0.3695
Depression	-	-	-0.0036	-0.0036	-	-	-0.0341	-0.0339
Diabetes	-	-	-0.0344***	-0.0344***	-	-	-0.2754***	-0.275***
Hypertension	-	-	0.0031	0.0031	-	-	0.0287	0.0291
Hypercholesterolemia	-	-	0.0499***	0.0499***	-	-	0.4032***	0.4021***
Liver Disease	-	-	-0.0022	-0.0022	-	-	-0.0145	-0.0155
Mental Health Problem	-	-	0.0332***	0.0332***	-	-	0.2979***	0.2975***
Mood Disorder	-	-	-0.0023	-0.0024	-	-	-0.0061	-0.0054
Mental Retardation	-	-	0.1100***	0.1101***	-	-	0.8398***	0.8405***
Obseity	-	-	0.0337***	0.0337***	-	-	0.2853***	0.2847***
Parkinson's MS	-	-	0.0086	0.0087	-	-	0.0870	0.0877
Pervasive Developmental Disorder	-	-	0.087***	0.087***	-	-	0.7075***	0.7058***
Pervsistent Mental Health Disorder	-	-	-0.0074	-0.0074	-	-	-0.0644	-0.0662
Renal Failure	-	-	-0.0234***	-0.0233***	-	-	-0.2141***	-0.214***
Substance Abuse Problem	-	-	-0.0018	-0.0019	-	-	-0.0113	-0.0122
Schizophrenia	-	-	0.0585***	0.0585***	-	-	0.5209***	0.5204***
FPL								
FPL equal 0	-	-	-	-	-	-	-	-
FPL between 1-37	0.0227***	0.0224***	0.0221***	0.0218***	0.1739	0.1712	0.1698***	0.1671***
FPL between 38-75	0.0187***	0.0177***	0.0165***	0.0156***	0.1547	0.1479	0.1399***	0.1331***
FPL between 76-100	0.0265***	0.0246***	0.026***	0.0242***	0.2112	0.1984	0.2115***	0.1988***
FPL between 101-133	0.0268***	0.0147*	0.0269***	0.0149*	0.2141	0.1428	0.2148***	0.1427**
FPL greater than 134	0.0208*	0.0204*	0.0200*	0.0197*	0.1820	0.1803	0.1793**	0.1776*
Female Indicator	0.047***	0.0472***	0.0429***	0.0431***	0.3967	0.3968	0.3672***	0.3673***
In an IHH ≥ 6 months	0.0549***	0.055***	0.0274***	0.0274***	0.4866	0.4870	0.2537***	0.2541***
In an MHH ≥ 6 months	-0.0213***	-0.0213***	-0.0372***	-0.0372***	-0.2198	-0.2200	-0.3639***	-0.3638***
UIC	0.0182***	0.0183***	0.0212***	0.0212***	0.1753	0.1754	0.2012***	0.2012***
Time period (Post)	-0.0337***	-0.0336***	-0.0348***	-0.0348***	-0.3715	-0.3714	-0.3897***	-0.3897***
Age Indicators								
Age between 19-21	0.0073	0.0074	0.0158**	0.0159**	0.0581	0.0586	0.1388*	0.1391*
Age between 22-30	-0.0136***	-0.0135***	-0.006*	-0.0059	-0.1372	-0.1357	-0.0667*	-0.0653*
Age between 31-44	-	-	-	-	-	-	-	-
Age between 45-64	0.0183***	0.0182***	0.0179***	0.0178***	0.1587	0.1575	0.1517***	0.1505***
Race								
American Indian	-0.0162	-0.0165	-0.0101	-0.0104	-0.1583	-0.1592	-0.1099	-0.1111
Asian	0.0403***	0.0406***	0.0542***	0.0544***	0.2928	0.2928	0.4322***	0.4321***
Black	0.0014	0.0011	0.0095*	0.0093*	0.0131	0.0119	0.0810*	0.0796*
Hispanic	0.0047	0.0048	0.0058	0.0059	0.0394	0.0397	0.0518	0.0521
Multiple-Hispanic	-0.0126	-0.0125	-0.0117	-0.0116	-0.1134	-0.1113	-0.1058	-0.1038
Multiple-other	0.0106	0.0108	0.0169	0.0170	0.1103	0.1136	0.1752	0.1785
Pacific Islander	-0.0031	-0.0027	0.0000	0.0004	-0.0167	-0.0220	0.0181	0.0140
Unknown	0.0214***	0.0209***	0.0235***	0.023***	0.1750	0.1710	0.1956***	0.1916***
White	-	-	-	-	-	-	-	-
Program Indicators								
FMAP	0.0008	0.0001	0.0175***	0.0168***	0.0369	0.0322	0.2231***	0.2182***
SSI	-	-	-	-	-	-	-	-
IC -> MPC	-0.0091**	-0.0596***	0.0018	-0.0487***	-0.0751	-0.5877	0.0537	-0.4615***
IC -> WP	-0.0331***	-0.0229***	-0.0218***	-0.0116***	-0.3847	-0.2755	-0.2563***	-0.147***
DID Estimates								
MPC DID Estimator	0.156***	-	0.1576***	-	1.2362***	-	1.2689***	-
WP DID Estimator	0.2815***	-	0.283***	-	2.0869***	-	2.1302***	-
MPC/WP DID Estimator	-	0.2609***	-	0.2625***	-	1.9457***	-	1.9872***

Table 5. Regression estimates for the reduced model across all model types

Response	Linear	Linear	Linear	Linear	Logistic	Logistic	Logistic	Logistic
Predictors	Separated	Separated	Pooled	Pooled	Separated	Separated	Pooled	Pooled
DID Estimate	Subset	All	Subset	All	Subset	All	Subset	All
Parameter	Beta	Beta	Beta	Beta	Beta	Beta	Beta	Beta
Intercept	0.1206***	0.1223***	0.1253***	0.1269***	-	-	-	-
Had delivery	-	-0.0421***	-	-0.0424***	-	-0.5465***	-	-0.5480***
UIC	-0.0323*	-0.0330*	-0.0319*	-0.0319*	-0.1937	-0.1856	-0.1826	-0.1745
Age Indicators								
Age between 19-21	-0.0379	-0.0368	-0.0386	-0.0374	-0.4076**	-0.3656**	-0.4017**	-0.3595**
Age between 22-30	-0.0259	-0.0251	-0.0254	-0.0245	-0.2831*	-0.2635	-0.2775*	-0.2580
Age between 31-44	-	-	-	-	-	-	-	-
Age between 45-64	-0.0090	-0.0084	-0.0071	-0.0066	-0.0984	-0.0965	-0.1008	-0.0990
FPL Indicators								
FPL equal to zero	-	-	-	-	-	-	-	-
FPL between 1-37	0.0346***	0.0346***	0.0323***	0.0323***	0.1648**	0.1630**	0.1475*	0.1460*
FPL between 38-75	0.024*	0.0246*	0.0176	0.0173	0.0796	0.0723	0.0192	0.0119
FPL between 76-100	0.0344*	0.0343*	0.0138	0.0137	0.1249	0.1251	-0.0488	-0.0491
FPL between 101-133	0.0234	0.0231	-0.0300	-0.0302	0.0997	0.0989	-0.3442*	-0.3457*
FPL ≥ 134	0.0081	0.0076	-0.0183	-0.0188	0.1203	0.1182	-0.0822	-0.0849
In a MHH ≥ 6 months	0.0202	0.0200	0.0202	0.0200	0.1318	0.1312	0.1299	0.1294
In a IHH ≥ 6 months	-0.0006	-0.0004	-0.0007	-0.0005	0.0136	0.0167	0.0159	0.0191
Time Period (Post)	-0.0342***	-0.0357***	-0.0343***	-0.0358***	-0.4641***	-0.4844***	-0.4643***	-0.4848***
DID Estimates								
WP DID Estimator	0.2803***	0.2817***	-	-	2.3793***	2.4004***	-	-
MPC DID Estimator	0.1555***	0.1570***	-	-	1.4589***	1.4806***	-	-
MPC/WP DID Estimator	-	-	0.2615***	0.2629***	-	-	2.2312***	2.2524***

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

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

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

Measure 2 has been removed from the evaluation due to extremely small numbers. Across the four comparison groups we were able to identify 198 hospitalizations for mental illness over the 3 years 2013-2015. These results may be due to most members with mental illness severe enough to warrant hospitalization being moved into the medical frail group or the existing Integrated Health Home program, both of which remove them from our analyses as these programs provide additional access for members with mental illness.

Measure 3 Access to and unmet need for urgent care

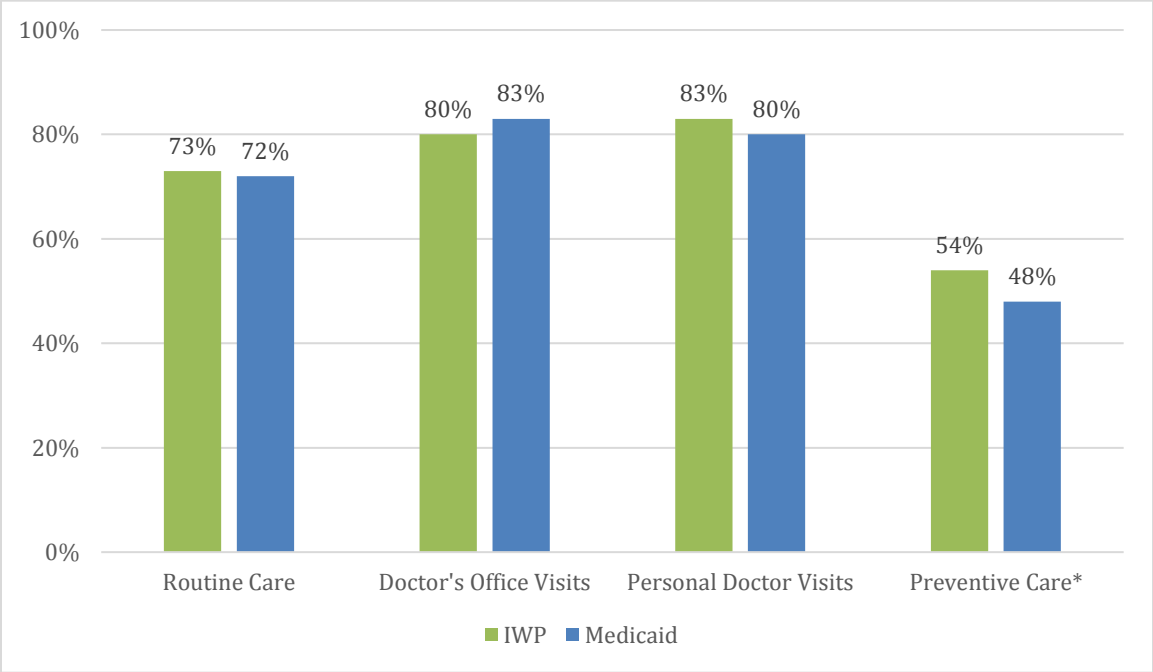
See results under Measure 7 Specialty Care.

Measure 4 Access to and unmet need for routine care

Primary care related services included making an appointment for a check-up or routine care, making any visit to a doctor's office or clinic to get health care, making any visits to their personal doctor (if they identified having one), and getting preventive care (such as a check-up, physical exam, mammogram, or Pap smear test).

Figure 6 shows the results of the comparison of primary care service utilization between IWP and Medicaid members. The majority of both IWP and Medicaid members reported using routine primary care services in the previous six months (73% routine care, 80% doctor's office visit, and 83% personal doctor visit). Significantly more IWP members (54%) reported having preventive care compared to Medicaid members (48%), p<.05.

Figure 6. Primary Care-Related Services Used by IWP vs Medicaid Members



* Statistically significant difference at p<.05

Note: Only members who reported having a personal doctor (n=1,367 IWP and n=680 Medicaid members) were asked about visits to their personal doctor.

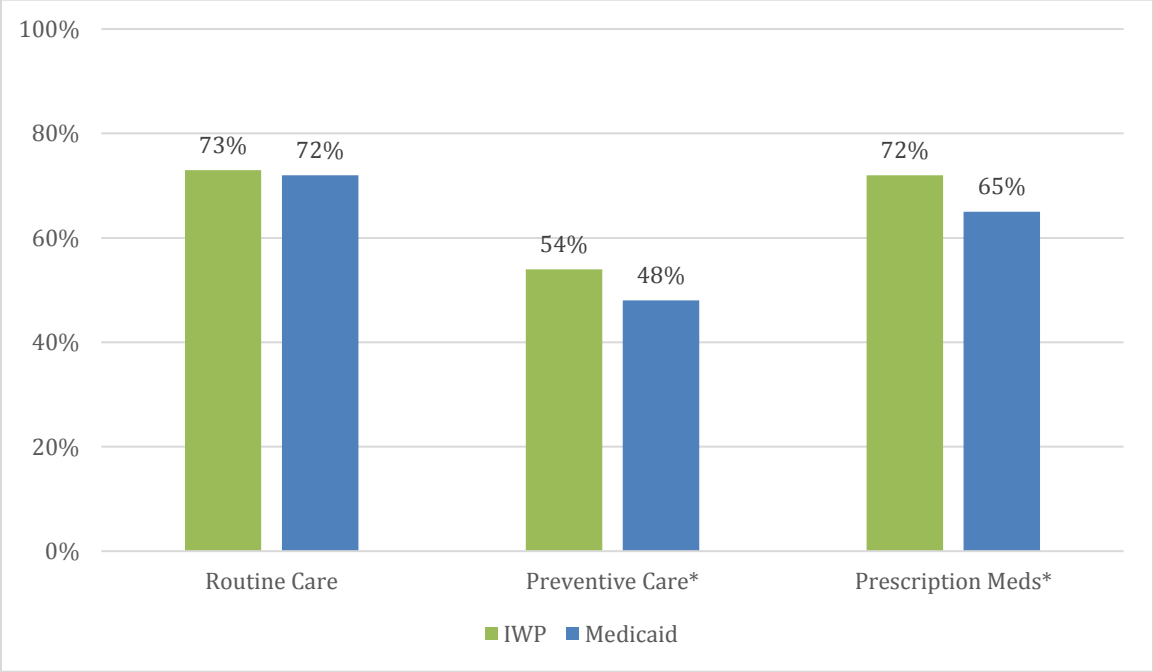
Need for primary care services was assessed by asking if respondents:

- made any appointments for a check-up or routine care
- got any preventive care
- thought (or a health professional thought) there was a time when they needed prescription medicine for any reason.

Figure 7 provides the need for primary care services for IWP and Medicaid members. A little over 70% of members reported a need for routine care with no difference between IWP and Medicaid. Significantly more IWP members (54%) compared to Medicaid members (48%) were able to receive preventive care. And, significantly more IWP members (72%) reported needing prescription medicine compared to Medicaid members (65%). At the same time, significantly more IWP members with a need for prescription medicine (89%) reported usually or always finding it

easy to get prescription medicine through their health plan when compared to Medicaid members with a need (84%).

Figure 7. Need for Primary Care-Related Services (IWP vs Medicaid)



* Statistically significant difference at p<.05

The survey included the following questions about unmet need for primary care services in the six months prior to the survey:

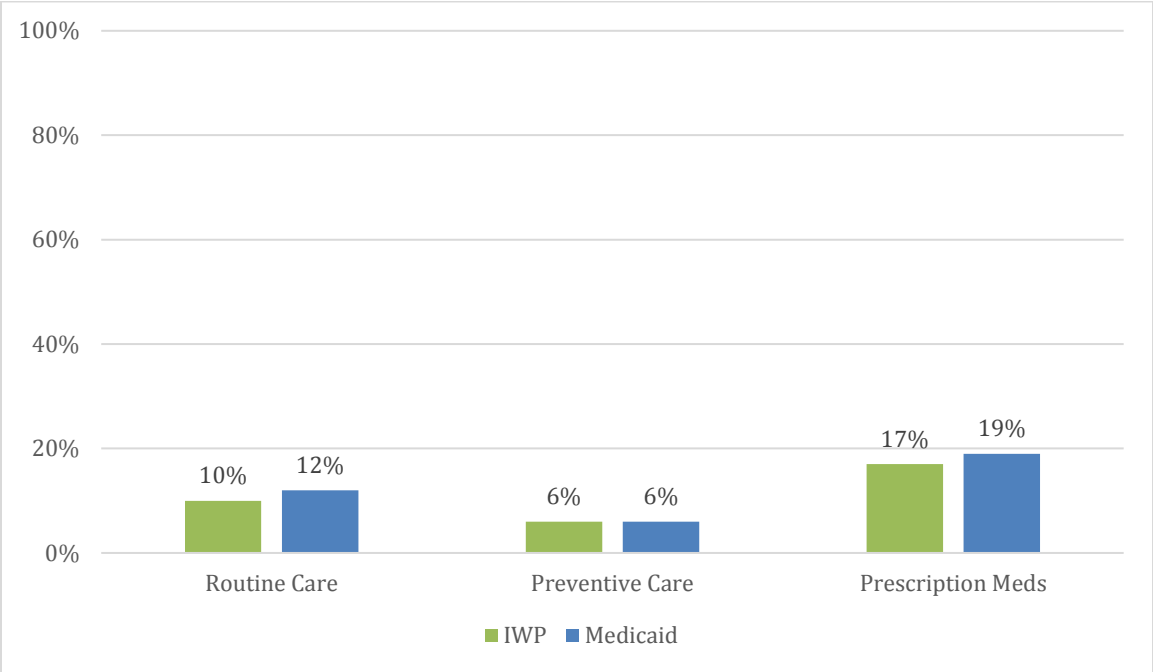
Was there any time when you needed a check-up or routine care but could not get it for any reason?

Was there any time when you needed preventive care but could not get it for any reason?

Was there any time when you needed prescription medicine but could not get it for any reason?

Figure 8 provides a comparison of IWP and Medicaid with regard to unmet need for primary care services. Overall, around 11% reported an unmet need for routine care and 6% an unmet need for preventive care with no statistically significant differences between IWP and Medicaid members. Almost one in five members (IWP 17%, Medicaid 19%) reported an unmet need for prescription medicine.

Figure 8. Unmet Need for Primary Care-Related Services (IWP vs Medicaid)



Measure 5 Timely Appointments, Care, and Information

The Patient-Centered Medical Home (PCMH) is a model of healthcare delivery that focuses on the core functions of primary care that should promote high quality in the provision of health care services.[2] In this evaluation, we focus on several aspects of the PCMH that are attributes of quality primary care. The attributes assessed were organized around three patient experiences with primary care: 1) identification of and continuity with a personal doctor, 2) experiences with the doctor's office [timely access to care and care coordination], and 3) experiences during office/provider visits [communication, comprehensive care, and self-management support]. These attributes are outlined below with full descriptions provided within each section.

1. Personal Doctor
    - Identification Of
    - Continuity With
2. Experiences with the Doctor's Office
    - Access to Care: Timely Access to Care
    - Access to Care: After-Hours Care
    - Care Coordination: Follow Up with Results of Testing
    - Care Coordination: Informed about Care with Specialists

[2] AHRQ. Patient-Centered Medical Home Resource Center. Available at http://pcmh.ahrq.gov/

- Care Coordination: Provider Knowledge of Patient Medical History
- Care Coordination: Provider Talked with Patient about Medications

3. Experiences During Office Visits
    - Communication with Personal Doctor
    - Comprehensive Care: Provider Talked with Patient about Stresses
    - Comprehensive Care: Preventive Care – Receipt of Flu Shot
    - Comprehensive Care: Smoking Cessation
    - Self-Management Support

Personal Doctor

All respondents were asked "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.]?" 82% of IWP and 80% of Medicaid members had a personal doctor. There were no significant differences by MCO for IWP 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 MCO?" 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 my MCO. Continuity with a personal doctor was defined as having had the same personal doctor before and after enrollment in their MCO. Significantly fewer IWP members (58%) than Medicaid members (64%) reported continuity with the same personal doctor ($p < .05$). Around 20% of IWP members had a different personal doctor after enrolling in their MCO compared to 16% of Medicaid members. And, around 20% (23% IWP, 20% Medicaid) of members reported not having a personal doctor before enrolling in their MCO. Again, for those in IWP, there were no significant differences by MCO with regard to personal doctor continuity.

Experiences with the doctor's office

To assess timely access to care, we used a three-item composite measure comprised of the following questions:

- When you needed care right away, how often did you get care as soon as you needed?
- 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?
- 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?

Access to after-hours care was assessed using one item that asked about whether or not the provider gave them information about how to access care after hours:

- Did a doctor's office give you information about what to do if you needed care during evenings, weekends, or holidays?

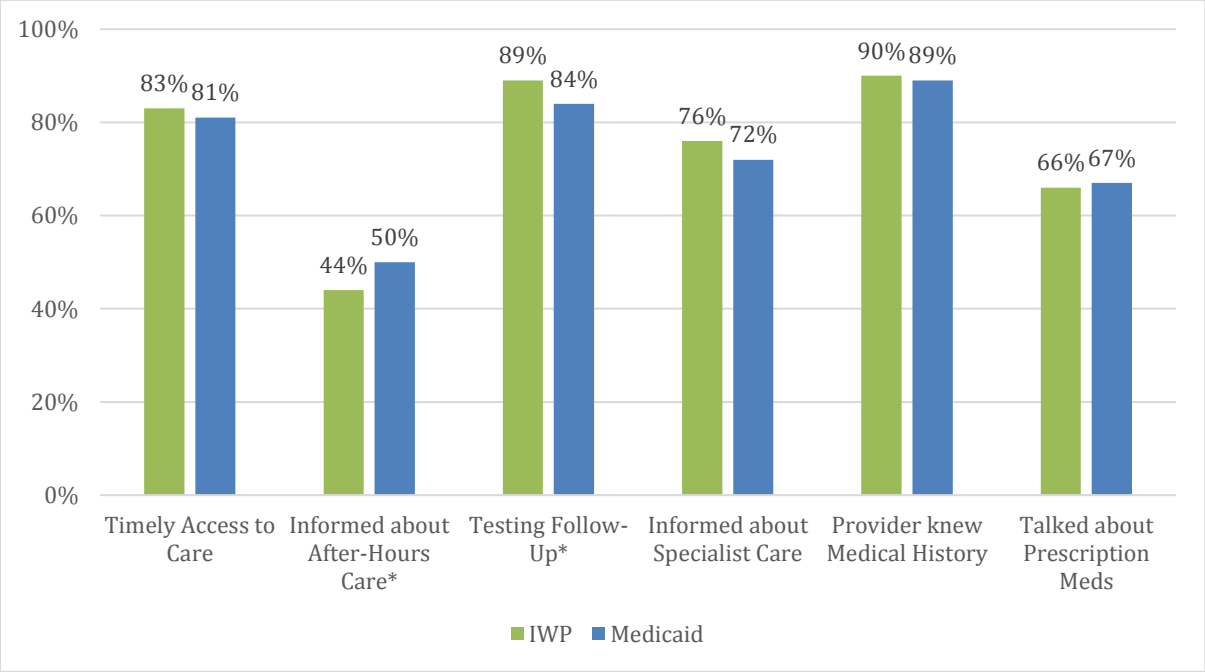
Care Coordination was assessed using four items related to different aspects of providing care coordination:

- 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?

- How often did your personal doctor's office seem informed and up-to-date about the care you got from specialists?
- How often did your personal doctor seem to know the important information about your medical history?
- How often did you talk with someone from your doctor's office about all the prescription medicines you were taking?

Figure 9 provides a summary of the findings with regard to members' experiences with their doctor's office. IWP and Medicaid members' experiences were similar with regard to timely access to care (83% IWP, 81% Medicaid), having a provider informed about specialist care (76% IWP, 72% Medicaid), having a provider who knew their medical history (IWP 90%, Medicaid 89%), and having talked about their prescription medicines (IWP 66%, Medicaid 67%). Yet, significantly more IWP members (89%) than Medicaid members (84%) reported that their doctor's office followed up with them to give them results of testing. And, around 50% of Medicaid members reported receiving information from their doctor's office about what to do if they needed care after-hours which was significantly higher than reported by IWP members (44%). Within IWP, there were no significant differences by MCO with regard to member experiences with their doctor's office.

Figure 9. IWP and Medicaid Member Experiences with their Doctor's Office



* Statistically significant difference at p<.05

Measure 6 After-hours care

See results under Measure 5 Timely Appointments, Care, and Information

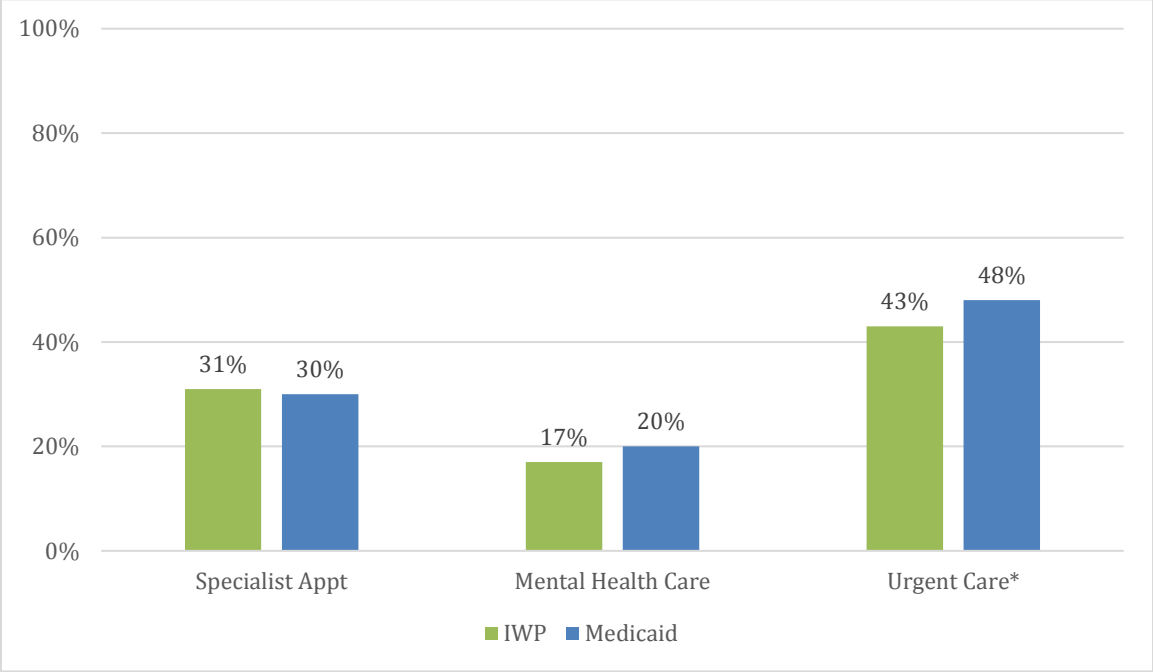
Measure 7 Specialist care

Specialty service use in the six months prior to the survey included any appointments with a specialist (defined as doctors like surgeons, heart doctors, allergy doctors, skin doctors, and others who specialize in one area of health

care), treatment or counseling for a mental or emotional health problem, and urgent care (defined as an illness, injury, or condition that needed care right away).

Figure 10 provides the results of the comparison of specialty service utilization between IWP and Medicaid members. Around one-third of IWP and Medicaid members (31% IWP, 30% Medicaid) made an appointment to see a specialist within the previous six months. And, around one in five (17% IWP, 20% Medicaid) reported receiving treatment or counseling for a mental or emotional health problem with no significant difference between IWP and Medicaid members. And, IWP members reported less need for urgent care (43%) when compared to Medicaid members (48%).

Figure 10. Specialty Care-Related Services Used by IWP vs Medicaid Members



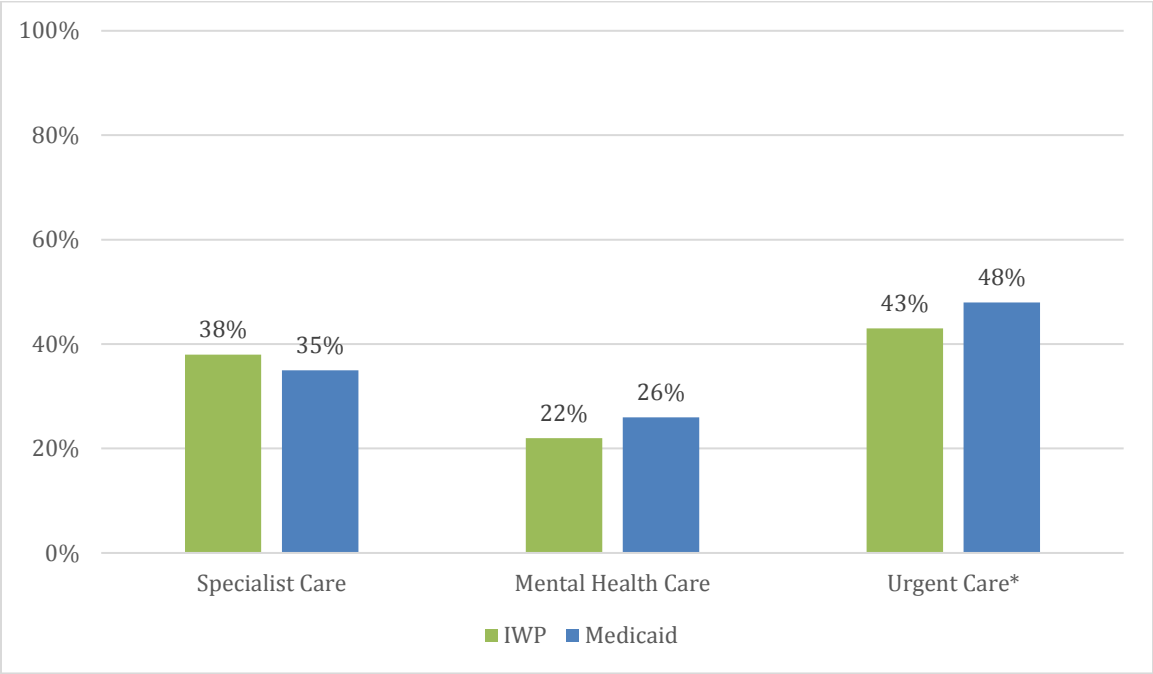
* Statistically significant difference at p<.05

Need for specialty care services was assessed by asking:

- if there was a time when they or a doctor thought they needed care from a specialist
- if they or a health care provider believed they needed any treatment or counseling for a mental or emotional health problem
- if they had an illness, injury or condition that needed care right away (need for urgent care)

Figure 11 provides the need for specialty care services for IWP and Medicaid members. There were no statistically significant differences in need for specialty or mental/emotional health care between IWP and Medicaid members. A little over one-third of members reported a need for specialty care and around one-quarter reported a need for mental/emotional health care. However, significantly more Medicaid members (48%) reported a need for urgent care compared to IWP members (43%).

Figure 11. Need for Specialty Care-Related Services (IWP vs Medicaid)



* Statistically significant difference at p<.05

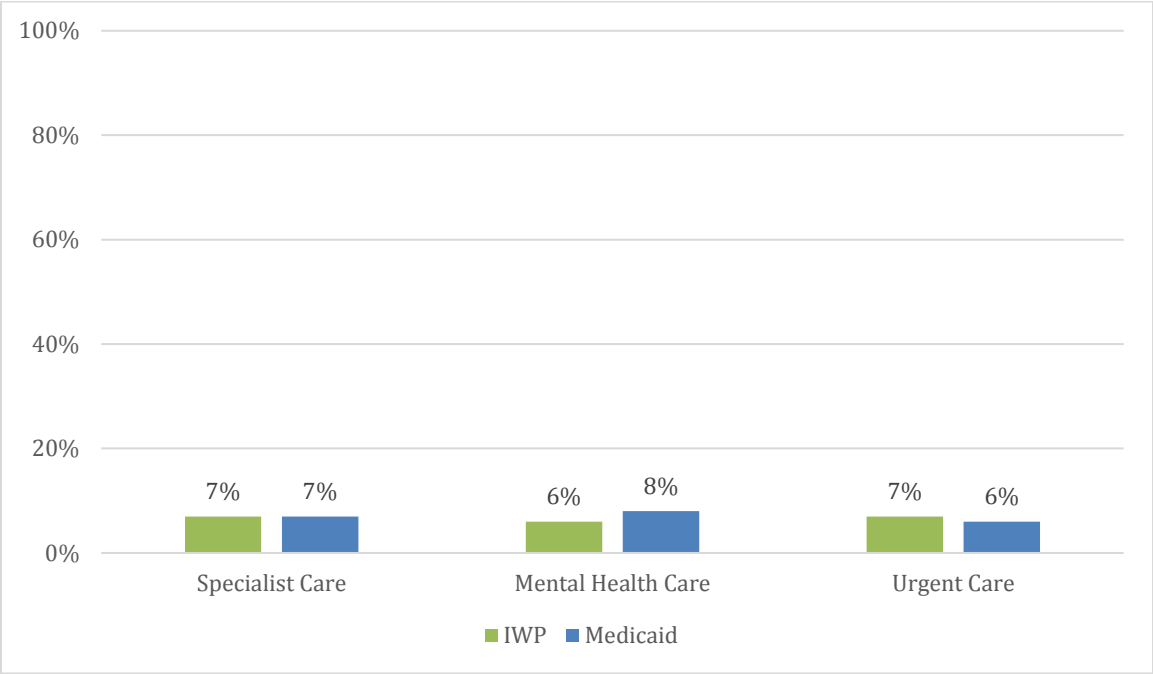
Access to Specialty Care Services: Unmet Need for Care

The survey included the following questions about unmet need for specialty services in the six months prior to the survey:

- For those who reported a need for seeing a specialist: Was there any time when you needed care from a specialist but could not get it for any reason?
- For those who reported a need for mental or emotional health care: Was there any time when you needed treatment or counseling for a mental or emotional health problem but could not get it for any reason?
- For those who reported a need for care right away (urgent care): Was there any time when you needed care right away but could not get it for any reason?

Figure 12 provides a comparison of IWP and Medicaid with regard to unmet need for specialty care services. There were no significant differences in unmet need for these services between IWP and Medicaid members. Overall, for IWP and Medicaid members, around 7% reported an unmet need for a specialist, 7% reported an unmet need for mental health care, and 6% an unmet need for urgent care.

Figure 12. Unmet Need for Specialty Care-Related Services (IWP vs Medicaid)



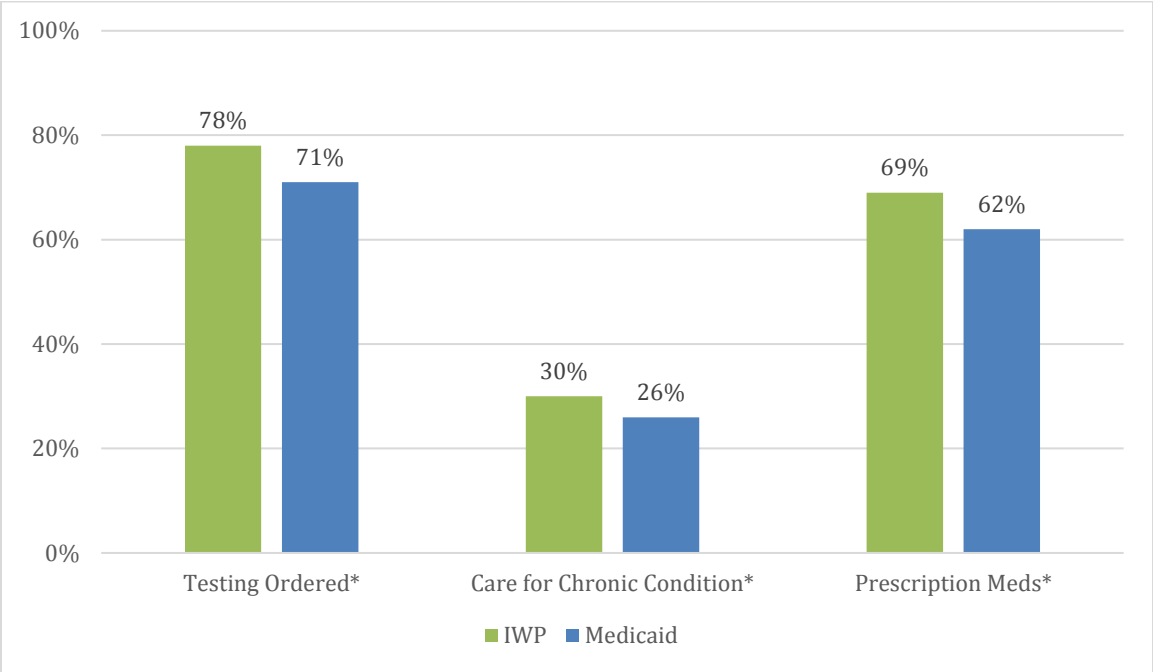
Note: The graph shows the percentage of unmet need for the total sample.

Measure 8 Prescription medication

Diagnostic or treatment service use in the six months prior to the survey included a doctor's office ordering a blood test, x-ray, or other test, any experience receiving health care 3 or more times for a condition or problem that had lasted for at least 3 months, and reported use of prescription medication (excluding birth control).

Figure 13 provides the results of the comparison of diagnostic or treatment service utilization between IWP and Medicaid members. Significantly more IWP members (78%) reported that a doctor's office ordered tests for them when compared to Medicaid members (71%). Also, significantly more IWP members received health care for a chronic condition (30%) than Medicaid members (26%). Finally, significantly more IWP members (69%) reported having used a prescription medication in the previous six months compared to Medicaid members (62%).

Figure 13. Diagnostic or Treatment Services Used by IWP vs Medicaid Members



* Statistically significant difference at p<.05

Hypothesis 1.2

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

Measure 9 Breast cancer screening

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

Definition

This measure protocol is derived from HEDIS 2018 (see also NQF 0031; CMS adult core measure #3). It includes women 50-64 that were eligible for at least 11 months in the measurement year and in for at least 11 months each of the two years prior to the measurement year. The measure provides the percentage of these women that had a mammogram to screen for breast cancer. For example, for the measurement year CY 2017 only women eligible for at least 11 months in each of CY 2017, CY 2016, and CY 2015 are included in the results.

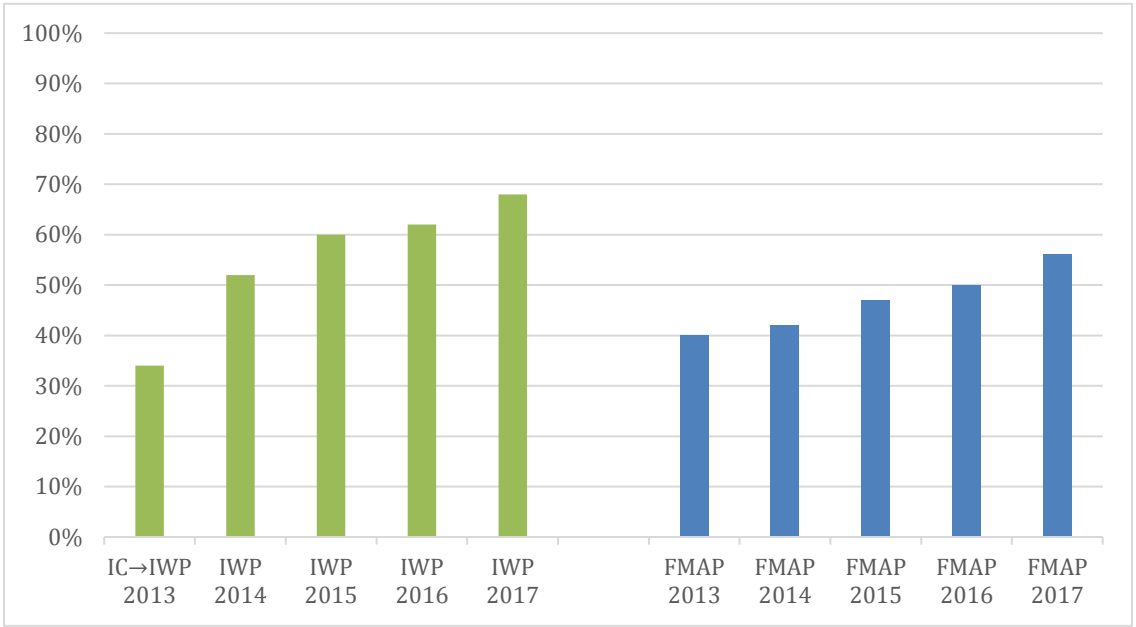
Results

Table 6 and **Figure 14** provide the proportion of women ages 50-64 who had a mammogram by program and year. Rates were consistently the highest among women in IWP from CY 2014 – CY 2017.

Table 6. Percent of women ages 50-64 who had a mammogram CY 2013-CY 2017

Age		FMAP 2013	IC→IWP 2013	FMAP 2014	IWP 2014	FMAP 2015	IWP 2015	FMAP 2016	IWP 2016	FMAP 2017	IWP 2017
50-64 years	#	122	1,125	144	1,827	149	1,855	246	4,430	332	6,116
	%	40%	34%	42%	52%	47%	60%	50%	62%	56%	68%

Figure 14. Percent of women ages 50-64 with a mammogram by program and year, CY 2013 – CY 2017



Whether a woman 50-64 had a mammogram to screen for breast cancer

Due to small numbers of women with a mammogram in the FMAP and IowaCare groups the modelling has been removed from the evaluation.

Measure 10 Cervical cancer screening

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

Definition

This measure is derived from HEDIS 2018 (See also NQF 0032; CMS adult core measure #4). It includes women 21-64 that were eligible for at least 11 months in the measurement year and at least 11 months in each of the two years prior to the measurement year. This measure provides the percentage of these women that were screened for cervical cancer.

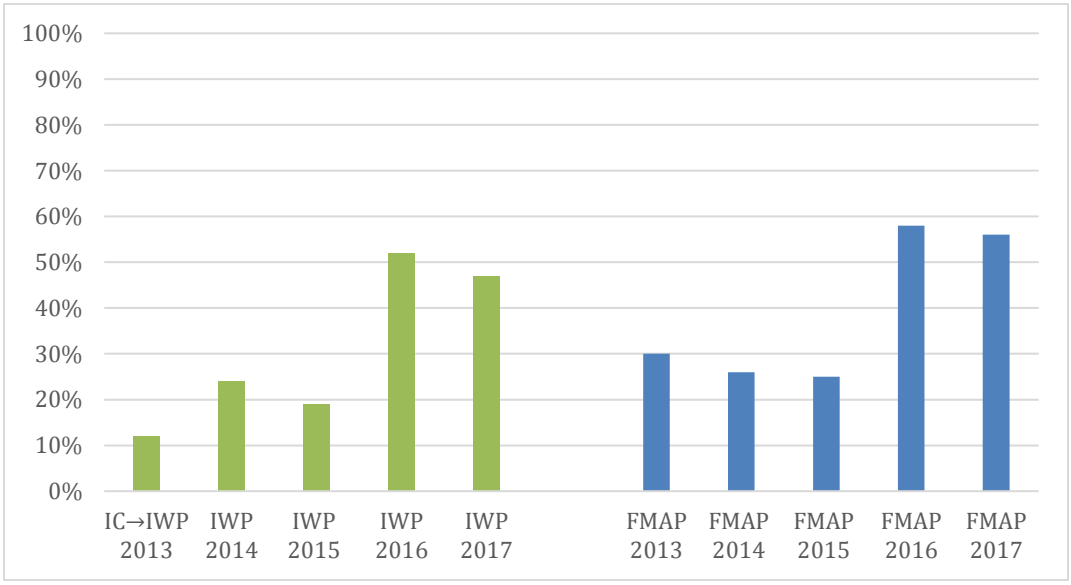
Results

Table 7 and **Figure 15** provide the proportion of women ages 21-64 who were screened for cervical cancer. The numbers of women screened for cervical cancer are higher than the number screened for breast cancer due to the expanded age range. Rates for cervical cancer screening were higher for women in FMAP than women in IWP across all years. In CY 2016 and CY 2017 the rates were much higher for both groups.

Table 7. Percent of women ages 21-64 who had cervical cancer screening CY 2013 - CY 2017

Age		FMAP 2013	IC→WP 2013	FMAP 2014	WP 2014	FMAP 2015	WP 2015	FMAP 2016	WP 2016	FMAP 2017	IWP 2017
21-64 years	#	4,385	1,866	4,204	4,861	4,263	5,822	6,424	11,094	6,728	12,647
	%	30%	12%	26%	24%	25%	19%	58%	52%	56%	47%

Figure 15. Percent of women ages 21-64 with cervical cancer screening by year and program, CY 2013 – CY 2017



Measure 11 Flu shots in past year (administrative data)

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

This measure was removed due to unreliability of determining whether members were sexually active.

Measure 13 Comprehensive diabetes care: Hemoglobin A1c

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

Definition

This measure is derived from HEDIS 2018 (See also NQF 0057; CMS adult core measure #19). Though there are seven components of comprehensive diabetes care as listed below only 3 can be calculated using administrative data alone.

- Hemoglobin A1c (HbA1c) testing
- HbA1c poor control (>9.0%)
- HbA1c control (<8.0%)
- HbA1c control (<7.0%) for a selected population
- Eye exam (retinal) performed
- Medical attention for nephropathy
- BP control (<140/90 mm Hg)

Hemoglobin A1c testing, having received an eye exam, and medical attention for nephropathy can be calculated using only administrative data. Hemoglobin A1c testing provides evidence that the glucose levels for members with diabetes are being monitored, which should lead to a reduction in poor outcomes such as neuropathy or diabetic retinopathy. Additionally, in CY 2017, the proportion of members with diabetes having an eye exam or receiving medical attention for nephropathy were added to indicate whether members with diabetes were being monitored for early signs of negative outcomes. For this measure, members with diabetes had to be eligible for 11 months in both the measurement year and the year prior to the measurement year.

Results

IWP consistently had a higher proportion of members diagnosed with diabetes than FMAP, as might be expected as IWP members tended to be older and more likely to have a chronic condition (**Table 8**, **Figure 16**). Members with diabetes in IWP were more likely to have a hemoglobin A1c than those in FMAP, though the rates for both groups fell over time (**Table 8** and **Figure 17**). IWP members with diabetes were less likely to have had an eye exam and more likely to have had medical attention for nephropathy providing mixed results for monitoring of early signs of negative outcomes.

Table 8. Proportion of population age 19-64 identified as having diabetes CY 2013-CY 2017

	FMAP 2013	IC→IWP 2013	FMAP 2014	IWP 2014	FMAP 2015	IWP 2015	FMAP 2016	IWP 2016	FMAP 2017	IWP 2017
Proportion with diabetes	4%	9%	5%	10%	5%	10%	8%	12%	8%	12%
Hemoglobin A1c rate	86%	90%	84%	89%	83%	90%	75%	84%	75%	82%
Eye Exam									61%	55%
Attention for Nephropathy									79%	81%

Figure 16. Proportion of members diagnosed with diabetes by program and year

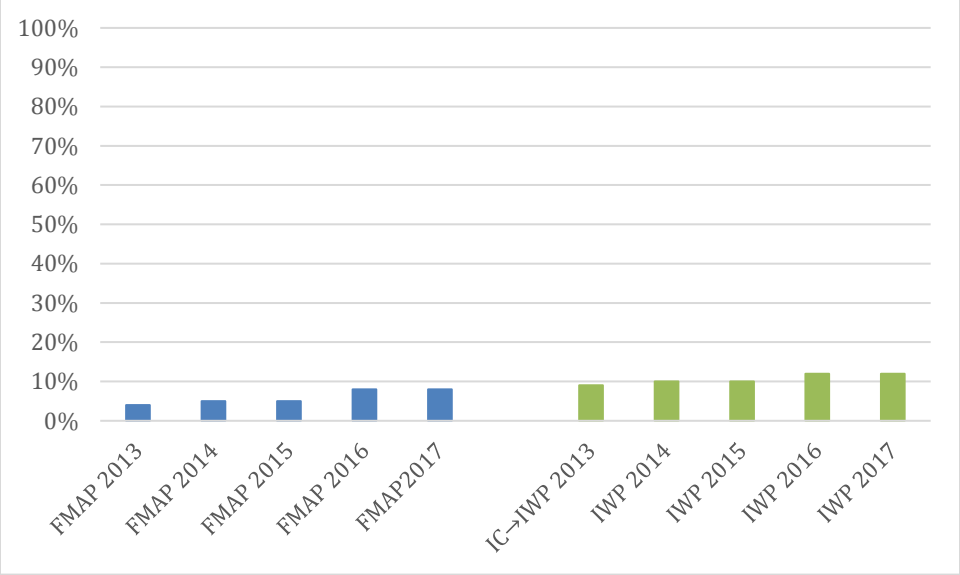
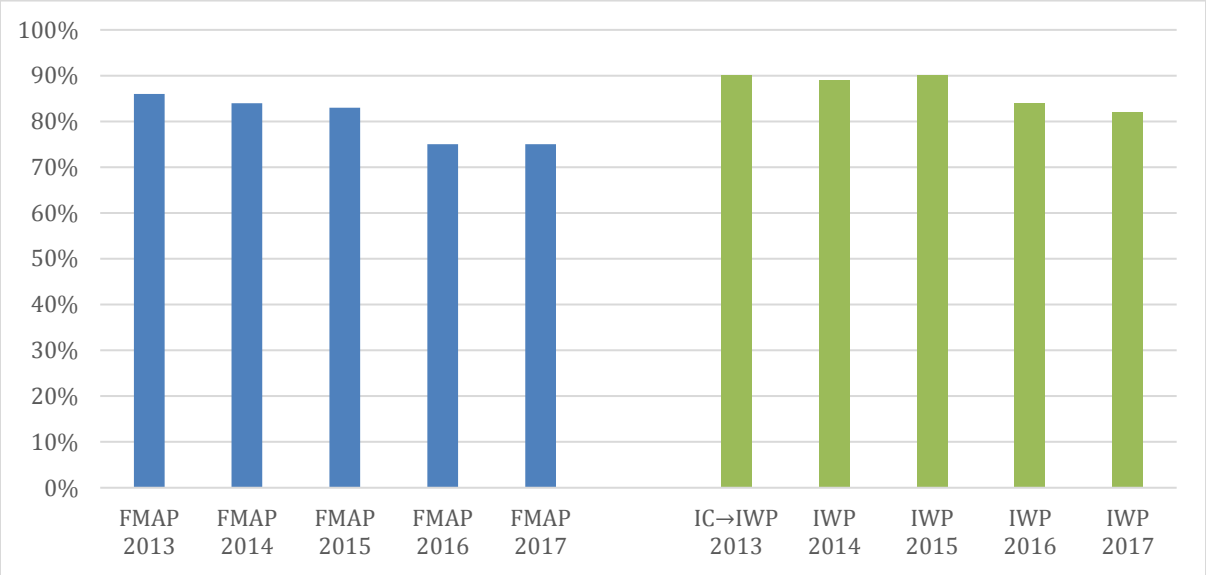


Figure 17. Proportion of population age 19-64 identified as having diabetes and receiving a hemoglobin A1c test



Measure 14 Comprehensive diabetes care: LDL-C screening

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

Definition

LDL-C screening for people with diabetes was originally contained within the comprehensive diabetes measure, however in CY 2015 it was retired from this measure and included in a joint measure calculating the rate of LCL-C screening in people with diabetes and schizophrenia. Since the IWP evaluation had never included members with schizophrenia in the LDL-C screening measure, it remains a measure only for those with diabetes. This measure is derived from HEDIS 2018.

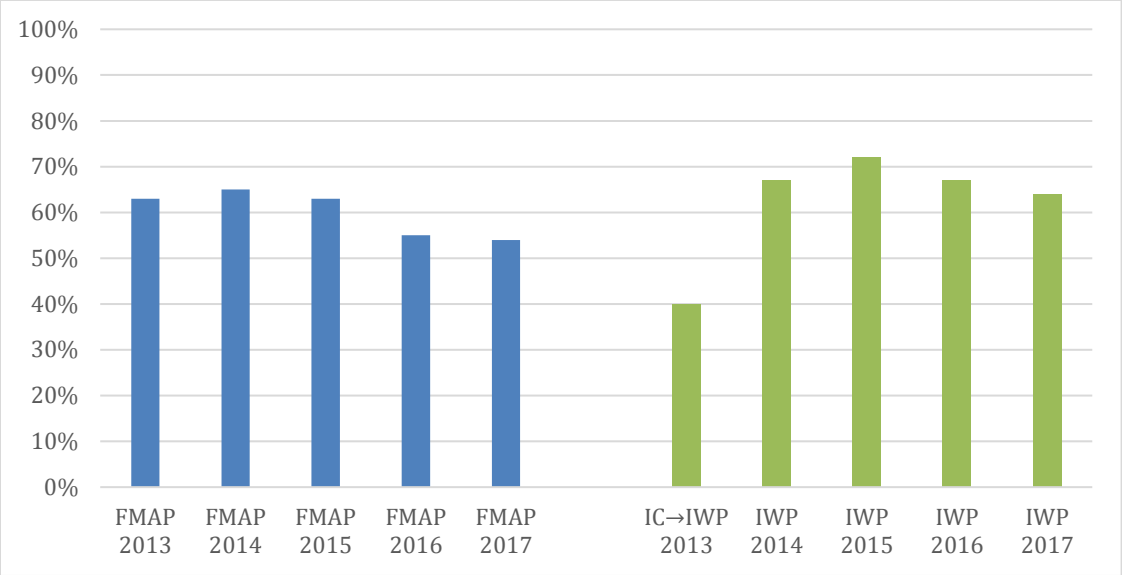
Results

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 (**Table 9** and **Figure 18**). Rates of LDL-C screening in IWP members with diabetes were higher than the rates for FMAP members with diabetes for all four years.

Table 9. Proportion of population age 19-64 identified as having diabetes with LDL-C screening CY 2013-CY 2017

	FMAP 2013	IC→IWP 2013	FMAP 2014	IWP 2014	FMAP 2015	IWP 2015	FMAP 2016	IWP 2016	FMAP 2017	IWP 2017
Proportion with diabetes	4%	9%	5%	10%	5%	10%	7%	11%	8%	12%
LDL-C rate	63%	40%	65%	67%	63%	72%	55%	67%	54%	64%

Figure 18. Proportion of population age 19-64 identified as having diabetes with LDL-C screening CY 2013-CY 2017



Measure 15 Annual monitoring for patients on persistent medication

Definition

This measure derives from HEDIS 2018 (See also NQF 2371). It provides the percent of members on a persistent medication (supplied at least 180 days of ACE/ARB, digoxin, diuretic, or anti-convulsant in the measurement year) who were monitored during the measurement year. Due to the small number of members on persistent medications, this measure is limited to monitoring for members on diuretics. This measure does not include IowaCare members, as the program did not provide prescription drug coverage.

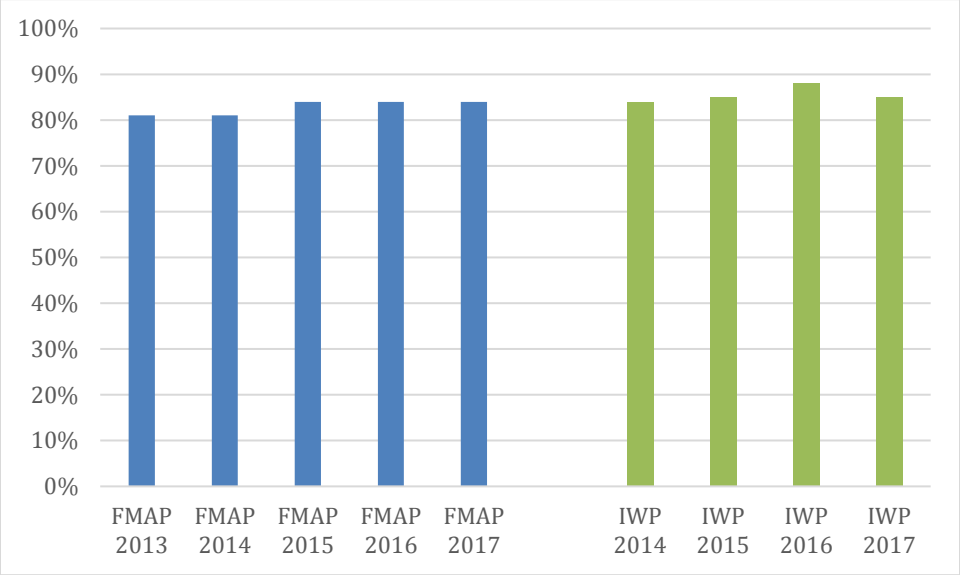
Results

Table 10 and **Figure 19** illustrate the proportion of members who were eligible for at least 11 months during the measurement year and on a diuretic for at least 180 days during the measurement year who received monitoring through a serum potassium or serum creatinine level. Initial rates of screening for IWP were comparable to or higher than the rates of screening for FMAP members for all four years.

Table 10. Proportion of population on diuretic medications screened for potassium and creatinine CY 2013-CY 2017

	FMAP 2013	IC→IWP 2013	FMAP 2014	IWP 2014	FMAP 2015	IWP 2015	FMAP 2016	IWP 2016	FMAP 2017	IWP 2017
Proportion on diuretic	2%	N/A	2%	5%	2%	5%	4%	8%	2%	3%
Monitoring rate	81%	N/A	81%	84%	84%	85%	84%	88%	84%	85%

Figure 19. Proportion of population on diuretic medications monitored for changes in potassium and creatinine, CY 2013 – CY 2017



Measure 16 Preventive care

See results under Measure 4.

Hypothesis 1.3

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

Measure 17 Anti-depressant medication management

Measure 17 has been removed from the evaluation due to most members with mental illness being moved into the medically frail group or the existing Integrated Health Home program, both of which remove them from our analyses and provide additional access for members with mental illness.

Measure 18 Mental health utilization

Measure 18 has been removed from the evaluation due to most members with mental illness being moved into the medically frail group or the existing Integrated Health Home program, both of which remove them from our analyses and provide additional access for members with mental illness.

Measure 19 Behavioral/emotional care

See Measure 7 Specialty Care.

Hypothesis 1.4

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

Measure 20 Non-emergent ED use

Definition

The number of non-emergent ED visits per 1,000 member months (total number of months that people are eligible across all members) is calculated using all members in the program. The NYU ED algorithm is used to determine the degree to which the ED visits in a given year for a given program were non-emergent[3]. Each visit is provided with a number between 0 and 1 that indicates the degree to which it may be considered non-emergent. These are summed for all visits in the measurement year across all visits made by members and then divided by the total number of member months and multiplied by 1,000.

Results

The number of non-emergent ED visits per 1,000 members in FMAP was much higher than for members in IC in 2013. This was due, in part, to the IC program policy of reimbursing only ED visits that occurred at the University of Iowa Health Care in Iowa City or Broadlawns Medical Center in Des Moines, leaving many ED visits out of the Medicaid claims data. Members in IWP did not have these restrictions leading to an increase in the number of non-emergent ED visits as compared to IC members prior to implementation of IHAWP. Following the introduction of the IWP, the numbers of non-emergent ED visits were consistently below those for FMAP members from CY 2014 – CY 2017 (**Table 11**).

Table 11. Number of non-emergent visits per 1,000 member months, CY 2013-CY 2017

	FMAP 2013	IC→IWP 2013	FMAP 2014	IWP 2014	FMAP 2015	IWP 2015	FMAP 2016	IWP 2016	FMAP 2017	IWP 2017
Number of non-emergent visits/1,000 member months	23.2	7.7	23.0	12.3	22.2	12.9	21.1	15.6	23.2	16.5

Measure 21 Follow-up ED visits

Definition

We developed a measure for ED readmission based on the HEDIS 2018 Plan all-cause readmissions measure as the percent of members with an emergency department (ED) visit within the first 30 days after an index ED visit may indicate a lack of access to primary care for ED follow-up and ongoing management of an acute problem originally treated in the ED.

[3] https://wagner.nyu.edu/faculty/billings/nyued-background

Results

The rates of ED visits and follow-up ED visits for IWP members are lower than for FMAP members for all four years, CY 2014-CY 2017 (**Table 12**).

Table 12. Proportion of members age 19-64 eligible for at least 11 months identified as having an index ED visit with at least one ED readmission within 30 days, CY 2013-CY 2017

	FMAP 2013	IC→IWP 2013	FMAP 2014	IWP 2014	FMAP 2015	IWP 2015	FMAP 2016	IWP 2016	FMAP 2017	IWP 2017
Proportion with index ED visit	68%	42%	67%	66%	71%	69%	49%	37%	44%	35%
Proportion with ED readmission	29%	19%	30%	24%	28%	23%	29%	27%	28%	26%

Measure 22 Ambulatory Care

Definition

This measure is derived from HEDIS 2018. It summarizes utilization of outpatient visits and emergency department (ED) visits as a rate per 1,000 member months for those ages 19-64 years enrolled for at least one month during the measurement year.

Results

The rate of ED visits/1,000 member months was higher for FMAP members for all four years however, the rates for IWP members increased from CY 2014 – CY 2016 before dropping slightly in CY 2017 (**Table 13**). The ED rates/1,000 member months for FMAP members and IWP members began to converge in CY 2016 (**Figure 20**). During this same time frame, the rate of ambulatory care visits increased from nearly 200 per 1,000 member months in CY 2013 to over 300 per 1,000 member months in CY 2017, while the rate of ambulatory care visits decreased for FMAP members (**Figure 21**). By CY 2017 the rate of ambulatory care visits for IWP members is very close to the rate for FMAP members.

Table 13. Number of ED visits and number of ambulatory care visits per 1,000 member months for members 19-64 years of age CY 2013-CY 2017

	IWP 2013	IC→IWP 2013	FMAP 2014	IWP 2014	FMAP 2015	IWP 2015	FMAP 2016	IWP 2016	FMAP 2017	IWP 2017
ED visits/1,000 member months	106.4	34.7	104.1	65.9	103.5	68.4	100.9	78.6	95.5	70.4
Ambulatory care visits/1,000 member months	398.9	197.0	422.3	316.1	452.4	346.4	374.4	344.8	326.8	300.4

Figure 20. ED visits per 1,000 member months by program and year, CY 2013-CY 2017

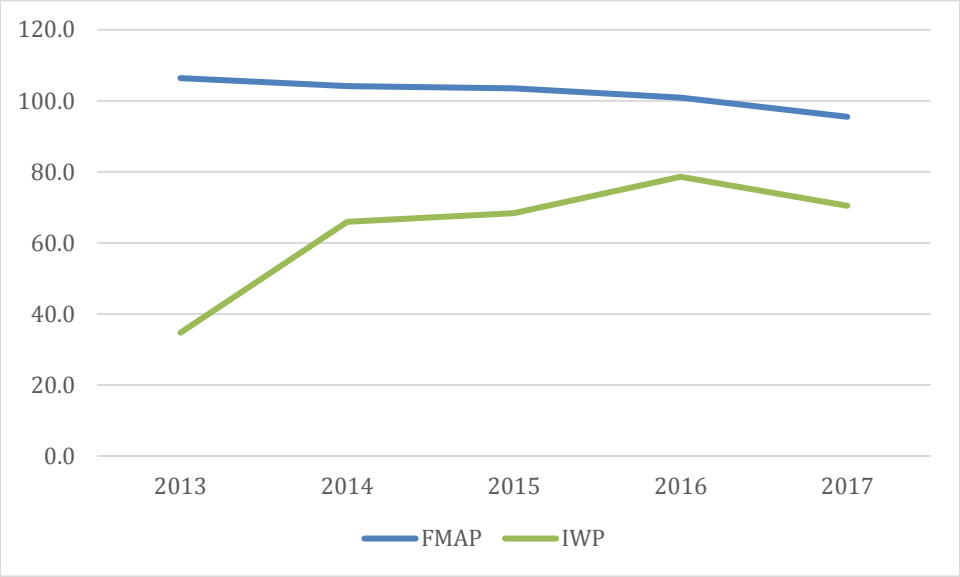
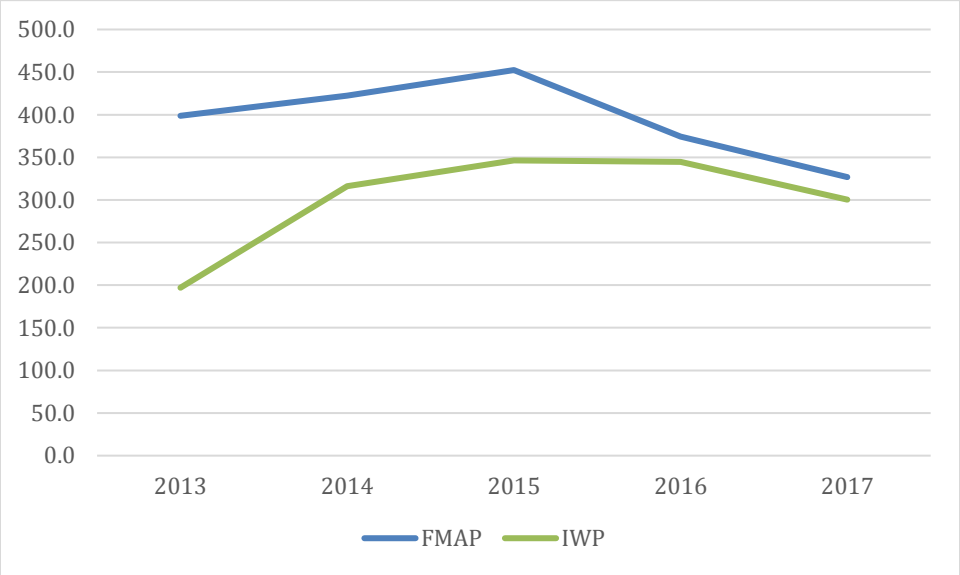


Figure 21. Ambulatory care visits per 1,000 member months by program and year, CY 2013-CY 2017



Hypothesis 1.5

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

Measure 23 Barriers to care due to transportation

NEMT is a mandated benefit for Medicaid members. However, the state of Iowa received a waiver of this mandate for its Medicaid expansion population. Therefore, NEMT is not mandated for members in IWP. To evaluate the

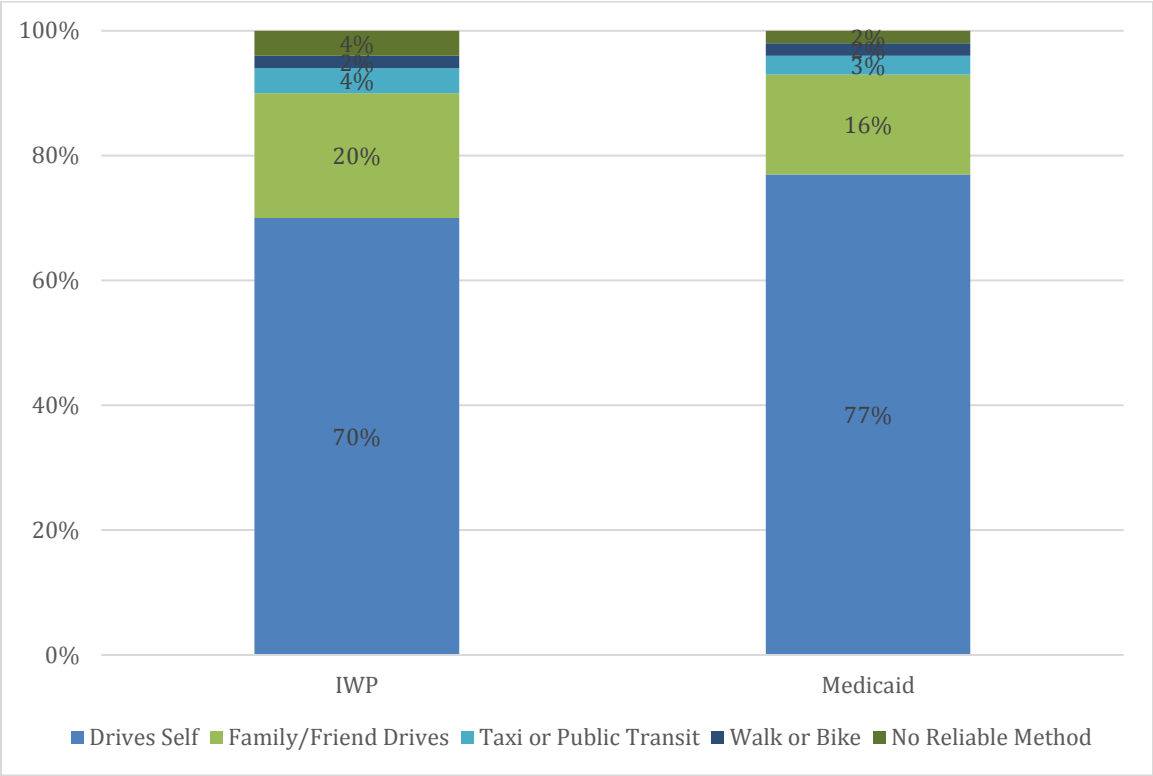
effects of waiving the NEMT benefit, transportation-related questions in the surveys covered the following topic areas:

- Mode of Transportation to Health Care Visits
    - The enrollees' mode of traveling for health care
- NEMT Assistance Issues
    - How frequently they needed assistance traveling for health care in the last 6 months
    - Unmet need for NEMT in the last 6 months
    - Concern about costs associated with NEMT in the last 6 months
    - Use and ease of use of NEMT paid for by their MCO
- Transportation Problems as a Barrier to Specific Health Care Services
    - Transportation as a barrier to going to the doctor's office or clinic instead of the emergency department for care
    - Transportation as a barrier to obtaining a ***medical*** check-up (only asked of IWP members)
    - Transportation as a barrier to obtaining a ***dental*** check-up (only asked of IWP members)

Mode of Transportation to Health Care Visits

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 of both groups drove themselves (70% IWP, 77% Medicaid) or were driven by family or friends (20% IWP, 16% Medicaid) to their health care appointments. Overall, few members reported having no reliable way to get to health care visits; however, there were significantly more IWP members reporting unreliable transportation (4%) when compared to Medicaid members (2%). Yet, within IWP, there were no significant differences by MCO in reporting of no reliable transportation to health care visits. **Figure 22** provides a summary of the responses from both IWP and Medicaid members.

Figure 22. Modes of Transportation to Health Care Visits (IWP vs Medicaid)



NEMT Assistance Issues

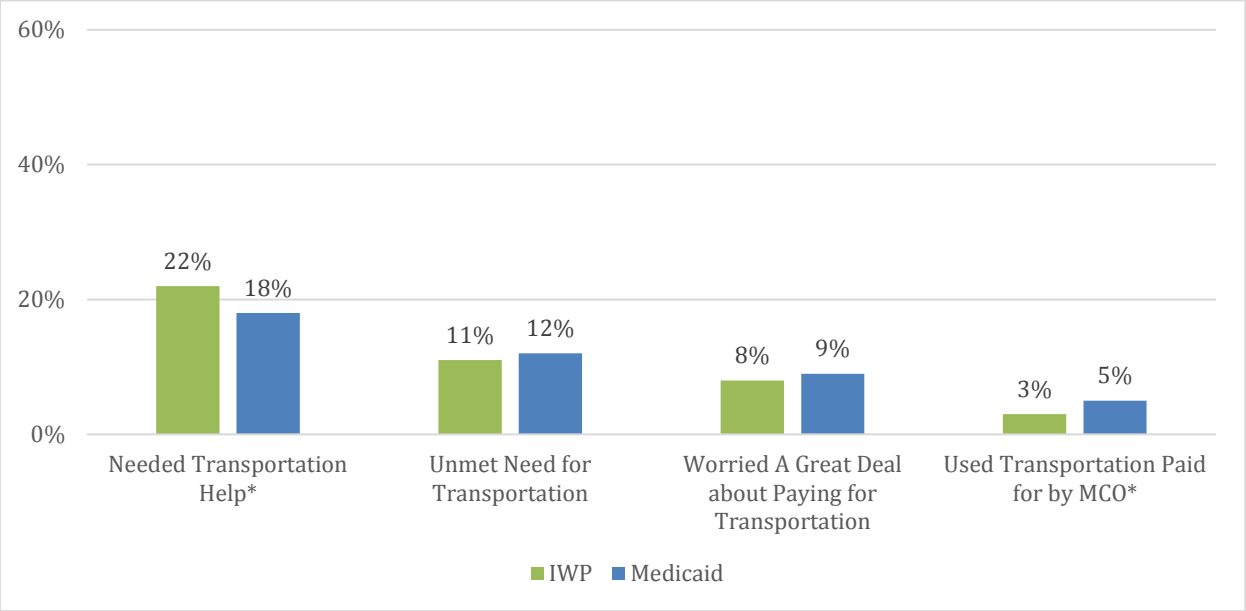
Four questions were specific to transportation assistance issues:

1. 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?
2. 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?
3. In the last 6 months, how much, if at all, have you worried about your ability to pay for the cost of transportation to or from a health care visit?
4. Since joining your MCO, have you ever used transportation paid for by your MCO to get to or from a health care visit? If yes, how easy was it for you to use the transportation services provided by your MCO?

Figure 23 summarizes the responses to these questions for IWP and Medicaid members. Significantly more IWP members (22%) reported usually or always needing help from other sources to get to health care visits compared to Medicaid members (18%). The reported unmet need for transportation was not statistically different for Medicaid members (12%) and IWP members (11%). There was no statistical difference between Medicaid and IWP in reported worry about the cost of transportation with around 8% of each reporting that they worried "a great deal" about their ability to pay for the cost of transportation to or from a health care visit.

Significantly more Medicaid members (5%) reported having used transportation paid for by their MCO to get to or from a health care visit when compared to IWP members (3%). For those who did use transportation paid for by their MCO, a little over half (58%) of Medicaid and IWP members reported that it was "very easy" to use the transportation services provided by their MCO.

Figure 23. Transportation Issues Experienced by IWP vs Medicaid Members



* Statistically significant difference at p<.05

Transportation Problems as a Barrier to Specific Health Care Services

The surveys included three questions about transportation as a barrier to accessing specific health care services. For these questions, respondents were asked to give reasons why they were not able to obtain particular health care services with difficulty getting transportation as a listed response.

On both the IWP and Medicaid surveys, the following question was asked of respondents:

> Do you think the care you received at your most recent visit to the ER could have been provided in a doctor's office if one was available at the time? If so,
>
> - What was the main reason you did not go to a doctor's office or clinic for this care [care received at the emergency room (ER) that could have been provided at a doctor's office or clinic]?
>
> Transportation-related response option: "I had transportation problems getting to a doctor's office or clinic"

Few members cited transportation issues as the main reason for using the ED instead of their doctor's office. Around 2.5% of IWP and Medicaid members (3% IWP, 2% Medicaid) reported transportation problems as the main reason for using the emergency room instead of their doctor's office.

A programmatic difference between IWP and Medicaid is the expectation of IWP members that they will get either a medical check-up or dental check-up in order **to keep from having to pay a premium** for their health care. Due to this difference, the following two questions were only included on the IWP surveys:

> Do you think any of the following would keep you from getting a medical check-up this year?
>
> Transportation-related response option: "Getting transportation to my doctor's office is hard"
>
> AND
>
> Do you think any of the following would keep you from getting a dental check-up this year?
>
> Transportation-related response option: "Getting transportation to my dentist's office is hard"

For IWP members, transportation difficulties were the fifth most reported barrier to obtaining a medical and dental check-up (approximately 5% self-report across all three MCOs).

Measure 24 EPSDT utilization

Measure 24 was removed due to the small number of members eligible for IWP with EPSDT benefits and not in a transitional program allowing young adults to remain on Medicaid State Plan until they turn 21.

Churn

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

Hypothesis 2.1

Iowa Wellness Plan members will experience equal or less churning.

Iowa Wellness Plan members experienced equal or more churning than FMAP members.

Additional findings

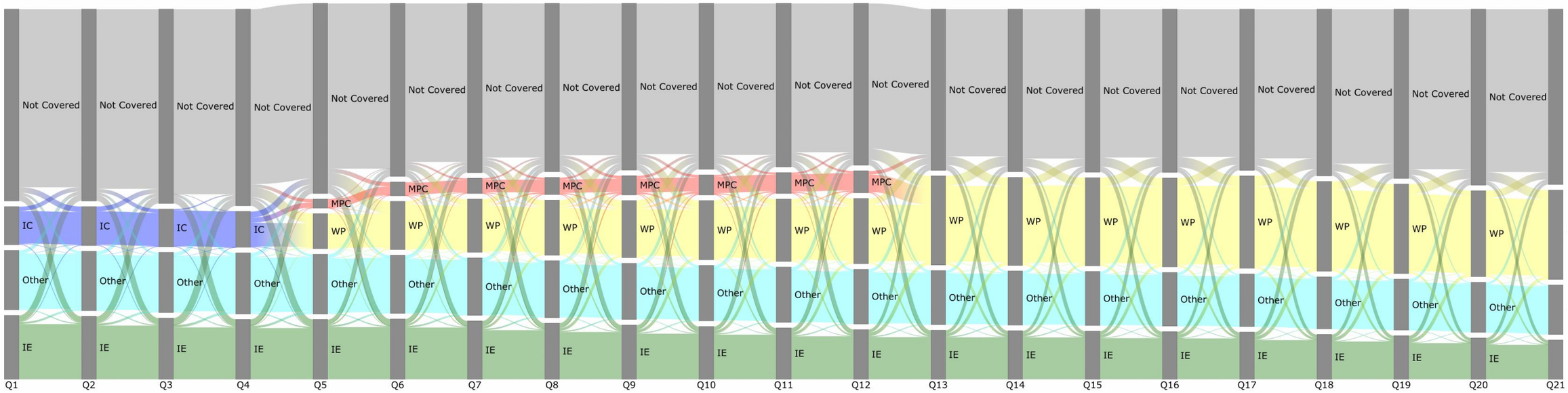
The movement of IWP members in and out of the Medicaid program and between MCOs is not practically different than that for a comparable study group, namely FMAP members. A few findings are worth noting.

1. There are significant numbers of members losing coverage in both programs and further study is needed to determine whether this is a positive result (have other coverage) or a negative result (uninsured).
2. The vast majority of transitions were from MCO 3 to MCO 1 or MCO 2 for both groups. Understanding why these transitions occurred is important to determine whether they are related to the satisfaction with and experience members have in each of these MCOs.
3. We continue to see that people of color and males are less likely to remain covered within Medicaid. Special emphasis should be placed on determining why this disparity exists.

Figure 24 visualizes Medicaid program churn from the 1st quarter 2013 through the 4th quarter 2017. This figure includes any member enrolled for at least 1 month in any Medicaid program from CY 2013 through CY 2017 as contained in the enrollment file for March 2018. Within the figure, lines moving away from the program from left to right indicate a movement out of the program, while lines moving toward the program from left to right indicate movement into the program. The thickness of the line is related to the number of members making a move. A thicker line indicates more members are moving. For example, the line portraying movement from IC to WP is thicker than the line portraying movement from IC to MPC from Q4 to Q5 because more members moved to WP than MPC.

Within the figure, FMAP member numbers remain stable, as does the number of members in other Medicaid programs including Supplemental Security Income (SSI). Within the last 2 years, the bulk of members have moved from MPC in IWP as expected when MPC became a dormant program. Since January 2016, the movement in and out of programs seems to be relatively stable with no large groups of members moving into or out of any program.

Figure 24. Churn in Medicaid programs, 1st Quarter 2013 through 4th Quarter 2017



IC=IowaCare Other=Other Medicaid programs, including SSI IE=Income Eligible WP=Wellness Plan MPC=Marketplace Choice

Previous reports have provided information on churn following the implementation of IWP. Program churn can be defined as the movement of enrollees into and out of Medicaid programs with or without a gap in coverage. Those results are found at http://ppc.uiowa.edu/health/study/evaluation-iowas-medicaid-expansion-iowa-health-and-wellness-plan.

Members in IWP and FMAP also lost coverage during the period January 2016 – December 2017. 81,336 members lost coverage in the IWP (30%), while 14,308 FMAP members (20%) lost coverage during this time. **Table 14** provides information on those who left IWP and **did not return** to IWP or any other Medicaid program and those who left and **returned** to another program (had a gap in coverage). Those who returned were significantly more likely to be female (p<0.000), white (p<0.000), and younger (p<0.000) than those who did not return.

Table 14. Demographic characteristics of IWP members who left by return status CY 2016 – CY 2017

		Returned N (%)	Did not return N (%)
Gender			
Female	**Number**	19,360	37,533
	%	55%	46%
Male	**Number**	15,967	43,525
	%	45%	54%
Race			
White	**Number**	23,660	49,916
	%	67%	62%
Black	**Number**	3,919	7,406
	%	11%	9%
American Indian	**Number**	659	1,147
	%	2%	1%
Asian	**Number**	735	1,790
	%	2%	2%
Hispanic	**Number**	1,824	4,775
	%	5%	6%
Pacific Islander	**Number**	137	480
	%	0%	1%
Multiple-Hispanic	**Number**	603	1,129
	%	2%	1%
Multiple-Other	**Number**	544	825
	%	2%	1%
Undeclared	**Number**	3,246	13,590
	%	9%	17%
Age			
18-21 years	**Number**	4,165	7,174
	%	12%	9%
22-30 years	**Number**	11,229	25,138
	%	32%	32%
31-40 years	**Number**	8,909	19,328
	%	26%	24%
41-50 years	**Number**	5,572	13,441
	%	16%	17%
51 and over	**Number**	5,072	14,491
	%	15%	18%
County rural/urban status			
Metropolitan	**Number**	21,892	49,703
	%	62%	61%

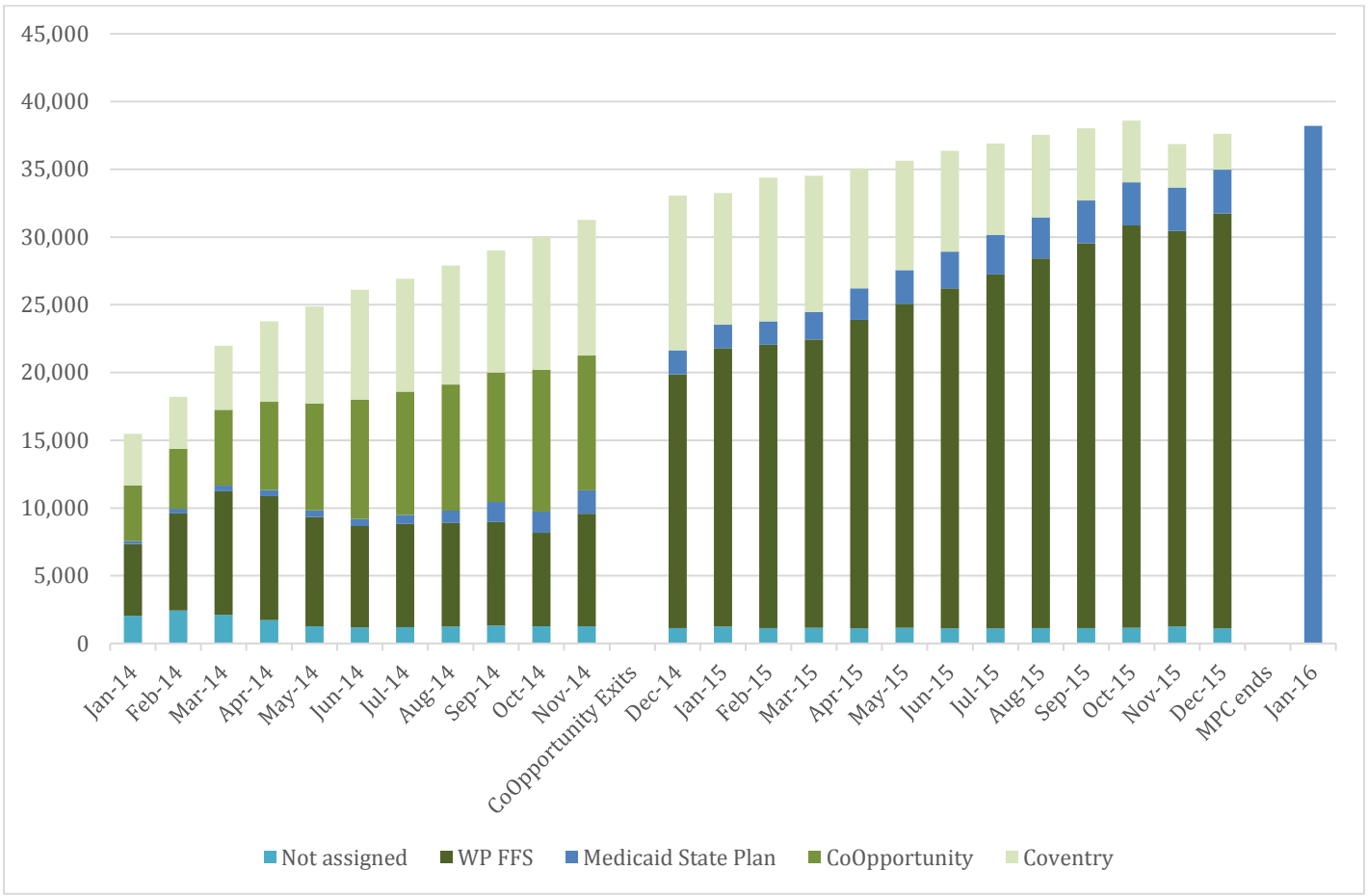
Non-metropolitan, urban	**Number**	1,428	3,677
	%	4%	5%
Non-metropolitan, rural	**Number**	12,007	27,678
	%	34%	34%

Transitions

This report contains information on transitions that occur within the IWP program for the period January 2014 through December 2017. During this time, IWP members who qualified for MPC (income 101-138% FPL), transitioned from QHPs to traditional fee-for-service Medicaid to MCOs. At each transition point members had to determine whether their health care providers were in the new option and, if not, how to access health care. Members who qualified for WP or who qualified for MPC but were determined to be 'medically frail' were not assigned to a QHP but remained in a traditional Medicaid managed care option; either Meridian HMO or the MediPASS primary care gatekeeper program. Additionally, members in MPC may not have been assigned a QHP during the first few months of enrollment.

Figure 25 shows the distribution of members in MPC from January 2014 through December 2015. By December 2014, the point at which CoOpportunity exits, most MPC members who had been enrolled in CoOpportunity had been transitioned to WP fee-for-service coverage, as Coventry was unwilling to add these members to their membership. A smaller proportion of former CoOpportunity members were enrolled in traditional Medicaid fee-for-service. None of these members were enrolled in either Meridian HMO or MediPASS.

Figure 25. Marketplace Choice enrollment, CY 2014 – CY 2015



Wellness plan members were primarily enrolled in MediPASS (WP PCP), (**Figure 26**) with a growing number enrolled in Medicaid fee-for-service from July 2014 through December 2015. This represents members who were deemed 'Medically Frail' and allowed to enroll in Medicaid fee-for-service to take advantage of services not available under Wellness Plan.

Beginning in January 2016, the WP and MPC became IWP. **Figure 27** shows the distribution of IWP enrollment by MCO. The numbers and distribution of members remains stable across the MCOs until November 2017 when MCO 2 exits the Medicaid program. As a result, enrollment in MCO 3 increased dramatically due to the influx of previously-enrolled MCO 2 members.

Figure 26. Wellness Plan enrollment, CY 2014 – CY 2015

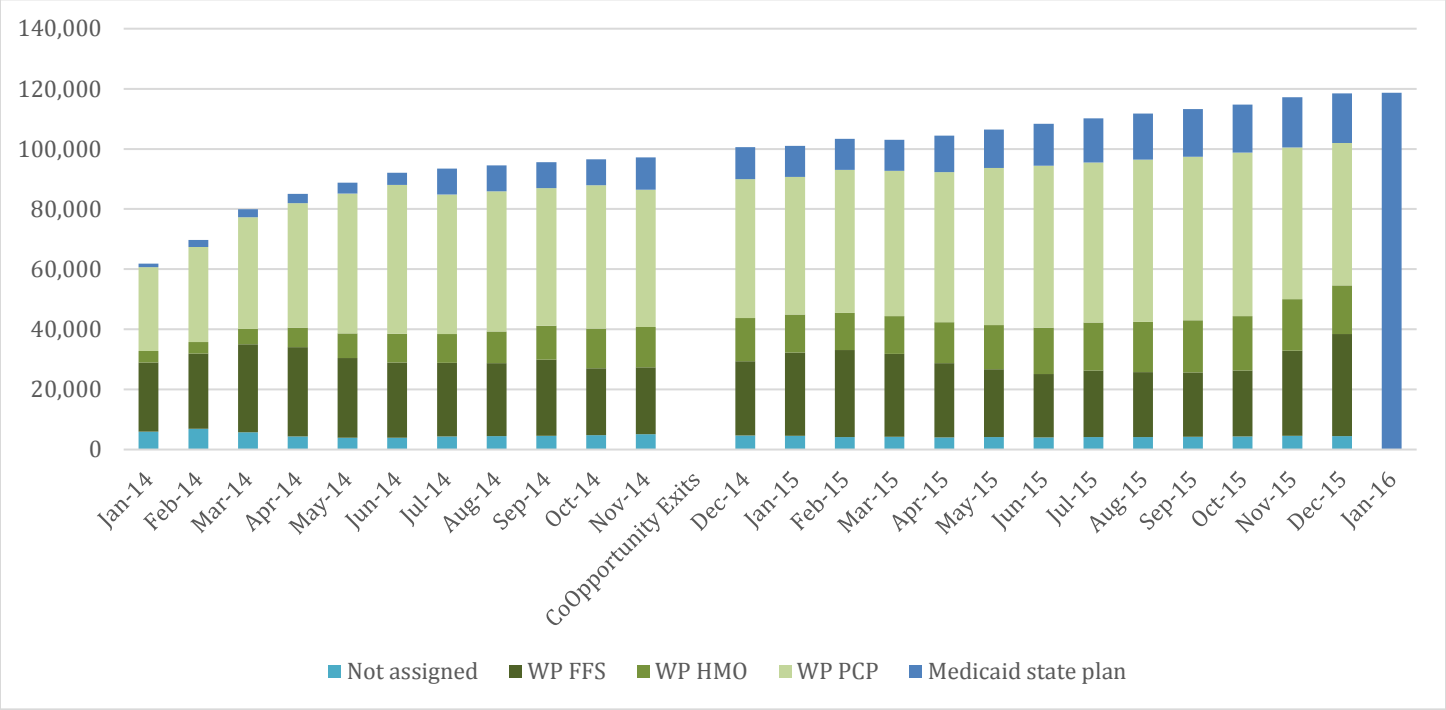
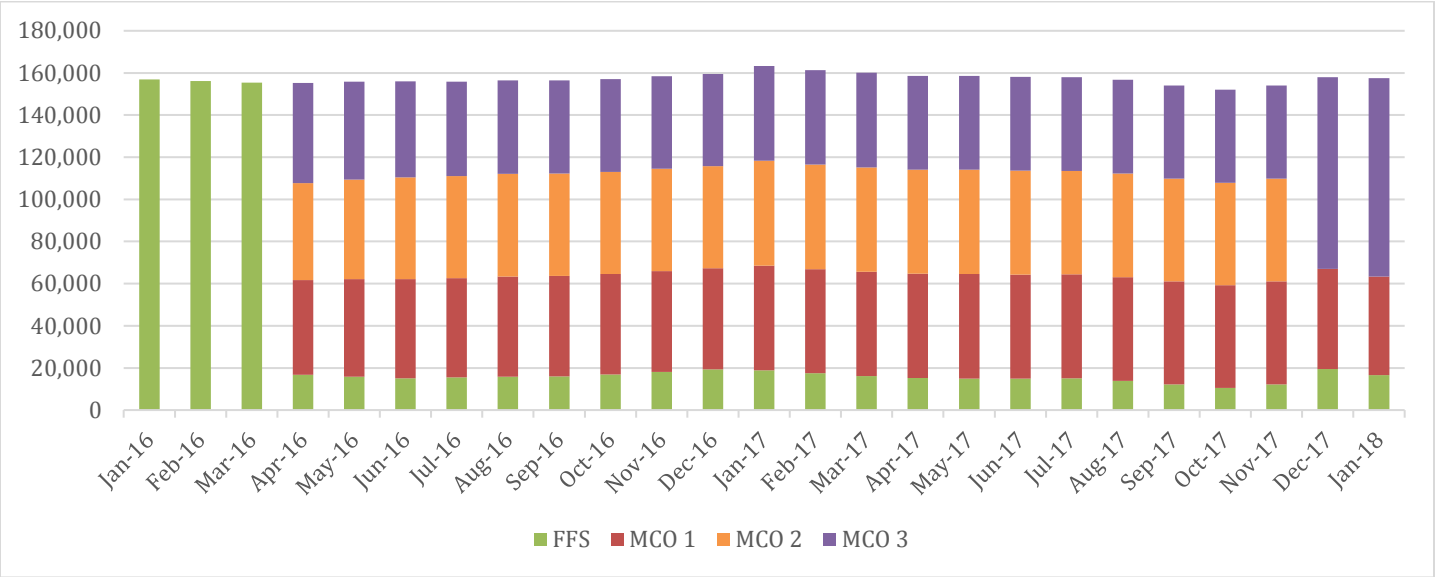


Figure 27. Iowa Wellness Plan enrollment, CY 2016 - CY 2017

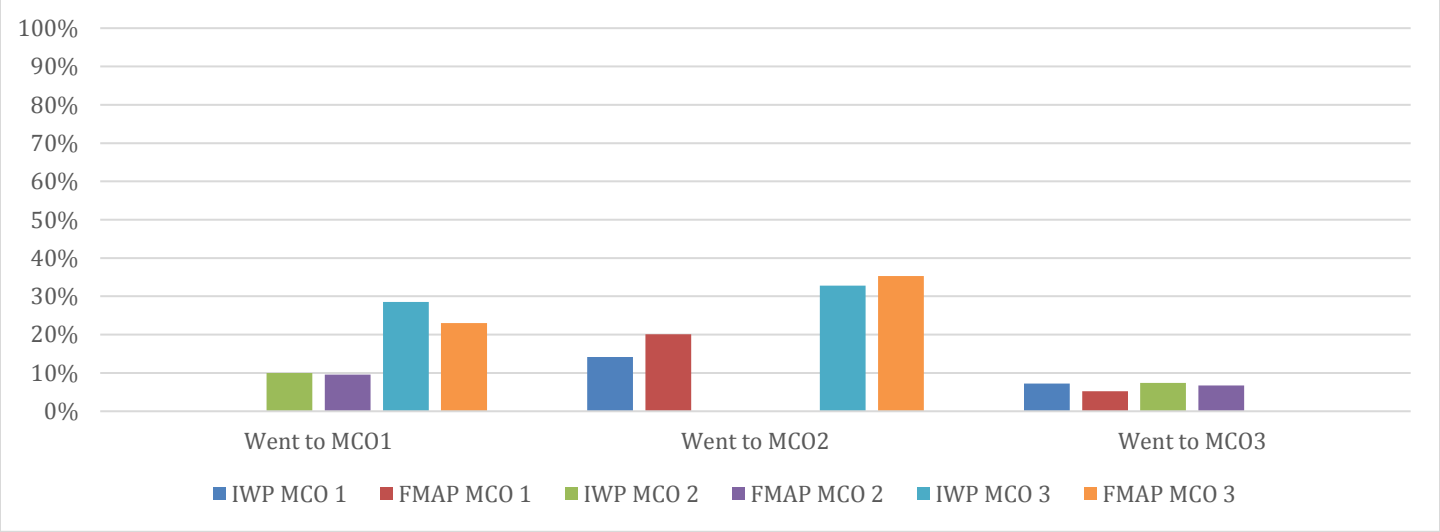


Transitions between MCOs are only allowed during the first 90 days of the first enrollment, the member's open enrollment period after the initial enrollment, and for 'Good Cause'. **Table 15** and **Figure 28** provide the transitions between MCOs for IWP members and FMAP members during the period January 2016 through November 2017 (we avoid December 2017 as this is when all the transitions were completed to move members from MCO 2 to MCO 3). Overall, both groups displayed similar patterns of transitions between MCOs over time.

Table 15. Number and proportion of transitions between MCOs, CY 2016 - CY 2017

			MCO they went to			Total
	MCO they came from		MCO 1	MCO 2	MCO 3	
IWP						
	MCO 1	Count	-	1,770	896	2,666
		%	0%	14%	7%	21%
	MCO 2	Count	1,249	-	922	2,171
		%	10%	0%	7%	17%
	MCO 3	Count	3,558	4,091	-	7,649
		%	29%	33%	0%	61%
	Total	Count	4,807	5,861	1,818	12,486
		%	39%	47%	15%	100%
FMAP						Total
	MCO 1	Count	-	2,852	740	3,592
		%	0%	20%	5%	25%
	MCO 2	Count	1,356	-	951	2,307
		%	10%	0%	7%	16%
	MCO 3	Count	3,256	5,000	-	8,256
		%	23%	35%	0%	58%
	Total	Count	4,612	7,852	1,691	14,155
		%	33%	56%	12%	100%

Figure 28. Proportion of transitions between MCOs, January 2016 - November 2017



Measure 25 Gaps in coverage in past 12 months

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 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.

Results

Gaps in coverage can be an indicator of positive life changes that result in other insurance or an indicator of negative consequences due to difficulty with continuing coverage requirements. Within the eligibility data, it is not possible to determine why members may have a gap period during which they are not covered. However, we are able to determine the number of individuals who experience a gap in coverage during the period January 2016 through December 2017 and ascertain how long the gap is.

The proportion of members with at least one gap does not vary by program. The length of gap is also comparable between FMAP and IWP. Most members experience a gap of only 1 month, indicating a very short duration without coverage. Of interest, the FMAP members are more likely to switch to a different Medicaid program at the end of the gap than IWP members. This may be primarily due to the income requirements within each program and wide variety of programs available to those with incomes under 100% FPL as compared to those with incomes over 100% FPL.

Table 16. Gap experience of FMAP and IWP members, CY 2016 - CY 2017

	FMAP	IWP
At least one gap	8,690 (5%)	34,255 (6%)
1-6 month gap	7,210 (75%)	26,135 (72%)
7-11 month gap	1,574 (16%)	6,609 (18%)
12-16 month gap	837 (9%)	3,750 (10%)
Switched programs during gap	4,291 (45%)	6,672 (18%)

Figure 29. Comparison of IWP and FMAP members with at least one gap, CY 2016 and CY 2017

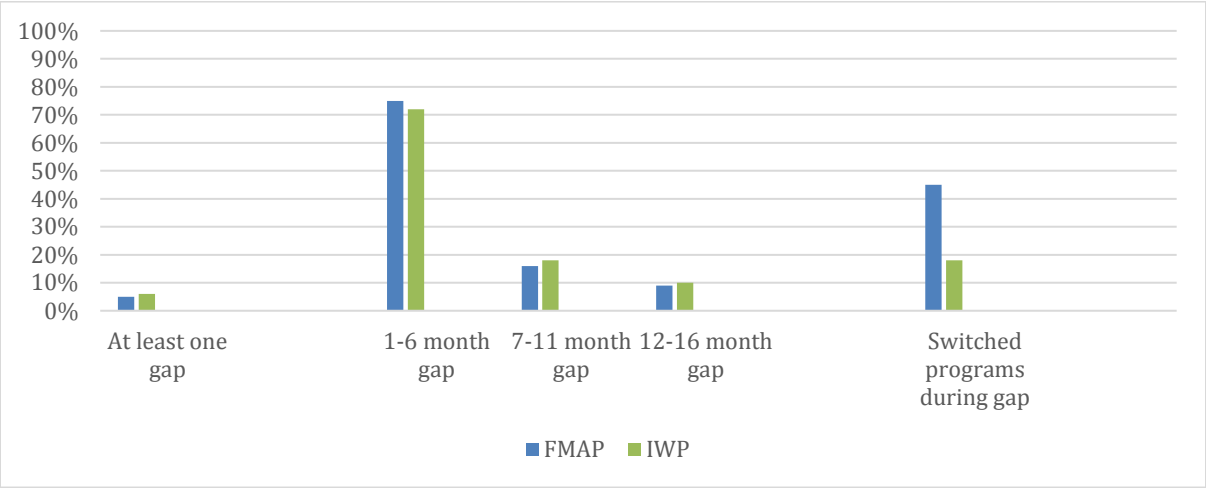
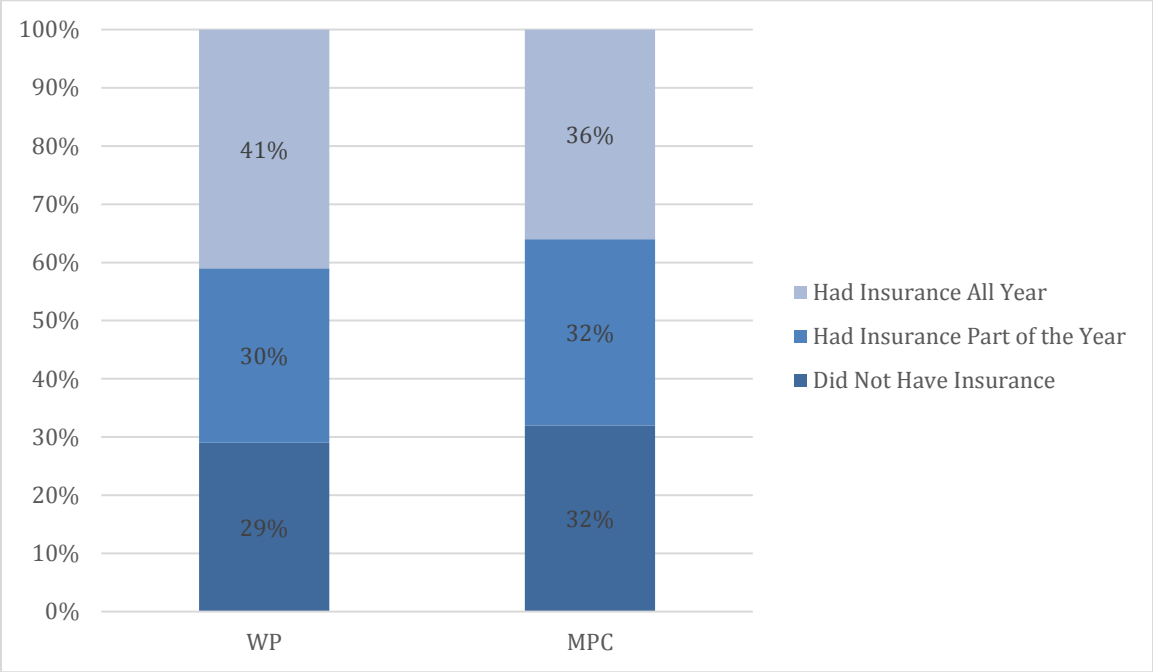


Figure 30 provides a comparison of insurance coverage between WP and MPC members. Around 30% of all IHAWP members reported that they did not have any health insurance coverage in the year prior to the IHAWP. There were no significant differences in past insurance coverage between WP and MPC members.

Figure 30. Insurance Coverage in the Year before IHAWP



Measure 26 Consecutive months covered by an insurance plan

See results under Measure 24.

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

Definition

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 times.

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 31**.

Figure 31. Gap in coverage for those not auto-enrolled in IHAWP, CY 2014

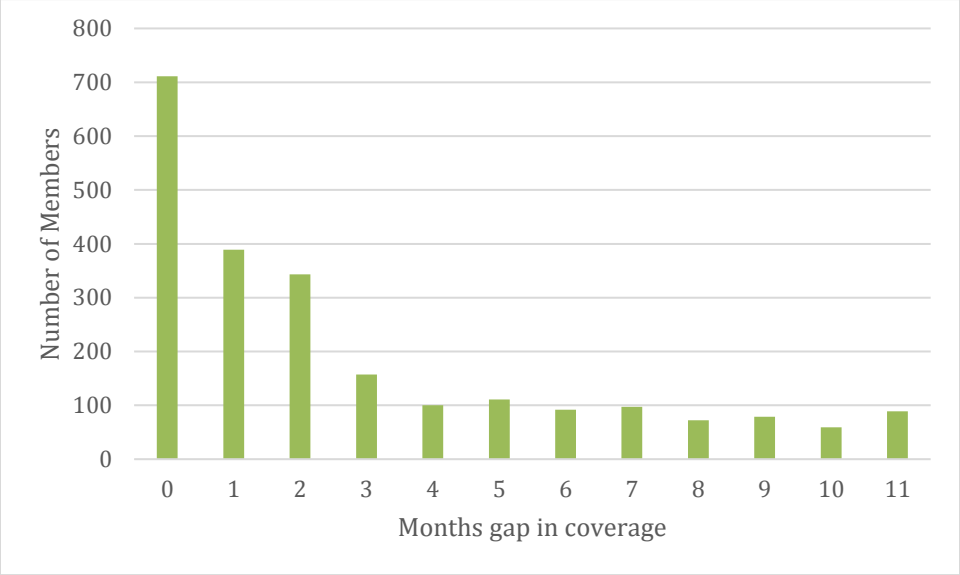


Table 17 provides the number of switches and length of gaps in coverage by program and year for both the year prior to the IHAWP and the first year of the program. Four groups are used in these comparisons: 1) FMAP CY 2013 and CY 2014; 2) IowaCare for CY 2013; 3) WP; and 4) MPC. Though members may have moved between programs, they are categorized according to the program of first enrollment for **Table 17**. 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 17. 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 32. Comparison of IowaCare and FMAP members with at least one switch and the months of gap during switch period by program, CY 2013

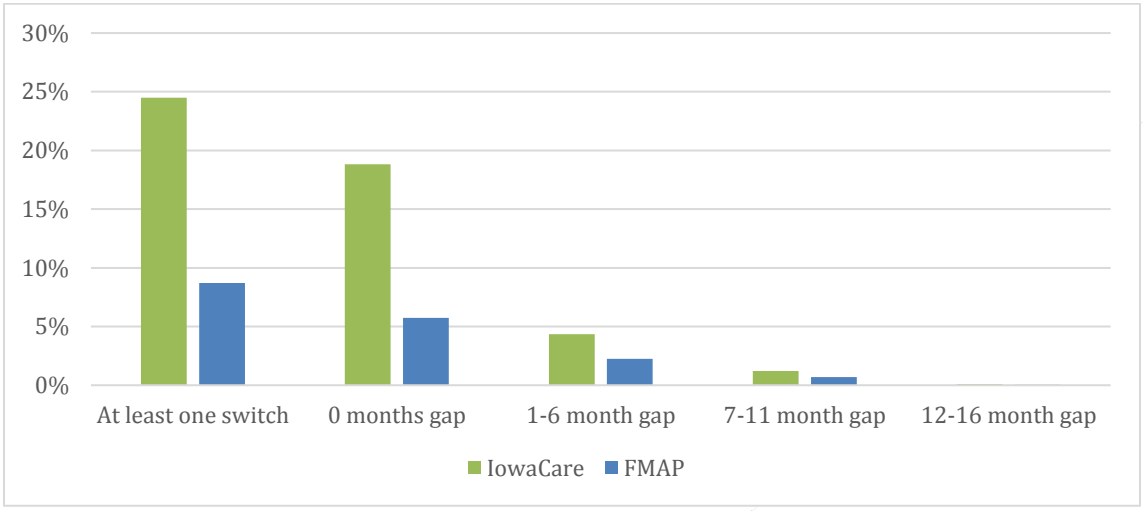
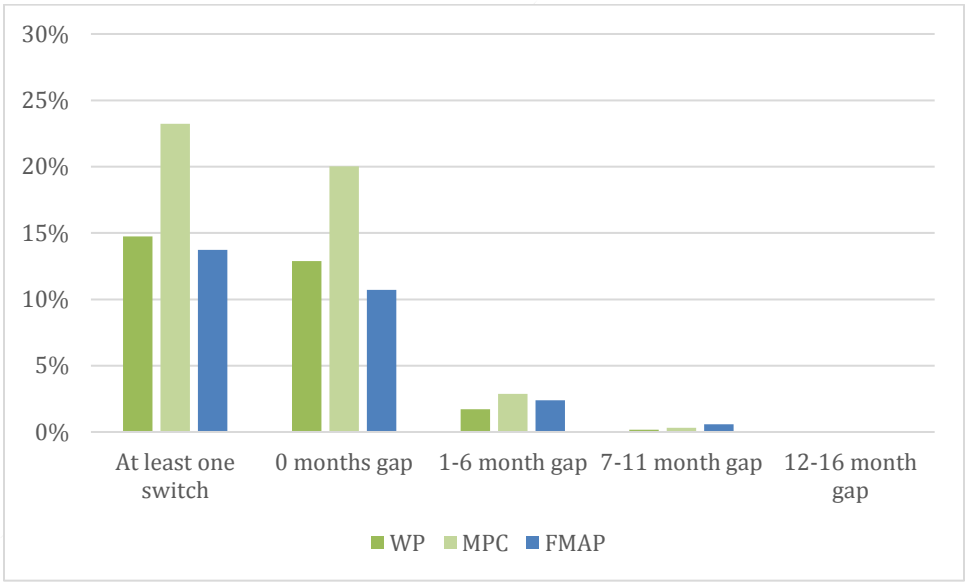


Figure 33. Comparison of WP, MPC, and FMAP members with at least one switch and the months of gap during switch period by program, CY 2014



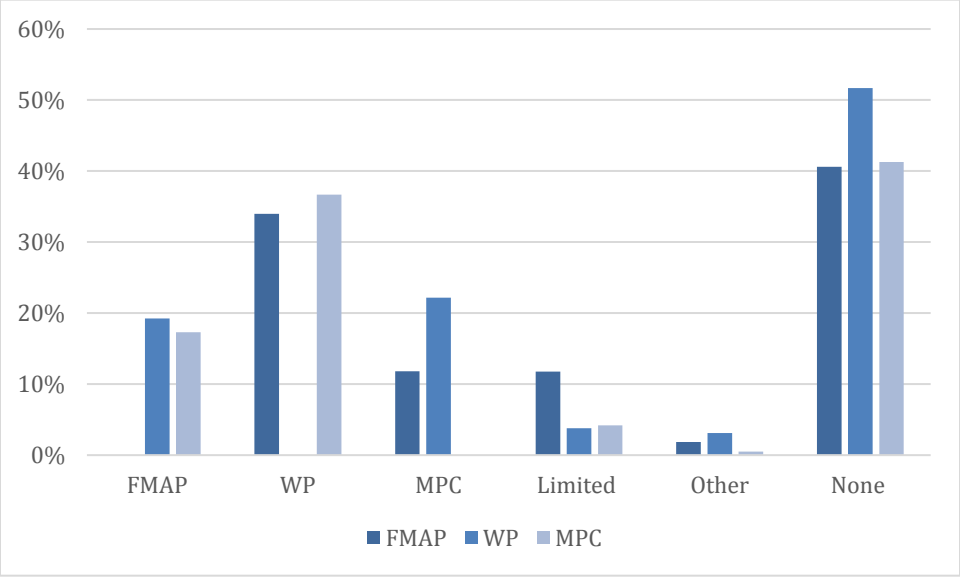
A primary reason for studying churn, particularly in the face of new programs, is to determine whether members who would have lost coverage are able to retain that coverage. Over 10,000 members lost their IowaCare coverage when that program was terminated and replaced with the IHAWP. Of these, 2,299 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 18** 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 34**. 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 18. 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 34. 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 19** 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 19. 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

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

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

Results

Figure 35 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

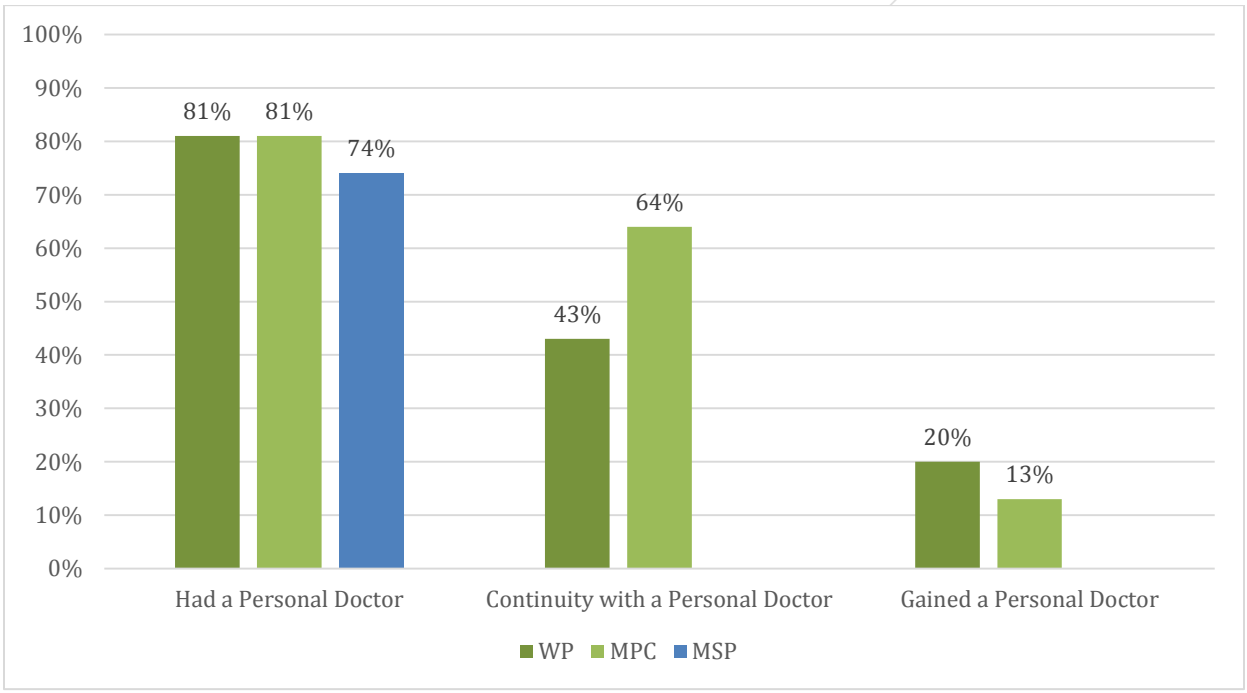
Definition

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.

Results

Figure 35 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: 81%, WP: 81%, MPC: 74%). Significantly fewer MPC members reported a usual source of care when compared to MSP.

Figure 35. Having a Personal Doctor and Continuity of Care



Quality of Care

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

Hypothesis 3.1

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

Measure 31 Avoidance of antibiotic treatment in adults with acute bronchitis

Removed due to difficulty with measure definition.

Measure 32 Use of appropriate medications for people with asthma

Removed due to removal from HEDIS measure set.

Measure 33 Medication management for people with asthma

Removed due to recent articles indicating this measure is not reflective of later outcomes.

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

Removed due to an inability to determine whether hospitalization was for exacerbation of COPD.

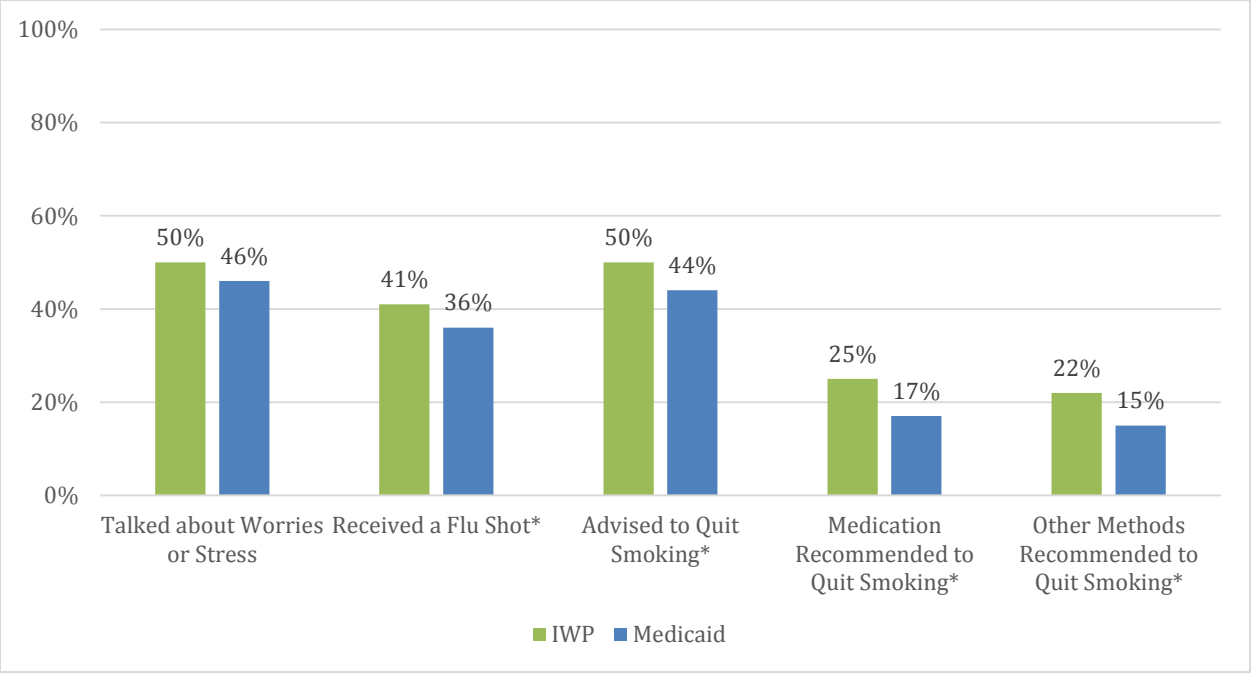
Measure 35 Cholesterol management for patients with cardiovascular conditions (Measures 35A and 35B)

Removed due to small numbers.

Measure 36 Self-reported receipt of flu shot

Significantly greater proportion of IWP members (41%) compared to Medicaid members (36%) reported receiving a flu shot.

Figure 36. Self-reported preventive activities at the office visit



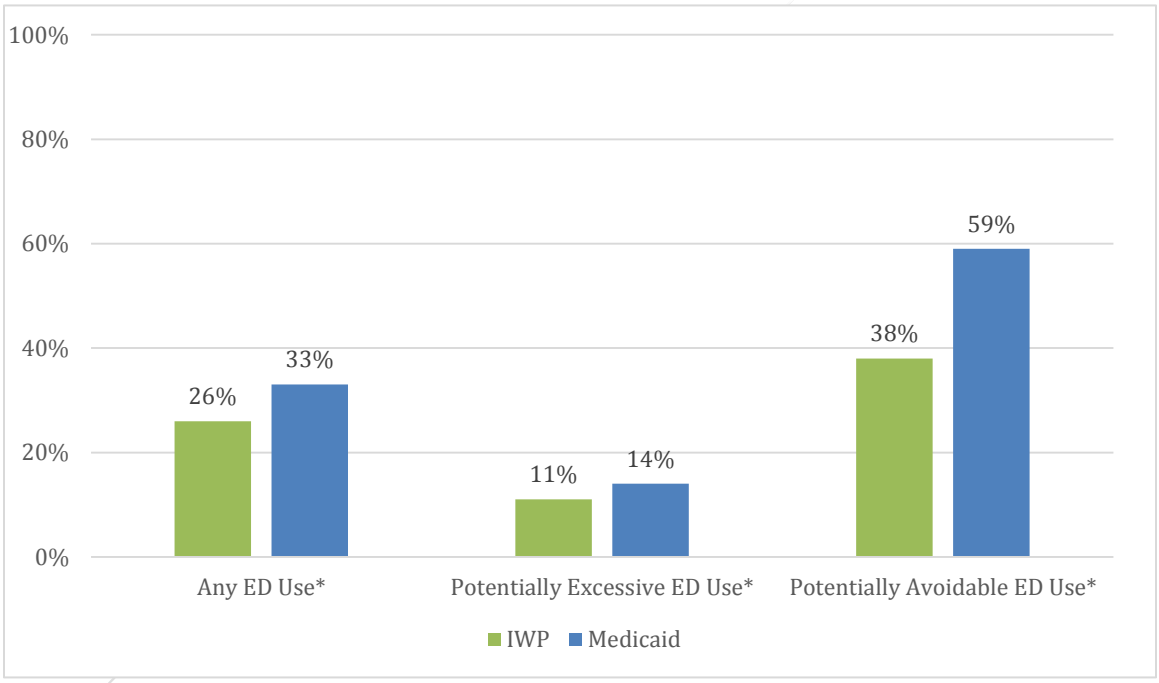
* Statistically significant difference at p<.05

Measure 37 Emergency department use

There were several questions in the survey that tried to assess "appropriate" emergency department (ED) use. In addition to reporting any ED use, we defined potentially "excessive" ED use if the respondent reported using the ED two or more times in the previous six months. The surveys included a question asking those with at least one ED visit if the care from their most recent ED visit could have been provided in a doctor's office if one was available at the time. Affirmative responses to that question defined potentially "avoidable" ED use.

Figure 37 provides the ED experiences of IWP and Medicaid members. One-third of Medicaid members (33%) and around one-quarter (26%) of IWP members used the ED at least once in the six month period, and that difference was significant. Significantly fewer IWP members (11%) than Medicaid members (14%) reported two or more visits to the ED in a six month period. Also, significantly fewer IWP members (38%) compared to Medicaid members (59%) reported that the care at their last visit to the ED could have been provided in a doctor's office. There were no significant differences by MCO with regard to emergency department use for IWP members.

Figure 37. Emergency Department Use by IWP and Medicaid Members



* Statistically significant difference at p<.05

As a follow-up to the assessment of potentially avoidable ED use, IWP and Medicaid members were asked about barriers to their ability to go to a doctor's office instead of the ED for their health care (**Table 20**). A little less than half of IWP (40%) and Medicaid (45%) members reported using the ED instead of the doctor's office or clinic because the doctor's office or clinic was not open when they needed care. Over one in five (IWP 27%, Medicaid 23%) reported that their health problem was too serious for the doctor's office (i.e., they needed to use the ED). A healthcare provider advised ED use for 13% of IWP and 10% of Medicaid members and inability to get an appointment at the doctor's office was reported by 6% of IWP and 11% of MPC members.

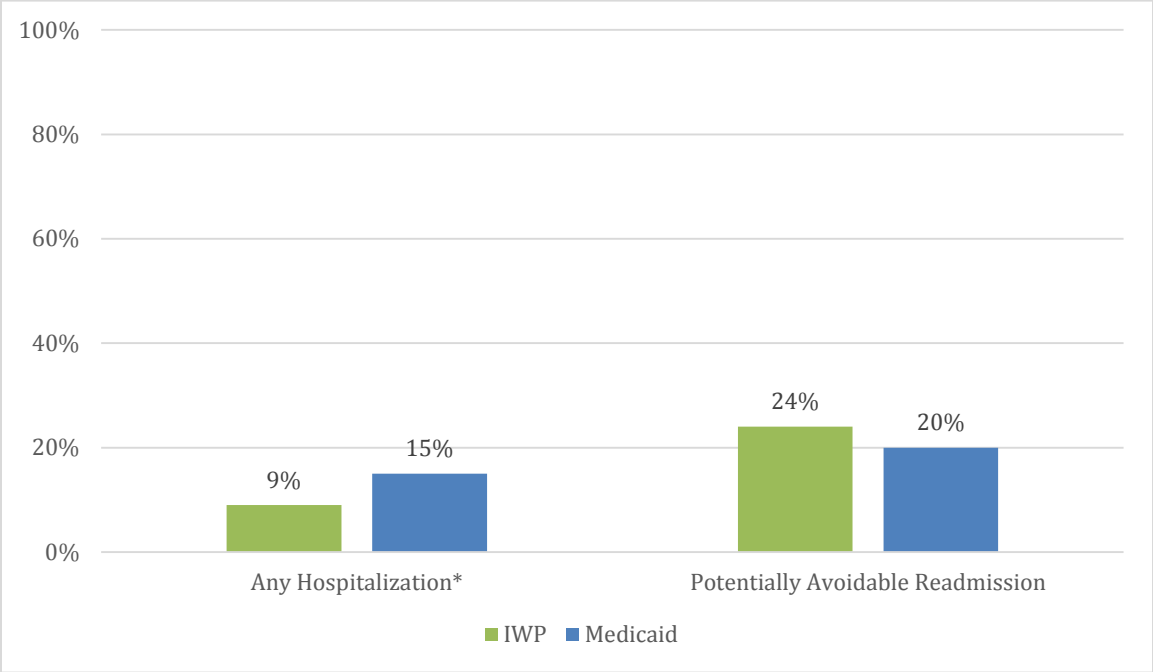
Table 20. Barriers to Going to a Doctor's Office Instead of the ER for Health Care

IWP (n=420)	Medicaid (n=278)	Response Options
40%	45%	A doctor's office or clinic was not open when I needed care
27%	23%	Health problem was too serious for the doctor's office
13%	10%	Healthcare provider told them to go to the ER for care
6%	11%	Could not get an appointment with the doctor's office or clinic
7%	6%	Did not have a doctor or clinic to go to
3%	2%	I had transportation problems getting to a doctor's office or clinic

The results of two questions asking about hospital stays are summarized in **Figure 38**. The first asked how many nights the respondent spent in the hospital for any reason in the six months prior to the survey. The second was used to get a sense of potentially "avoidable" readmissions to the hospital and asked respondents who had reported a hospitalization if they ever had to go back into the hospital within 30 days of being allowed to go home because they were still sick or had a problem.

Significantly fewer IWP members (9%) than Medicaid members (15%) reported any hospital stays in the six month period. However, there were no significant differences between IWP and Medicaid members with regard to recent readmissions. And there were no significant differences in reported hospitalization and readmission by MCO for IWP members.

Figure 38. Hospitalization and Readmission by IWP and Medicaid Members



* Statistically significant difference at p<.05

Hypothesis 3.2

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

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

Removed due to lack of admissions for diabetes short-term complications.

Measure 39 Admission rate for COPD

Definition

The Prevention Quality Indicators (PQI) include the number of discharges for COPD and asthma per 100,000 Medicaid members. We utilized the AHRQ WinQI calculator to identify the hospitalizations reflecting COPD/asthma admission. The number of admissions was then calculated as number of admissions per 100,000 members who were enrolled for at least 11 months of the year. The rates are reported for CY 2016 and CY 2017 only, as the change in diagnosis coding from ICD-9 to ICD-10 resulted in a new AHRQ WinQI calculator for CY 2016.

Results

Rates of admission for COPD/asthma were much higher for IWP than for FMAP in both years with the rate of admission being nearly three times higher for IWP than for FMAP members (**Table 21**). This may be expected due to the increased age of IWP members and the higher likelihood of chronic conditions in this group.

Table 21. COPD/asthma admission rate for members 19-64 years of age CY 2016 – CY 2017

	FMAP 2016	IWP 2016	FMAP 2017	IWP 2017
Members	26,411	100,377	37,589	115,867
Number of admissions	16	178	14	183
Admission rate/100,000	61	177	37	158

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

Removed due to lack of admissions for diabetes short-term complications.

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

Definition

The Prevention Quality Indicators (PQI) include the number of discharges for CHF per 100,000 Medicaid members. We utilized the AHRQ WinQI calculator to identify the hospitalizations reflecting CHF admission. The number of admissions was then calculated as the number of admissions per 100,000 members who were enrolled for at least 11 months of the year.

Results

Rates of admission for CHF were much higher for IWP than for FMAP in both years (**Table 22**). This might be expected as the FMAP population is younger than the IWP population and much less likely to be experiencing chronic diseases such as CHF.

Table 22. CHF admission rate for members 19-64 years of age CY 2016 – CY 2017

	FMAP 2016	IWP 2016	FMAP 2017	IWP 2017
Members	26,411	100,377	37,589	115,867
Number of admissions	23	163	29	195
Admission rate/100,000	87	162	77	168

Measure 42 Avoidance of antibiotic treatment in adults with acute bronchitis

Removed from the evaluation in consultation with CMS.

Measure 43 Inpatient utilization-general hospital/acute care

Removed from the evaluation.

Measure 44 Plan "all cause" hospital readmissions

Removed as current HEDIS measures do not allow for risk adjustment.

Measure 45 Rate of hospital admissions in past 6 months

See results under Measure 37.

Measure 46 Rate of 30 day hospital readmissions

See results under Measure 37.

Hypothesis 3.3

Iowa Wellness Plan 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

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

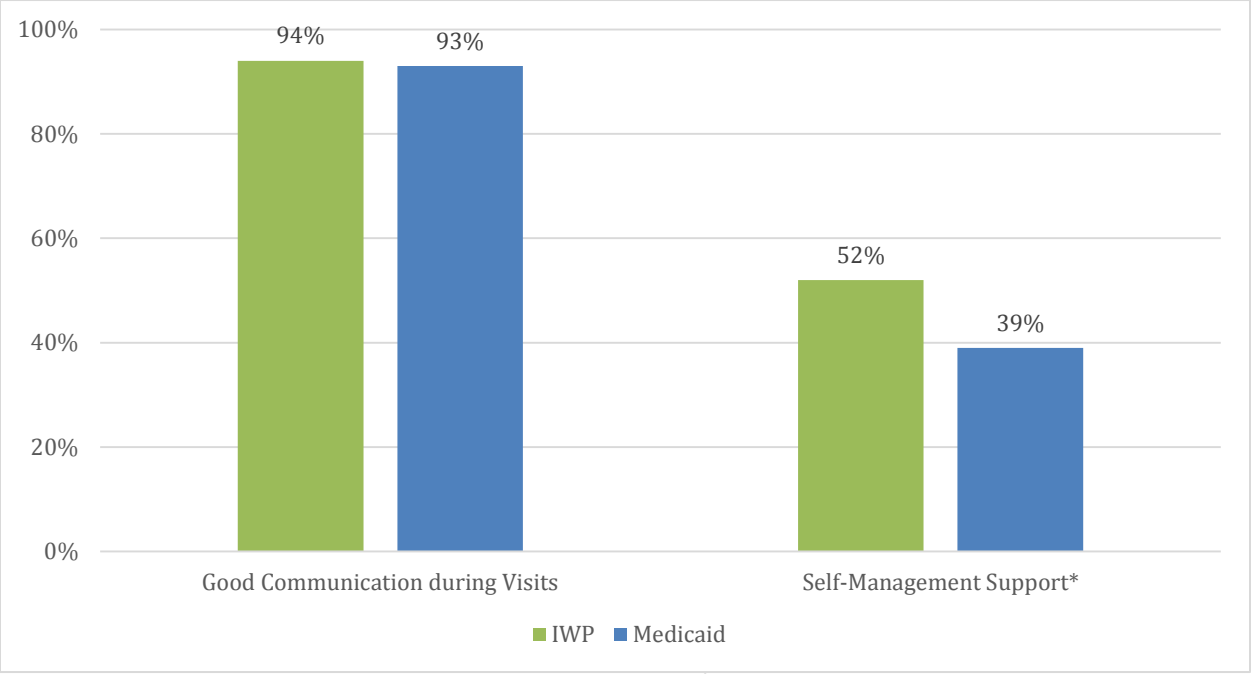
- How often did your personal doctor explain things in a way that was easy to understand?
- How often did your personal doctor listen carefully to you?
- How often did your personal doctor show respect for what you had to say?
- How often did your personal doctor spend enough time with you?

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

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

Figure 39 provides a summary of the findings for IWP and Medicaid member experiences with communication with their provider and receipt of self-management support. The vast majority of IWP (94%) and Medicaid members (93%) reported good communication ('usually' or 'always' communicated well) with their provider during their office visits. Significantly more IWP members (52%) compared to Medicaid members (39%) reported receiving self-management support from their provider. Within IWP, there were no significant differences by MCO with regard to communication and self-management support.

Figure 39. IWP and Medicaid Member Experiences with Communication and Self-Management Support



* Statistically significant difference at p<.05

Measure 48 Self-management support

See results under Measure 47.

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

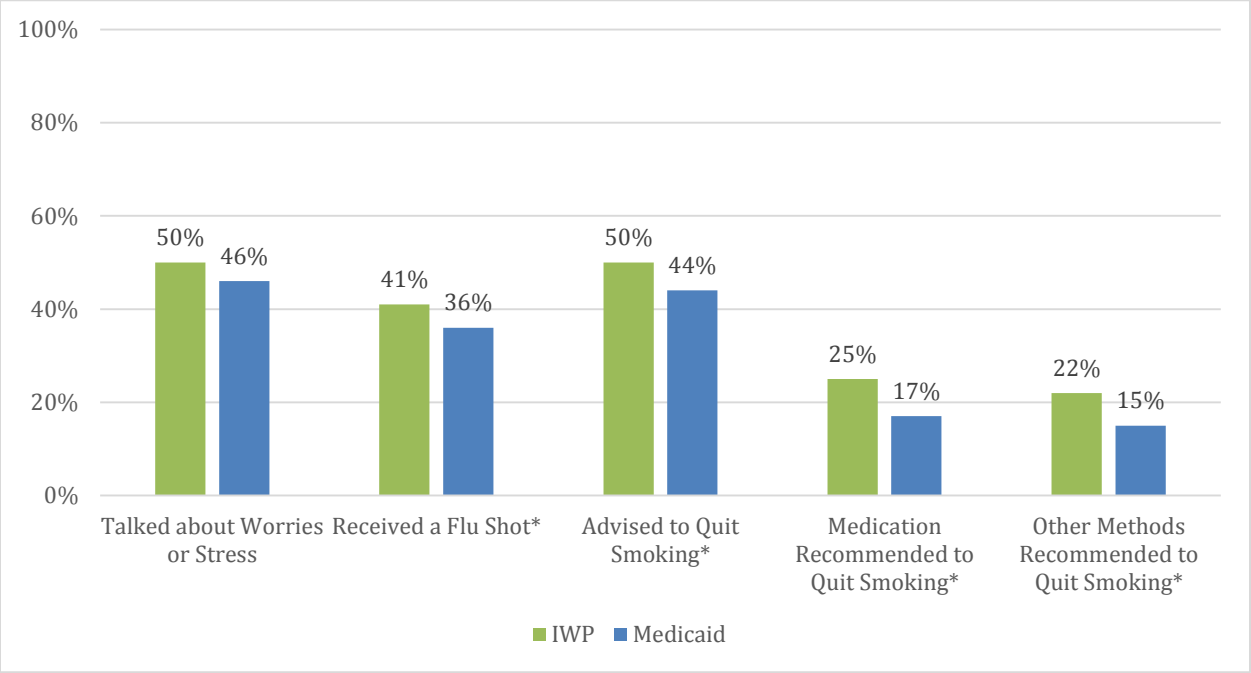
Comprehensiveness of Care was assessed using the following items:

- Did you and anyone in a doctor's office talk about things in your life that worry you or cause you stress?
- Have you had a flu shot since September 1, 2016?
- For smokers, how often were you advised to quit smoking or using tobacco by a doctor or other health provider in your plan?
- For smokers, how often was medication (such as nicotine gum, patch, nasal spray, inhaler, or prescription medicine) recommended or discussed by a doctor or health provider to assist you with quitting smoking or using tobacco?
- For smokers, how often did your doctor or health provider discuss or provide methods and strategies other than medication (such as telephone hotline, individual or group counseling, or a cessation program) to assist you with quitting smoking or using tobacco?

Figure 40 provides a summary of the findings for IWP and Medicaid member comprehensive care experiences. Around one-half of IWP and Medicaid members reported talking with someone from

their doctor's office about things in life that worried them or caused them stress. Significantly more IWP members (41%) compared to Medicaid members (36%) received a seasonal flu shot. As reported earlier, around 40% of IWP members and 38% of Medicaid members reported smoking cigarettes or using tobacco at least some days. Of these, significantly more IWP members than Medicaid members reported being advised to quit smoking and were recommended ways to quit. Within IWP, there were no differences by MCO with regard to these concepts.

Figure 40. IWP and Medicaid Member Experiences with Comprehensive Care



* Statistically significant difference at p<.05

Measure 50 Shared decision-making regarding medications

Definition

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

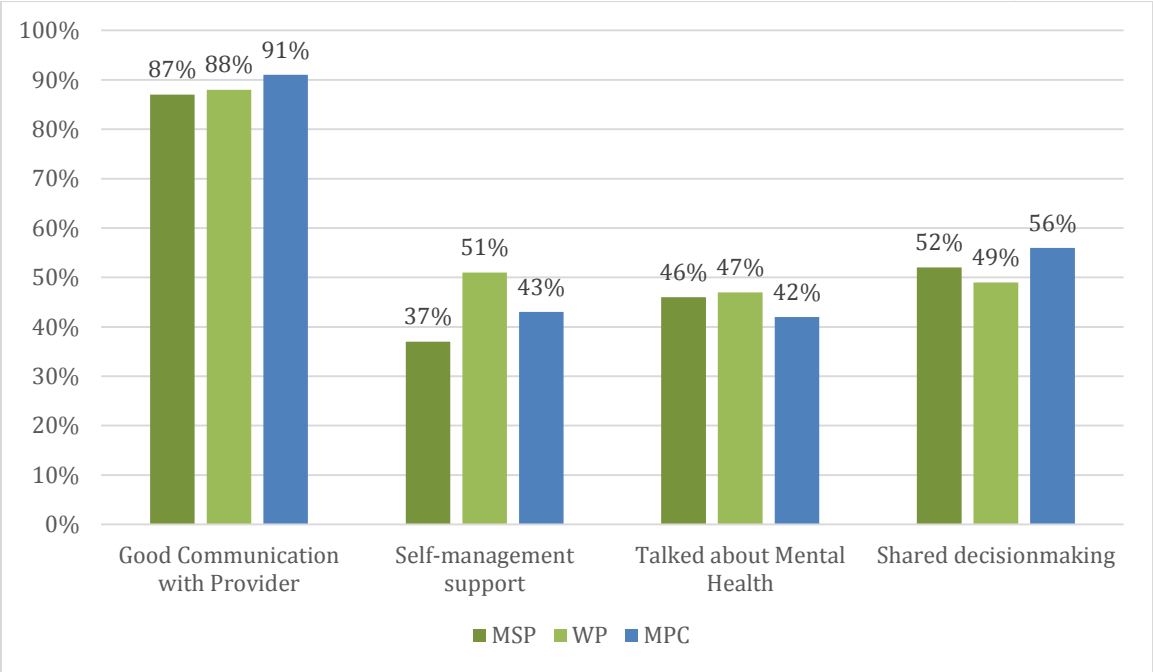
1. When you talked about starting or stopping a prescription medicine, how much did the doctor or other health provider talk about the reasons you might want to take a medicine?
2. When you talked about starting or stopping a prescription medicine, how much did the doctor or other health provider talk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

Results

Figure 41 below provides the results of this analysis. Around half of the members from each group (52% of MSP members, 49% of WP members, and 56% of MPC members) reported that their provider shared decision making with them regarding prescription medications.

Figure 41. Member Experiences during Office Visits



Measure 51 Care coordination

To assess timely access to care, we used a three-item composite measure comprised of the following questions:

- When you needed care right away, how often did you get care as soon as you needed?
- 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?
- 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?

Access to after-hours care was assessed using one item that asked about whether or not the provider gave them information about how to access care after hours:

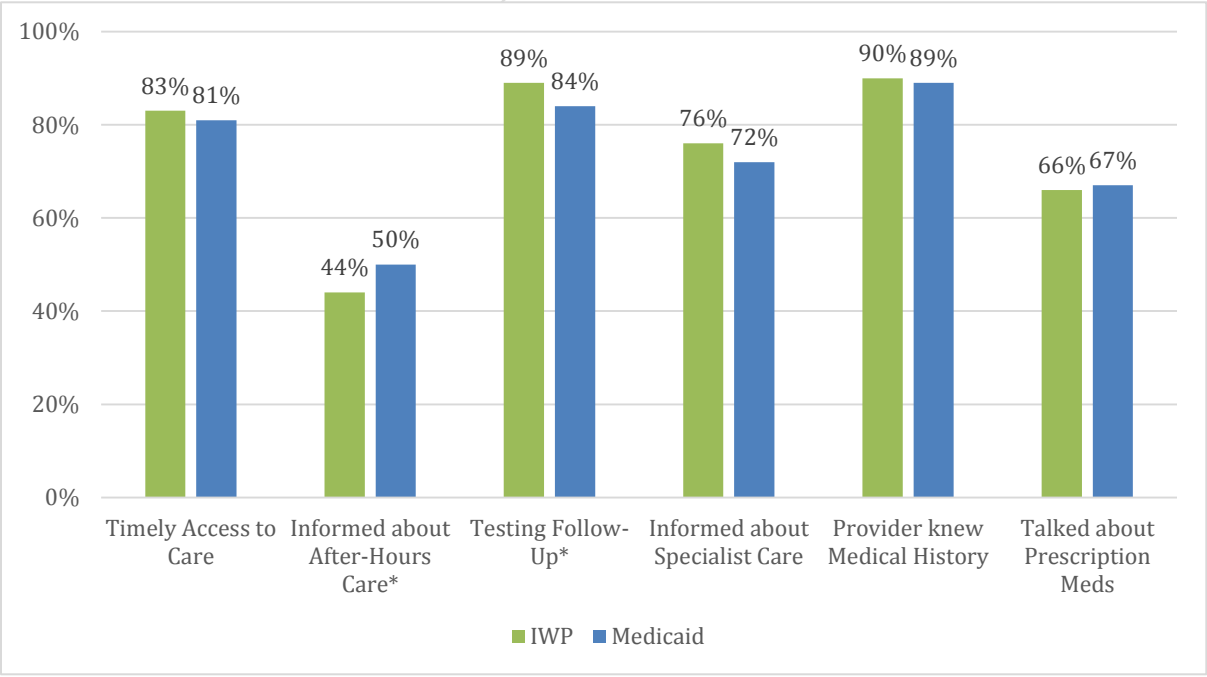
- Did a doctor's office give you information about what to do if you needed care during evenings, weekends, or holidays?

Care Coordination was assessed using four items related to different aspects of providing care coordination:

- 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?
- How often did your personal doctor's office seem informed and up-to-date about the care you got from specialists?
- How often did your personal doctor seem to know the important information about your medical history?
- How often did you talk with someone from your doctor's office about all the prescription medicines you were taking?

Figure 42 provides a summary of the findings with regard to members' experiences with their doctor's office. IWP and Medicaid members' experiences were similar with regard to timely access to care (83% IWP, 81% Medicaid), having a provider informed about specialist care (76% IWP, 72% Medicaid), having a provider who knew their medical history (IWP 90%, Medicaid 89%), and having talked about their prescription medicines (IWP 66%, Medicaid 67%). Yet, significantly more IWP members (89%) than Medicaid members (84%) reported that their doctor's office followed up with them to give them results of testing. And, around 50% of Medicaid members reported receiving information from their doctor's office about what to do if they needed care after-hours which was significantly higher than reported by IWP members (44%). Within IWP, there were no significant differences by MCO with regard to member experiences with their doctor's office.

Figure 42. IWP and Medicaid Member Experiences with their Doctor's Office



* Statistically significant difference at p<.05

Measure 52 Rating of personal doctor

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 the following:

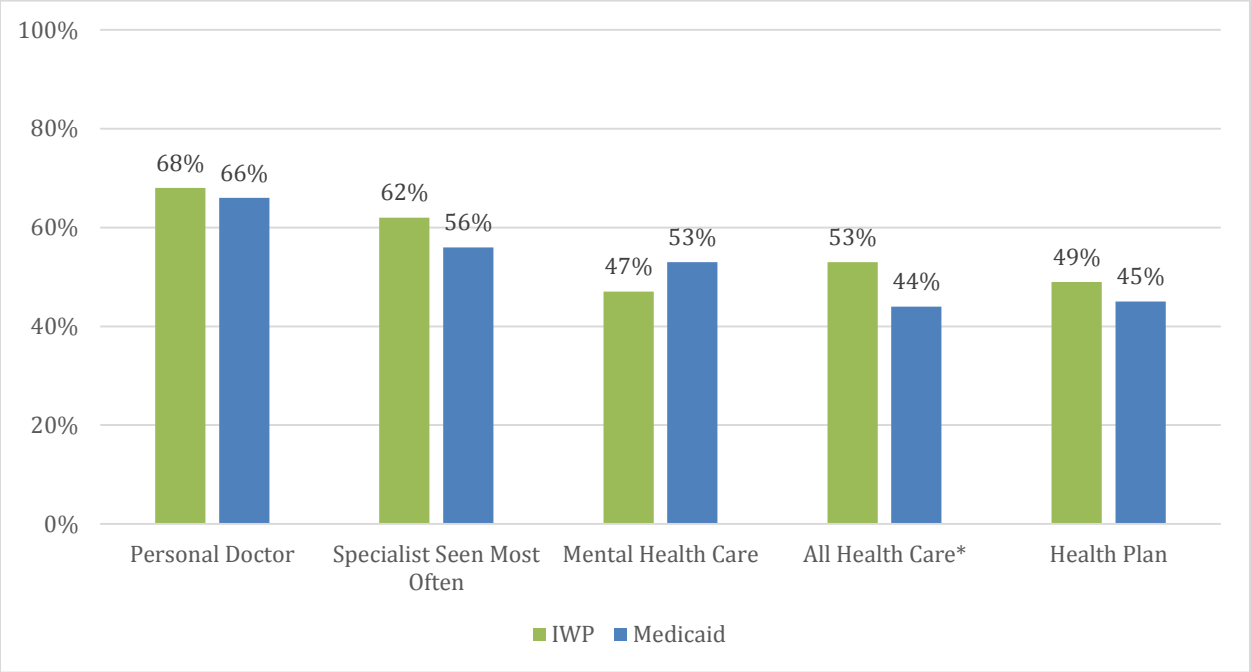
- Personal Doctor
- Most Often Seen Specialist
- Mental Health Treatment or Counseling
- All Health Care Received
- Health Plan

Figure 43 provides a summary of the percentage of respondents who rated each of these areas as a '9' or '10' which indicates the highest possible ratings. Around two-thirds of respondents rated their personal doctor as a '9' or '10' and there was no significant difference between IWP (68%) and Medicaid (66%). There were no statistically significant differences between IWP and Medicaid members in their ratings of specialist care, mental health care, or health plan. However, significantly more IWP members (53%) than Medicaid members (44%) rated their overall health care highly. The CAHPS online reporting system contains National Comparative Data[4] (NCD) for each of these rating measures with the exception of mental health care. IWP and Medicaid members' ratings of their personal doctor and their overall health care are similar to the NCD (NCD: 65% personal doctor; 53% overall health care) but are somewhat lower than reported in the NCD for specialist care (NCD, 65%) and health plan (NCD, 57%).

For IWP members, there were no significant differences by MCO with regard to ratings of their providers, health care, and health plan.

[4] Formerly known as National CAHPS Benchmarking Database (NCBD). More information available at https://cahpsdatabase.ahrq.gov/cahpsidb/

Figure 43. High Ratings of Care and Health Plan Quality for IWP and Medicaid



* Statistically significant difference at p<.05

Measure 53 Rating of all health care received

See results under Measure 52.

Measure 54 Rating of health care plan

See results under Measure 52.

Cost

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

Hypothesis 4.1

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

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

Costs analyses were removed for the current waiver period as a capitated payment mechanism was introduced. Previous results indicated that costs for IWP members were lower than costs for adult members in Medicaid State Plan.

Premiums and Cost Sharing

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

Hypothesis 5.1

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

Measure 56 Awareness of Premium Incentive

By getting a wellness exam (either a medical check-up or a dental check-up) and completing an HRA, IWP members would avoid having to pay a monthly premium for their health care in the following year of the program. In the survey, IWP members were given the following information about the incentives to avoid paying a monthly premium:

"As part of your health plan from your MCO, you are supposed to get a medical or dental check-up and complete a health risk assessment (a survey that asks questions about your health). If you do not, you may have to pay a monthly premium/fee (depending on your income) in the following year."

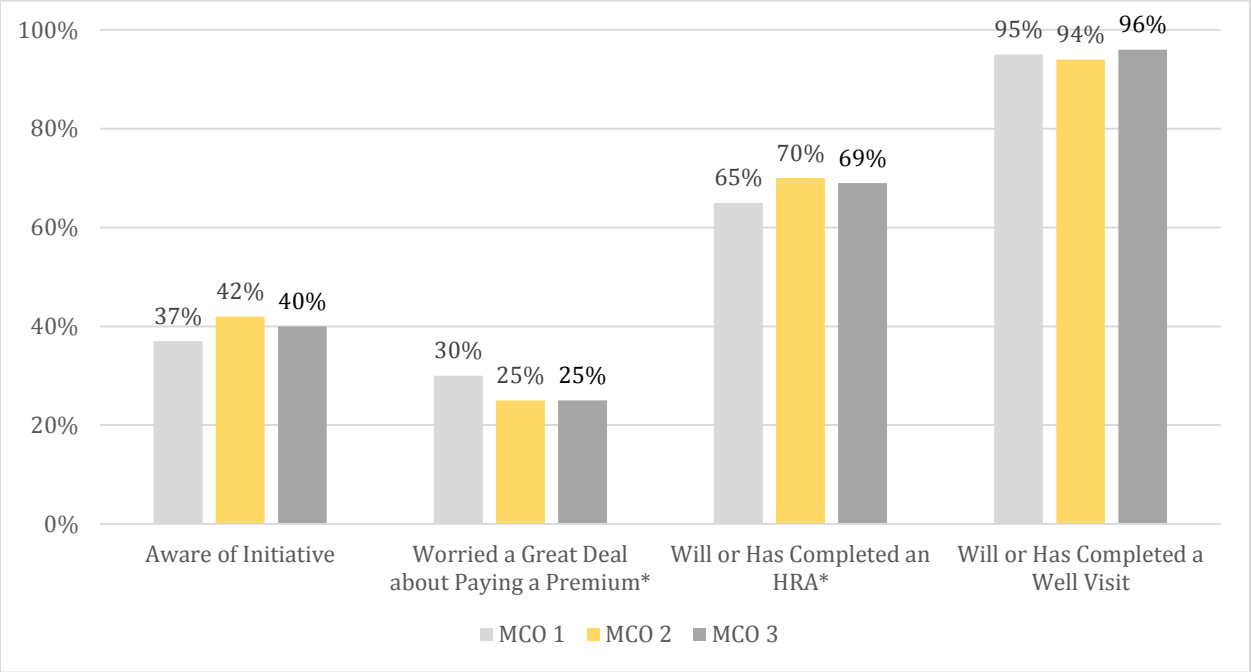
Members were then asked the following:

- Did you know you may have to pay a monthly premium (fee) next year if you do not get a medical or dental check-up and complete a health risk assessment this year? [Awareness of initiative]
- Do you think you will complete a health risk assessment this year? [Willingness to participate]
- Do you think you will get a medical or dental check-up this year? [Willingness to participate]
- Do you think any of the following would keep you from getting a medical check-up this year? [Barriers to complying]
- Do you think any of the following would keep you from getting a dental check-up this year? [Barriers to complying]
- How much would it worry you if you had to pay a premium (a $5 or $10 fee) every month for your health plan? [Hardship for non-compliance]

Figure 44. Healthy Behaviors Program Premium Avoidance Incentives within IWP provides a summary of the findings related to the HBP premium avoidance incentives. Overall, around 40% of IWP members were aware that they would have to pay a premium if they did not get a medical or dental check-up and complete an HRA in the year of their enrollment (37%-42% across all three MCOs).

Around 70% of IWP members either had already completed or were intending to complete an HRA; around 25% reported not knowing what an HRA was. The vast majority of IWP members, regardless of MCO enrollment (94%-96%), reported either having already obtained a medical or dental check-up or intent to get one.

Figure 44. Healthy Behaviors Program Premium Avoidance Incentives within IWP



* Statistically significant difference at p<.05

Measure 57 Member Perception of Ease of Obtaining Annual Physical Exam

Table 23 provides a summary of the barriers to obtaining a medical check-up reported by IWP members. Around 40% of IWP members reported that they had already obtained a medical check-up. Around 8% reported that they did not think they needed a medical check-up.

Table 23. Barriers to Obtaining a Medical Check-Up

MCO 1	MCO 2	MCO 3	Response options
6%	8%	10%	I don't believe I need a medical check-up
6%	6%	6%	I am not sure where to go to get a medical check-up
7%	5%	6%	I don't currently have a doctor
4%	8%	5%	I don't like getting a medical check-up
5%	4%	3%	Getting transportation to my doctor's office is hard
5%	4%	3%	I can't get the time off of work/can't get child care
3%	1%	3%	It is hard to get an appointment for a medical check-up from my doctor
2%	2%	2%	I don't like my current doctor

Table 24 provides a summary of the barriers to obtaining a dental check-up reported by IWP members. Around 28% of IWP members reported that they had already obtained a dental check-up. Access to a dentist was a common reason reported by IWP members for not being able to get a dental check-up. Regardless of MCO type, the most commonly reported barrier to obtaining a dental check-up was current lack of having a dentist. Around 12% reported not being sure about where to go to get a dental check-up.

Table 24. Barriers to Obtaining a Dental Check-Up

MCO 1	MCO 2	MCO 3	Response options
17%	17%	19%	I don't currently have a dentist
13%	11%	12%	I am not sure where to go to get a dental check-up
8%	8%	7%	I don't like getting a dental check-up
4%	5%	7%	I don't believe I need a dental check-up
6%	4%	3%	Getting transportation to my doctor's office is hard
4%	4%	3%	It is hard to get an appointment for a dental check-up from my dentist
4%	2%	3%	I can't get time off from work/can't get check care
1%	1%	2%	I don't like my current dentist

Measure 58 Member Perception of Hardship of Premium Levels

See results under Measure 57.

Measure 59 Ability to receive services for those who are disenrolled due to the lack of a premium payment in year two and three

See results under Hypothesis 5.2.

Hypothesis 5.2

The majority of IWP members will complete the healthy behaviors and therefore not have to pay a premium incentive or be disenrolled.

Disenrollment was studied for the first waiver period. The results can be found in the following report http://ppc.uiowa.edu/publications/healthy-behaviors-dis-enrollment-interviews-report-depth-interviews-iowa-health-and

Measure 60 Completion of healthy behaviors in the specified time period without a monthly premium

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

Measure 61 Completion of healthy behaviors only after paying a monthly premium

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

Measure 62 Disenrollment as a result of not completing the healthy behaviors or not paying the monthly premiums

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

Hypothesis 5.3

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

Measure 63 Awareness of the copayment

Another behavior change initiative within the IWP involves the appropriate use of ED services. As part of the IWP coverage, members may have to pay an $8 copayment each time they use an ED for a non-emergent condition. The implementation of this requirement (copayment for non-emergent use of the ED) was delayed until late in 2016.

In the IWP survey, we were able to assess members' knowledge and potential impact of the copayment for non-emergent ED use. IWP members were given the following information about the fee for non-emergent use of the ED:

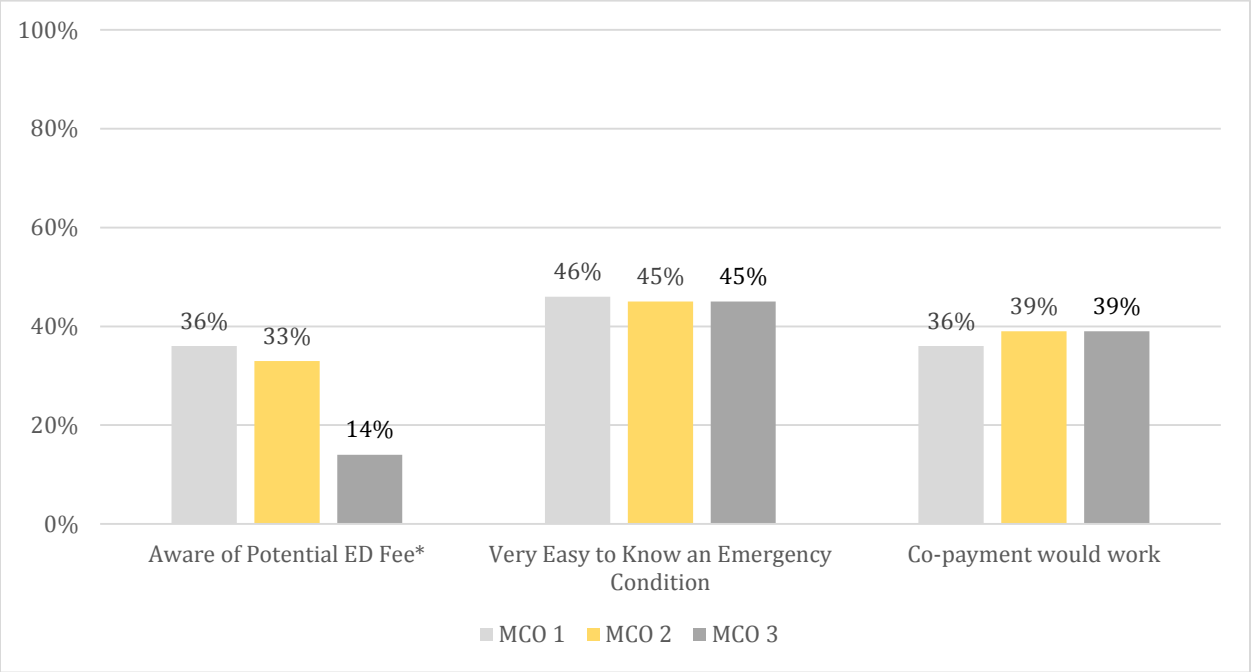
"As part of your health plan from your MCO, after you have been enrolled for one year, you may have to pay $8.00 each time you use an emergency room for a non-emergency condition. An emergency is considered to be any condition that could endanger your life or cause permanent disability if not treated immediately."

They were then asked the following:

- Did you know that you may have to pay an $8 fee anytime you use the emergency room when your health condition is not an emergency, beginning one year after you started in this program? [Awareness of initiative]
- How easy do you think it would be to know when your health condition would be considered an emergency? [Ease of complying]
- Do you think having to pay an $8 fee would keep you from going to the emergency room when you have a health condition that could be treated in your doctor's office instead? [Effectiveness of fee]

Figure 45 provides a summary of the findings related to the non-emergent ED use co-payment. While around one-third of MCO 1 (36%) and MCO 2 (33%) enrollees reported being aware of the ED use co-payment, significantly fewer MCO 3 enrollees (14%) reported awareness of the co-payment potential. Survey results from 2014-15 noted that only around 10% of members knew about the potential ED co-payment. Around 45% of IWP members, regardless of MCO enrollment, reported that it would be 'very easy' and around 3% reported that it would be 'very hard' to know when a health condition would be considered an emergency. And, around 40% reported that an $8 co-payment would keep them from going to the ED for a health condition that could have been treated in a doctor's office instead.

Figure 45. Non-Emergent ED Use Disincentives within IWP



* Statistically significant difference at p<.05

Measure 64 Awareness of non-emergent condition

See results under Measure 59.

Measure 65 Copayment as a disincentive

See results under Measure 59.

Provider Network Adequacy

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

Hypothesis 6.1

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

Measure 66 Geographic distance and time spent travelling to primary care provider

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 .

This report indicates that Iowa Wellness Plan members have the same access to an adequate provider network during the first waver period. This hypothesis was removed during the most recent waiver period as the adoption of statewide Medicaid Managed Care utilizing Managed Care Organizations to provide services to all Medicaid and IWP members brought the provider networks for both groups into alignment.

Measure 67 Analysis of rules and procedures for determining the adequacy of the provider network

Removed from evaluation due to difficulty in obtaining QHP documentation.

Measure 68 Provider willingness to accept new patients

See results under Measure 66.

Measure 69 Provider satisfaction with plan key components such as fee schedules and documentation

Removed from evaluation.

Measure 70 Comparison of network overlap between plans

Removed from evaluation due to difficulty of obtaining accurate, clean provider data from QHPs.

Measure 71 (MARKETPLACE CHOICE only) Provider network inclusion of safety net providers.

See results under Measure 66.

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.

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)

A special study was undertaken to determine the effects of no longer requiring NEMT be provided under the waiver. The study indicated that IWP members had equal or better access to transportation for health care than MSP members.

All other areas of emphasis were covered within existing hypotheses or additional reports.