IOWA Public Policy Center

RESEARCH REPORT

Iowa Wellness Plan Evaluation

Claims-based Outcome Report CY 2013 – 2018

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EXECUTIVE SUMMARY

Overall

This report provides health care utilization outcomes for the Iowa Wellness Plan (IWP), Iowa's version of the Medicaid expansion, from CY 2013 through CY 2018. IWP expanded health care coverage to Iowans who, with incomes from 0-138% of the Federal Poverty Level, were not categorically eligible for Medicaid. This report found that trends in quality measures indicate that this coverage improved access to primary care and screening during the first five years of the program.

Enrollment Trends

- Membership in IWP has stabilized with small but steady growth in the last year to over 170,000 in January 2019.
- The demographic characteristics of IWP members has not changed significantly over the first 5 years of the program. Members are most likely to be female, white, living in a metropolitan area and in the 22-30-year old age group.
- In December 2016, over 85,000 AmeriHealth members were switched to UHC as AmeriHealth exited the Iowa Medicaid program.
- Members who returned after a gap in enrollment, as opposed never coming back into Medicaid, 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.

Access to Care

- Rates of ambulatory care visits were similar between IWP members and income eligible adults in the Medicaid Family Medical Assistance Program (FMAP) program over time. Access to ambulatory care seemed to be high, with over 85% of members in both groups having an ambulatory care visit of some kind across all age groups over time.
- Screening rates were mixed for women in IWP compared to FMAP. Though the rates of mammograms to screen for breast cancer were higher for IWP members, the rates for cervical cancer screening were lower across the five years of IWP.
- The proportion of members with diabetes is higher in IWP than FMAP.
- Rates of Hemoglobin A1c testing, LDL-C screening, and medical attention for nephropathy were higher for IWP members with diabetes than for FMAP members with diabetes. Yet, FMAP members with diabetes were more likely to have had an eye exam than IWP members with diabetes. These results, though mixed, seem to indicate that IWP members with diabetes have equal or better access to care than FMAP members with diabetes.
- The rates of non-emergent emergency department (ED) visits and 30-day ED readmission rates were lower for IWP members than for FMAP members, though over time the rates for both programs are converging. Some of this convergence may derive from FMAP members and IWP members being enrolled in the same set of MCOs.

Quality of Care

- The admission rates for COPD/asthma and CHF among IWP members were higher than for adults in FMAP, a finding which may be related to the higher proportion of members over 40 in IWP. Over the three years from CY 2016 to CY 2018 the rates for these admissions decreased.
- Although the proportion of members in IWP with a well person visit was slightly higher, the proportion in both groups with a 'well person' (preventive) care visit was quite low, hovering around 25%.

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
- Churn - http://ppc.uiowa.edu/health/study/evaluation-iowas-medicaid-expansion-iowa-health-and-wellness-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: 1) 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 2) 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.

During calendar year 2015 it was mandated that all Medicaid members, including all IHAWP members, were to be placed into one of three managed care organizations (MCOs) beginning January 1, 2016. Due to a three-month implementation delay, IHAWP members previously enrolled with Coventry 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.

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

Effective November 30, 2017 AmeriHealth stopped serving as an MCO for Iowa Medicaid. Amerigroup was not prepared to accept the AmeriHealth members, so UnitedHealthcare accepted the transfer of the bulk of AmeriHealth members. Effective June 30, 2019, UnitedHealthcareexited the Iowa Medicaid program and Iowa Total Care will be added.

Table 1. IHAWP timeline

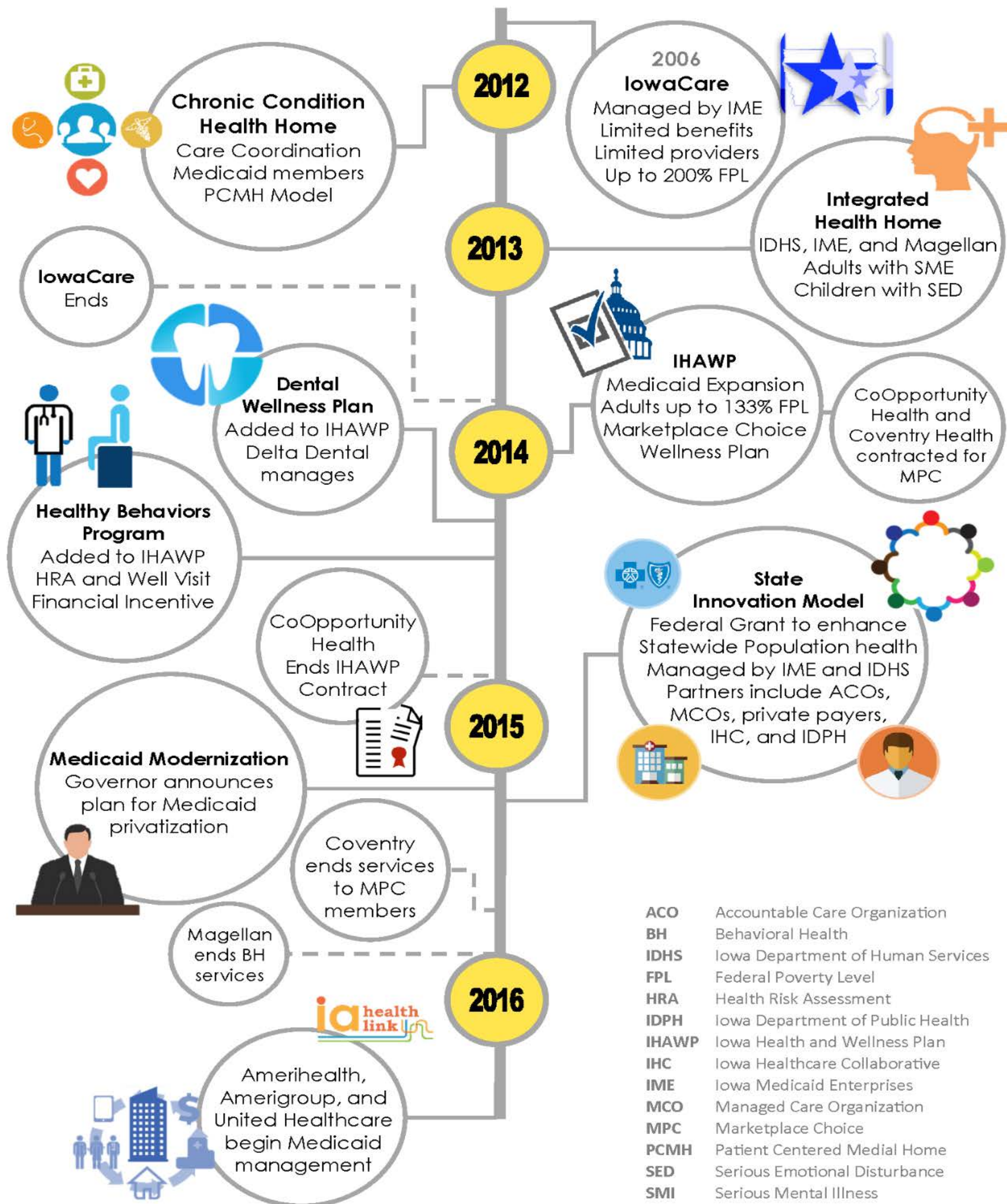
Date	Change
January 2014	First IHAWP members enrolled
May 2014	MPC members enrolled in Dental Wellness Plan with Delta Dental of Iowa
July 2014	MPC members enrolled in the Healthy Behaviors Incentive Program
November 2014	MPC members in CoOportunity were moved to MediPASS (PCCM program), Meridian (HMO), or Coventry (QHP)
November 2015	MPC members in Coventry were moved to MediPASS or Fee-for-service (MPC component dormant)
April 2016	MPC members were moved to one of three MCOs - AmeriGroup Iowa, AmeriHealth Caritas, or UnitedHealthcare Plan of the River Valley
November 2017	AmeriHealth Caritas exists Medicaid program
July 2019	UnitedHealthcare exits Medicaid program Iowa Total Care enters Medicaid program

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.

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

Medicaid members encompass a wide variety of programs. Often, a member may move through more than one program over the course of one or more years. We created study groups that would allow us to have the maximum amount of accurate data for each member. For example, during a given study year some members will move into reduced coverage programs. The Family Planning Waiver is one example of a reduced coverage program. Members who are 64 years old will move into Medicare, making their health care utilization data unavailable. In addition, members may move between programs in a way that enhances coverage for certain types of care such as the Home and Community Based Services Waiver or the Integrated Health Home for adults with severe mental illness and children with severe emotional disturbance. Our study minimizes the use of data for members who move into reduced spending programs or into specialized Medicaid initiatives to the extent that these members can be identified through enrollment files.

Within the IWP evaluation there are up to three distinct groups of adult health plan members being assessed: 1) Iowa Wellness Plan (IWP) members as described above, 2) Family Medical Assistance Program (FMAP) members, and 3) IowaCare (IC)[2] members.

Family Medical Assistance Program (FMAP)

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 parents earn more income they are able to increase the percent FPL allowed for eligibility as a means to encourage and reward employment. They may have been covered through a Health Maintenance Organization (HMO), Primary Care Case Management (PCCM), or Fee for Service (FFS) structure prior to April 1, 2016, at which time FMAP members were enrolled with an MCO.

IowaCare (IC)

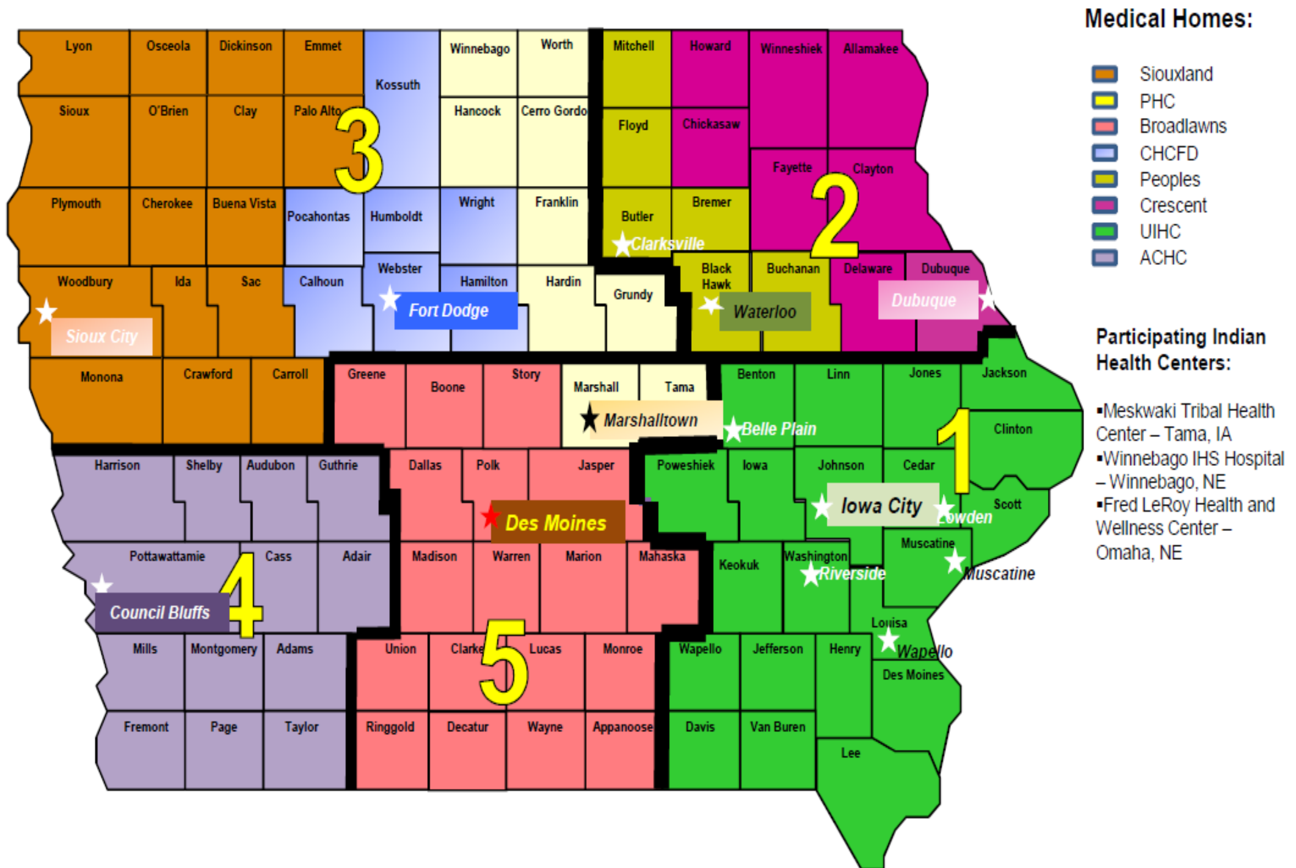
IowaCare was a limited provider/limited benefit program that operated from 2005 to 2013. The provider network included a public hospital in Des Moines, the largest teaching hospital in the state located in Iowa City, and six federally qualified health centers (FQHC). The plan served adults not otherwise eligible for Medicaid, with incomes up to 200% FPL. IHAWP replaced IowaCare, providing the opportunity to utilize pre-implementation administrative and survey data (pre-implementation data) for enrollees from this program. IowaCare enrollees were distributed into three places following the elimination of this program in 2013.

1. People with incomes 101-133% FPL were enrolled into Marketplace Choice.
2. People with incomes 0-100% FPL were enrolled in Wellness Plan.
3. People with incomes 133-200% FPL or with unverifiable incomes were not enrolled in any program.

IowaCare did not provide coverage for routine dental care 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. While IWP only covers uninsured adults up to 133% FPL (instead of 200% FPL), it does provide coverage for prescription drugs and dental care and has a much broader provider network than was available for members in IowaCare. Members who were eligible for IWP and enrolled in the IowaCare program as of December 31, 2013, were automatically enrolled into IWP as of January 1, 2014, if they met the eligibility criteria. Since IowaCare provided coverage for adults up to 200% FPL and IWP provides coverage to only 133% FPL, IowaCare members with incomes between 134-200% FPL were not auto-enrolled into IWP.

2 IowaCare is a program for uninsured adults in Iowa up to 200% FPL. More information about the PPC's previous evaluation of the IowaCare program is available at: http://ppc.uiowa.edu/health/study/evaluation-iowacare-program.

Figure 2. Map of IowaCare Medical Home Regions



RESULTS

Enrollment Trends

After initially rapid growth due to auto-enrollment of IowaCare members, enrollment in IWP climbed more slowly and steadily through December 2015, leveling off around 158,000 members and remaining at roughly that level through December 2017. Enrollments rose 91% from 61,895 initially to nearly 118,512 in WP and 143% from 15,483 to 37,609 in MPC. Beginning January 2016, MPC became dormant and all enrollees in IHAWP became members of Iowa Wellness Plan (IWP). Ultimately, by December 2018 there were over 170,000 members enrolled in IWP (Figure 3).

There are two times at which IWP enrollment dips during the first 5 years of the program. The first dip occurs in July 2016 and is most likely due to MCOs communicating with IME regarding eligibility verification for the first time. Members whose incomes are unable to be verified may be disenrolled and then reenrolled once information is provided. By September 2016, the number of members returns to pre-July levels, providing some evidence that members were able to regain eligibility. The second dip occurs in October 2017 the month prior to AmeriHealth ending participation in IWP. Enrollment was suspended as IME developed a mechanism to reassign and notify members. Members were primarily shifted to UHC. As with the previous reduction in enrollment, the number of members rose within two-month to pre-shift levels, continuing to climb to over 170,000 members as of December 2018.

Figure 3. Monthly enrollment in IWP by plan-all enrollees, CY 2014-CY 2018

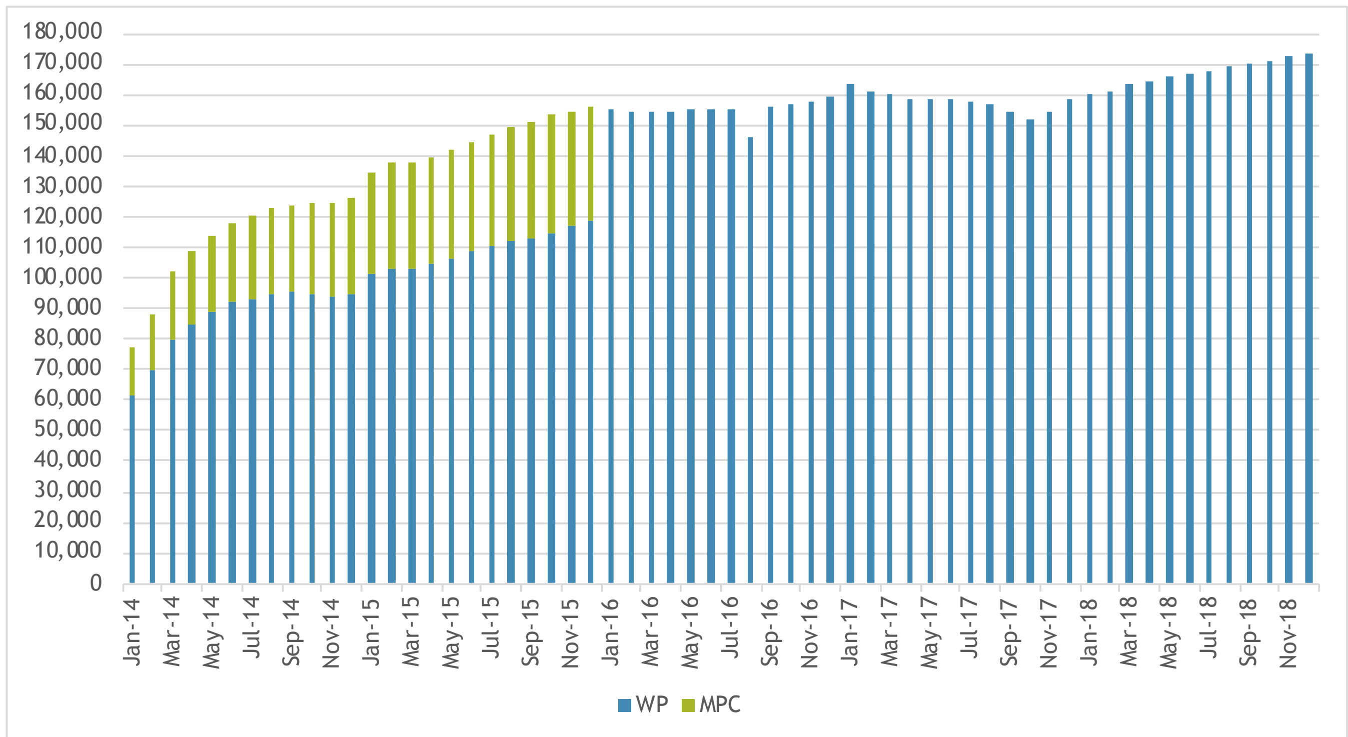


Table 2 provides comparisons of the IWP members over time. The characteristics of IWP members remained relatively stable over the five years following implementation. IWP members were equally likely to be male or female and most likely to be white, between 22 and 30 years of age, and living in a metropolitan area.

Table 2. Demographic characteristics of IWP members CY 2014 – 2018

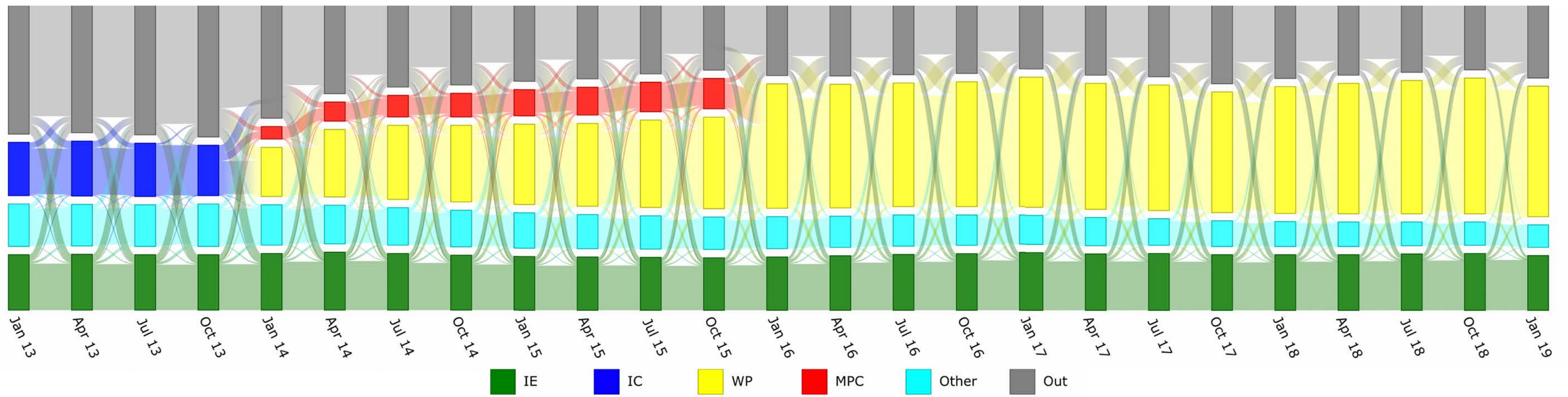
	CY 2018 N (%)	CY 2017 N (%)	CY 2016 N (%)	CY 2015 N (%)	CY 2014 N (%)
Gender					
Female	120,070 (53%)	117,991 (53%)	105,606 (51%)	102,598 (52%)	78,421 (51%)
Male	104,528 (47%)	102,372 (47%)	99,413 (49%)	95,086 (48%)	74,966 (49%)
Race					
White	140,236 (62%)	140,324 (64%)	134,327 (66%)	129,637 (66%)	99,487 (65%)
Black	19,338 (9%)	18,844 (9%)	17,337 (9%)	15,932 (8%)	11,908 (8%)
American Indian	3,656 (2%)	3,473 (2%)	3,145 (2%)	2,609 (1%)	2,017 (1%)
Asian	5,352 (2%)	5,226 (2%)	4,687 (2%)	4,323 (2%)	3,066 (2%)
Hispanic	10,874 (5%)	10,156 (5%)	9,182 (5%)	8,122 (4%)	5,548 (4%)
Pacific Islander	1,129 (<1%)	1,102 (<1%)	1,075 (<1%)	1,243 (1%)	819 (1%)
Multiple—Hispanic	3,145 (1%)	2,904 (1%)	2,643 (1%)	2,330 (1%)	1,502 (1%)
Multiple—Other	2,448 (1%)	2,188 (1%)	2,064 (1%)	1,810 (1%)	1,179 (1%)
Undeclared	38,420 (17%)	36,146 (16%)	30,559 (15%)	31,678 (16%)	27,861 (18%)
Age					
18-21 years	26,432 (12%)	18,205 (8%)	20,666 (10%)	19,325 (10%)	11,599 (8%)
22-30 years	59,500 (27%)	62,203 (28%)	56,234 (27%)	53,039 (27%)	38,997 (25%)
31-40 years	52,413 (23%)	53,260 (24%)	47,067 (23%)	44,720 (23%)	33,722 (22%)
41-50 years	37,780 (17%)	38,780 (18%)	36,281 (18%)	35,588 (18%)	30,503 (20%)
51 and over	48,471 (22%)	47,915 (22%)	44,769 (22%)	45,012 (23%)	38,566 (25%)
County rural/urban status					
Metropolitan	134,897 (60%)	132,548 (60%)	121,398 (60%)	119,368 (60%)	93,551 (61%)
Non-metropolitan, urban	78,921 (35%)	77,167 (35%)	69,809 (34%)	68,988 (35%)	52,977 (35%)
Non-metropolitan, rural	10,780 (5%)	10,648 (5%)	9,705 (5%)	9,328 (5%)	6,859 (4%)
Total	**224,598**	**220,363**	**205,019**	**197,684**	**153,387**

Churn

Figure 4 visualizes Medicaid program churn from the 1st quarter 2013 through the 4th quarter 2018. This figure includes any member enrolled for at least 1 month in any Medicaid program from CY 2013 through CY 2018 as contained in the enrollment file for March 2019. 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, IE member numbers remain stable, as does the number of members in other Medicaid programs including Supplemental Security Income (SSI). Within the last 3 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. However, there is still significant movement between within IWP as seen in the results presented below.

Figure 4. Churn in Medicaid programs, 1st quarter 2013-4th quarter 2018



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

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 can determine the number of individuals who experience a gap in coverage during the period December 2016 through January 2019 and ascertain the gap length.

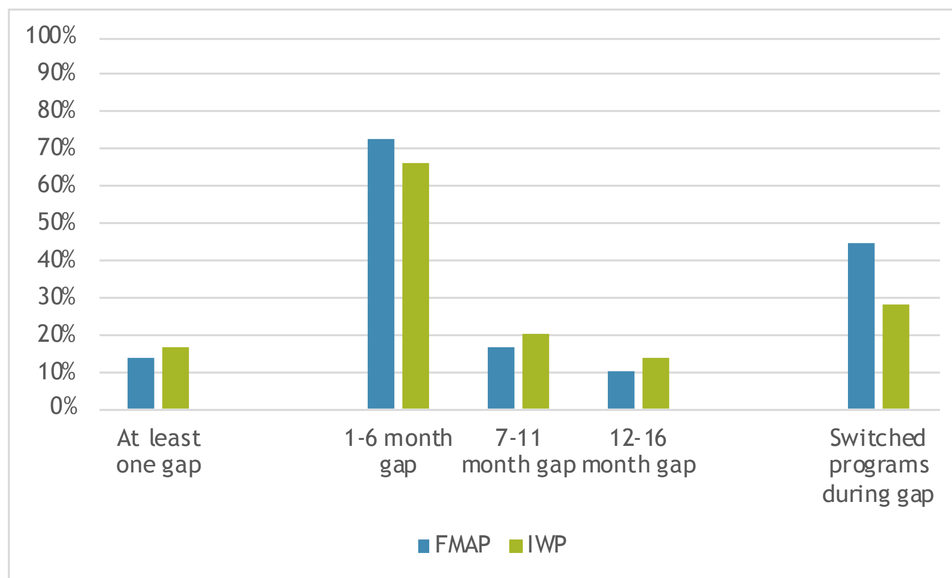
The proportion of members with at least one gap was significantly higher for IWP members, than for FMAP members (Table 3). The length of gap is also significantly different between IWP and FMAP members. IWP members are more likely to experience gaps greater than 6 months, the majority of members in both programs experience a 1-month gap in coverage. FMAP members are more likely to switch to a different Medicaid program at the end of the gap than IWP members. This may be a result of FMAP members having an increase in income allowing them to move up into the IWP group, while IWP members with an increase in income may have to leave the Medicaid program completely.

Table 3. Gap experience of FMAP and IWP members, December 2016 – January 2019

	FMAP	IWP
At least one gap	19,964 (14%)	36,659 (17%)*
1-6 month gap	15,184 (73%)	25,260 (66%)*
7-11 month gap	3,586 (17%)	7,777 (20%)
12-16 month gap	2,026 (10%)	5,177 (14%)
Switched programs during gap	8,906 (45%)	10,414 (28%)

p<=.001

Figure 5. Comparison of IWP and FMAP members with at least one gap, December 2016 and January 2019



Members in IWP and FMAP also lost coverage during the period December 2016 – January 2019. 69,503 member lost coverage in IWP (32%), while 33,332 FMAP members (23%) lost coverage during this time. Table 4 provides information on those who left IWP and either **did not return** to IWP or any other Medicaid program or **returned** to IWP or 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 4. Demographic characteristics of IWP members who left by return status, CY 2018

	Returned	Did not return
Gender		
Female	17,643	19,041*
	48%	52%
Male	14,354	18,465
	44%	56%
Race		
White	20,821	22,260*
	48%	52%
Black	3,851	3,272
	54%	46%
American Indian	648	573
	53%	47%
Asian	789	919
	46%	54%
Hispanic	1,727	2,568
	40%	60%
Pacific Islander	101	216
	32%	68%
Multiple-Hispanic	628	477
	57%	43%
Multiple-Other	493	357
	58%	42%
Undeclared	2,939	6,864
Age		
18-21 years	4,321	3,705*
	54%	46%
22-30 years	9,743	10,608
	48%	52%
31-40 years	8304	8931
	48%	52%
41-50 years	5068	6106
	45%	55%
51 and over	4,561	8,156
	36%	64%
County urbanicity		
Metropolitan	19,688	22,718
	46%	54%
Non-metro, urban	1,354	1,757
	44%	57%
Non-metro, rural	10,955	13,031
	46%	54%

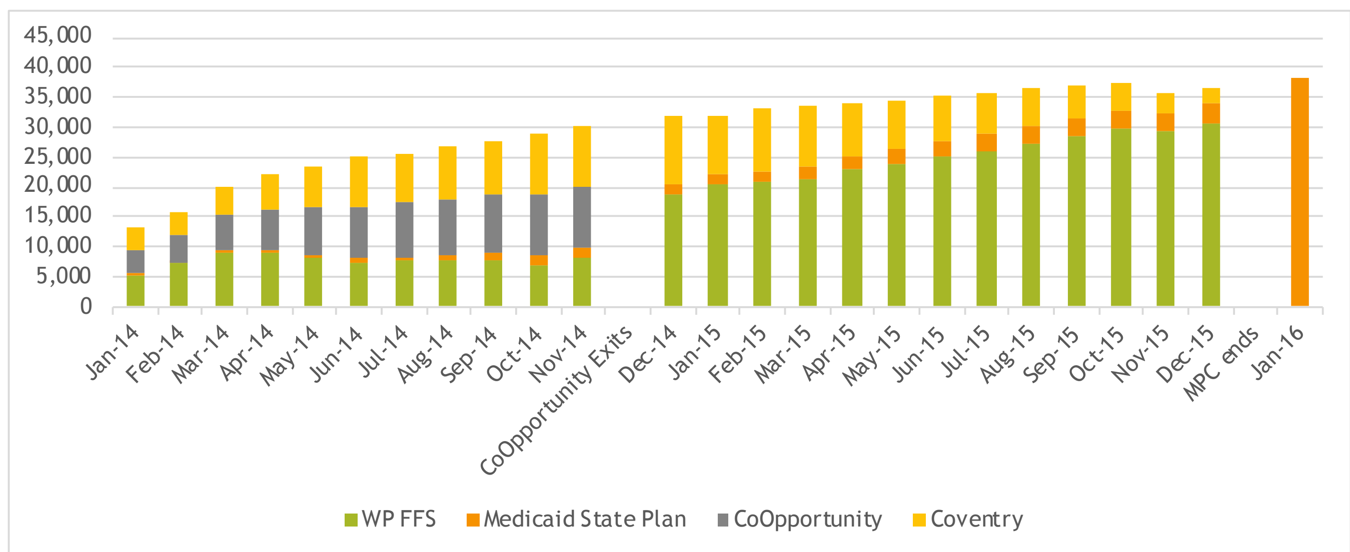
Transitions

This report contains information on transitions that occur within IWP for the period January 2014 through December 2018. 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 exempt' 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.

IHAWP Transitions - January 2014 Through December 2015

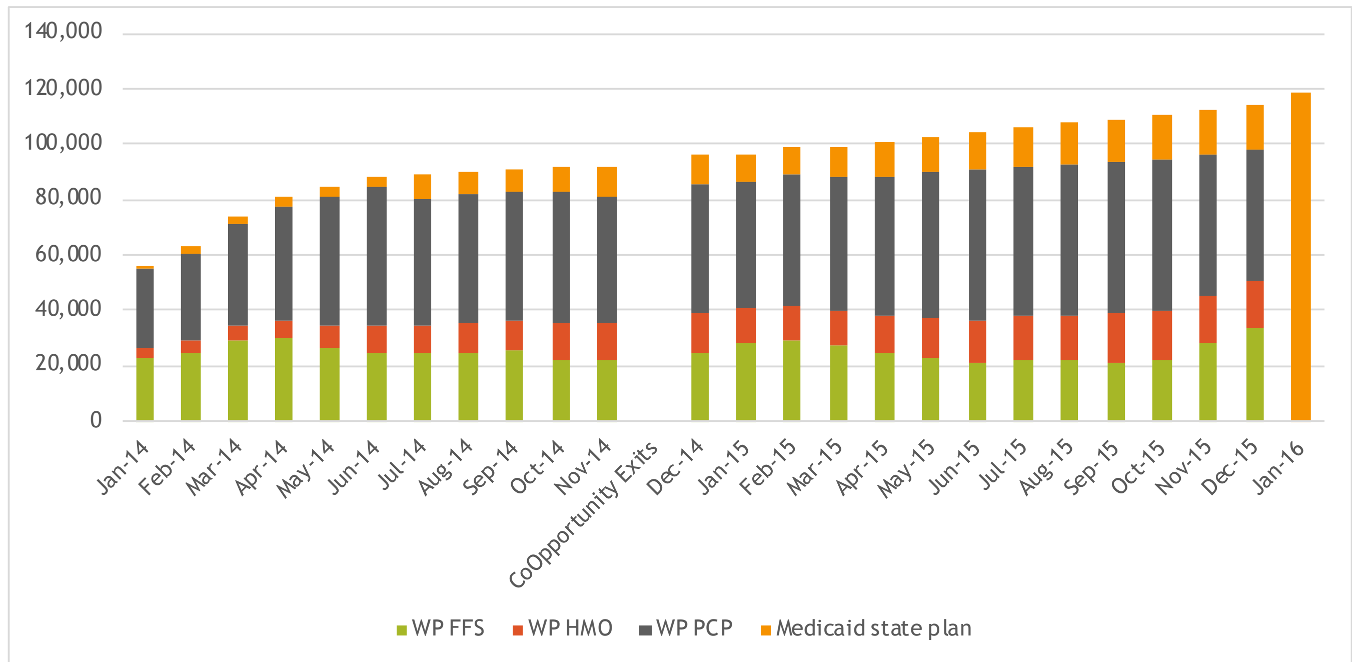
Figure 6 shows the distribution of members in MPC from January 2014 through December 2015. By December 2014, the point at which CoOpportunity exits, most MPC members who had been enrolled in CoOpportunity had been transitioned to WP fee-for-service coverage, as Coventry was unwilling to add these members 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 6. Marketplace Choice enrollment, CY 2014 – CY 2015



WP members were primarily enrolled in MediPASS (WP PCP), (Figure 7) with a growing number enrolled in Medicaid fee-for-service from July 2014 through December 2015. This represents members who were deemed 'Medically Exempt' and allowed to enroll in Medicaid fee-for-service to take advantage of waiver services not available under Wellness Plan.

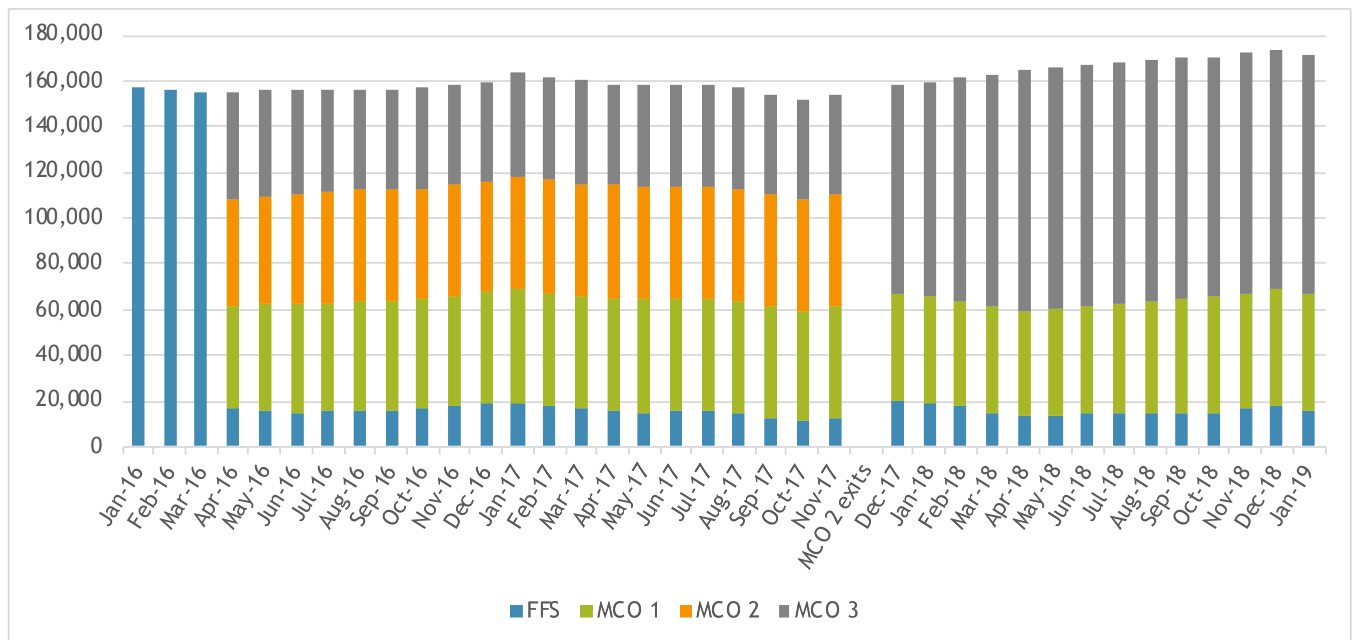
Figure 7. Wellness Plan enrollment, CY 2014 – CY 2015



IWP Transitions - January 2016 Through January 2019

Beginning in January 2016, the WP and MPC became IWP. Figure 6 shows the distribution of IWP enrollment by MCO. The numbers and distribution of members remains stable across the MCOs until November 2017 when AmeriHealth exits the Medicaid program. Members are almost exclusively enrolled in UHC because AmeriGroup was unable to take on additional members.

Figure 8. Iowa Wellness Plan enrollment, January 2016 – January 2019



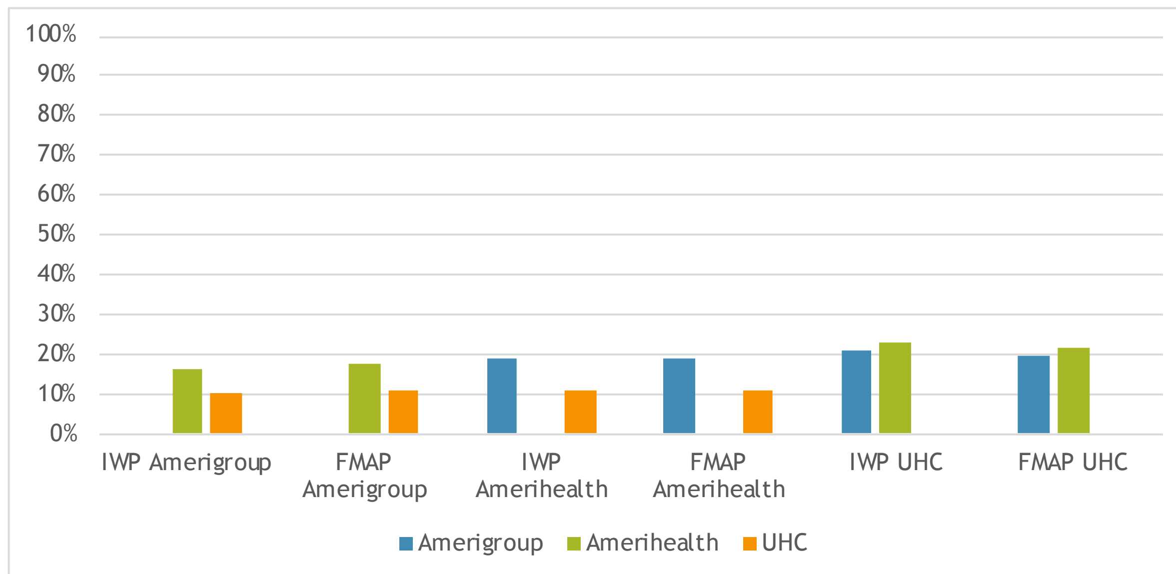
Transitions between MCOs are only allowed during the first 90 days of the first enrollment, the member's open enrollment period after the initial enrollment, and for 'Good Cause'. Table 5 and Figure 9 provide the transitions between MCOs for IWP members and FMAP members during the period December – November 2016. For both groups, the majority of transitions were from UHC to AmeriGroup or AmeriHealth (44% IWP; 41% FMAP), while the MCO with the fewest transitions to another MCO was AmeriGroup (27% IWP; 29% FMAP).

On November 30, 2016 AmeriHealth ceased operations as an MCO in Iowa Medicaid and over 85,000 members were moved to UHC beginning December 2016. Transitions for the period January 2017 - January 2019 are not shown, as members only moved between UHC and AmeriGroup with less than 1,000 members moving between the two in either IWP or FMAP.

Table 5. Number and proportion of transitions between MCOs, December – November 2016

			MCO they went to			
	MCO they came from		**AmeriGroup**	**AmeriHealth**	**UHC**	**Total**
IWP						
	AmeriGroup	Count	-	479	305	784
		%	0%	61%	39%	27%
	AmeriHealth	Count	566	-	313	879
		%	64%	0%	36%	30%
	UHC	Count	612	675	-	1,287
		%	48%	52%	0%	44%
	Total	Count	1,178	1,154	618	2,950
		%	40%	39%	21%	100%
FMAP						
	AmeriGroup	Count	-	459	288	747
		%	0%	61%	39%	29%
	AmeriHealth	Count	494	-	276	770
		%	64%	0%	36%	30%
	UHC	Count	503	549	-	1,052
		%	48%	52%	0%	41%
	Total	Count	997	1,008	564	2,569
		%	39%	39%	22%	100%

Figure 9. Proportion of transitions between MCOs, December – November 2016



Access to care

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

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 6 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 through CY 2016 and began to fall over CY 2017 and CY 2018. 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. By CY 2018 the rate for IWP members in this age group had fallen to near CY 2015 levels. 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 fell from 90% to 87% during that same time. (See Figure 10 and Figure 11).

Table 6. Adults' access to preventive/ambulatory health services, CY 2013 – CY 2018

Age Yrs		FMAP 2013	IC -> IWP 2013	FMAP 2014	IWP 2014	FMAP 2015	IWP 2015	FMAP 2016	IWP 2016	FMAP 2017	IWP 2017	FMAP 2018	IWP 2018
20 - 44	#	14,706	8,876	16,556	16,633	17,065	27,629	14,624	27,339	14,961	32,926	18,403	41,819
	%	86%	52%	87%	74%	87%	76%	90%	86%	89%	84%	88%	80%
45 - 64	#	1,494	9,016	2,049	14,428	2,386	20,287	2,309	23,832	2,323	25,238	2,945	28,451
	%	85%	66%	86%	83%	88%	84%	90%	90%	89%	90%	89%	87%
Total	#	16,200	17,892	18,606	31,061	19,451	47,916	16,933	51,271	17,329	58,474	21,348	70,270
	%	86%	59%	87%	78%	87%	79%	90%	88%	89%	86%	88%	83%

Figure 10. Access to preventive/ambulatory health services for adults 20-44 years of age, CY 2013 - CY 2018

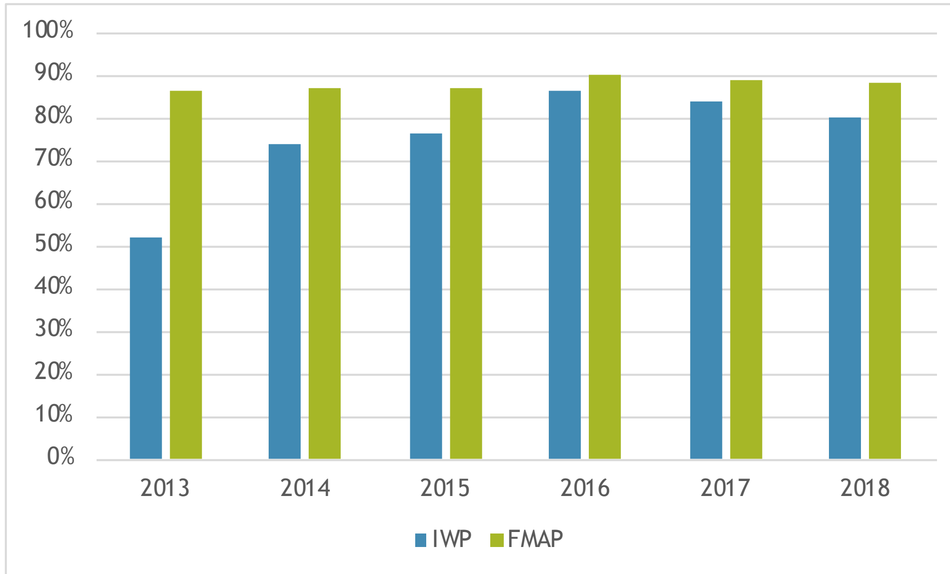
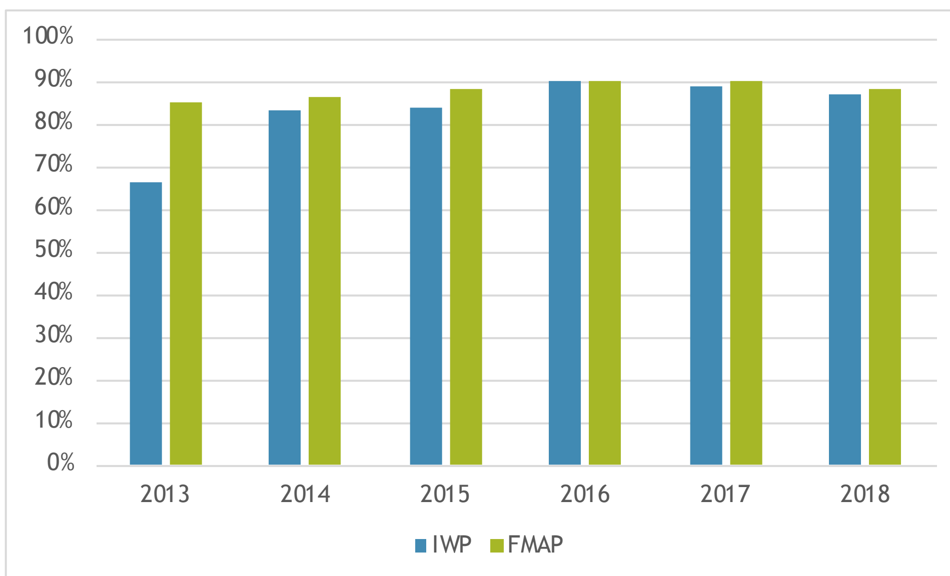


Figure 11. Access to preventive/ambulatory health services for adults 45-64 years of age, CY 2013 - CY 2018



Breast Cancer Screening

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 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 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.

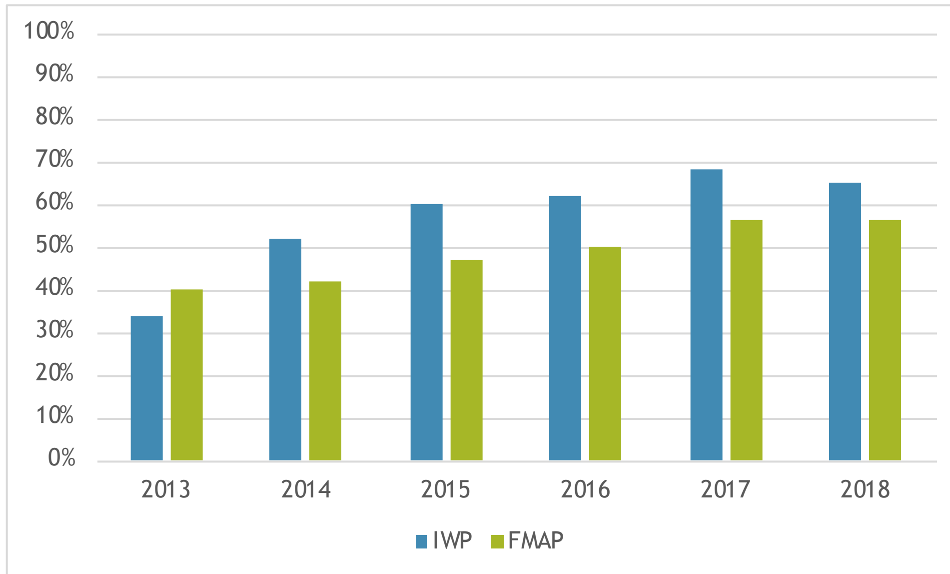
Results

Table 7 and Figure 12 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 7. Percent of women ages 50-64 who had a mammogram, CY 2013 - CY 2018

Age		FMAP 2013	IC -> IWP 2013	FMAP 2014	IWP 2014	FMAP 2015	IWP 2015	FMAP 2016	IWP 2016	FMAP 2017	IWP 2017	FMAP 2018	IWP 2018
50 -64 years	#	122	1,125	144	1,827	149	1,855	246	4,430	332	6,116	409	6,733
	%	40%	34%	42%	52%	47%	60%	50%	62%	56%	68%	56%	65%

Figure 12. Percent of women ages 50-64 with a mammogram, CY 2013 – CY 2018



Cervical Cancer Screening

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.

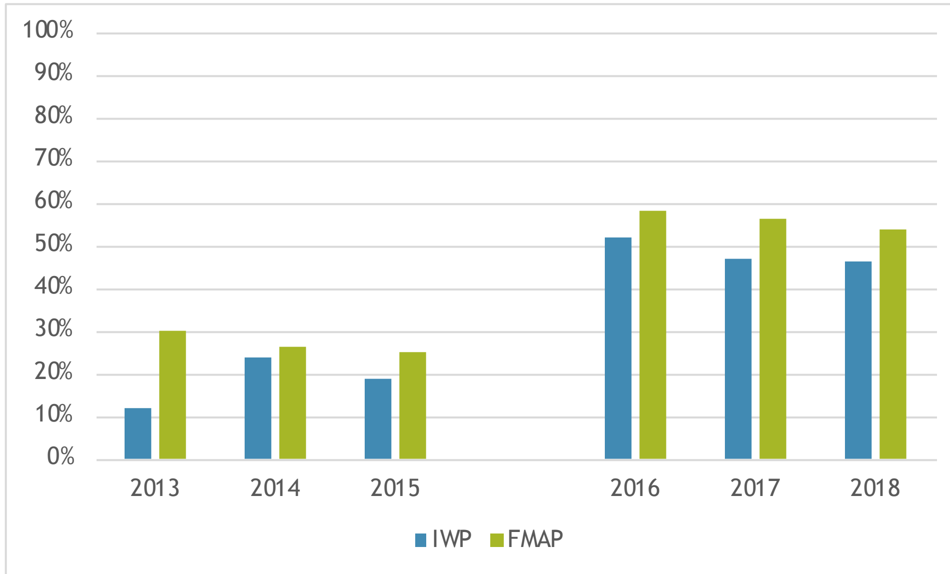
Results

Table 8 and Figure 13 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, which may be explained through better algorithms to detect cervical cancer screening within the administrative data. Additionally, over the period CY 2016 through CY 2018 cervical cancer screening rates fell for both groups.

Table 8. Percent of women ages 21-64 who had cervical cancer screening, CY 2013 - CY 2018

Age		FMAP 2013	IWP 2013	FMAP 2014	IWP 2014	FMAP 2015	IWP 2015	FMAP 2016	IWP 2016	FMAP 2017	IWP 2017	FMAP 2018	IWP 2018
21 - 64 years	#	4,385	1,866	4,204	4,861	4,263	5,822	6,424	11,094	6,728	12,647	8,144	15,173
	%	30%	12%	26%	24%	25%	19%	58%	52%	56%	47%	54%	46%

Figure 13. Percent of women ages 21-64 with cervical cancer screening, CY 2013 – CY 2018



Comprehensive Diabetes Care: Hemoglobin A1c

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, beginning 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 are older and more likely to have a chronic condition (Table 9, Figure 14). 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 9, Figure 15). 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 9. Proportion of population age 19-64 identified as having diabetes, CY 2013 - CY 2018

	FMAP 2013	IC-> IWP 2013	FMAP 2014	IWP 2014	FMAP 2015	IWP 2015	FMAP 2016	IWP 2016	FMAP 2017	IWP 2017	FMAP 2018	IWP 2018
Proportion with diabetes	4%	9%	5%	10%	5%	10%	8%	12%	8%	12%	7%	10%
Hemoglobin A1c rate	86%	90%	84%	89%	83%	90%	75%	84%	75%	82%	76%	84%
Eye Exam									61%	55%	57%	54%
Attention for Nephropathy									79%	81%	75%	78%

Figure 14. Proportion of members diagnosed with diabetes, CY 2013 – CY 2018

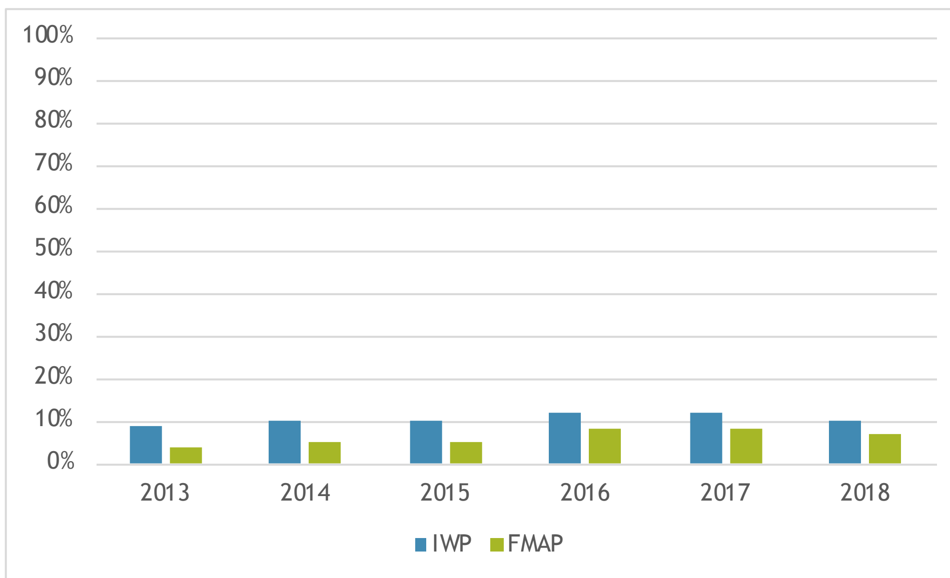
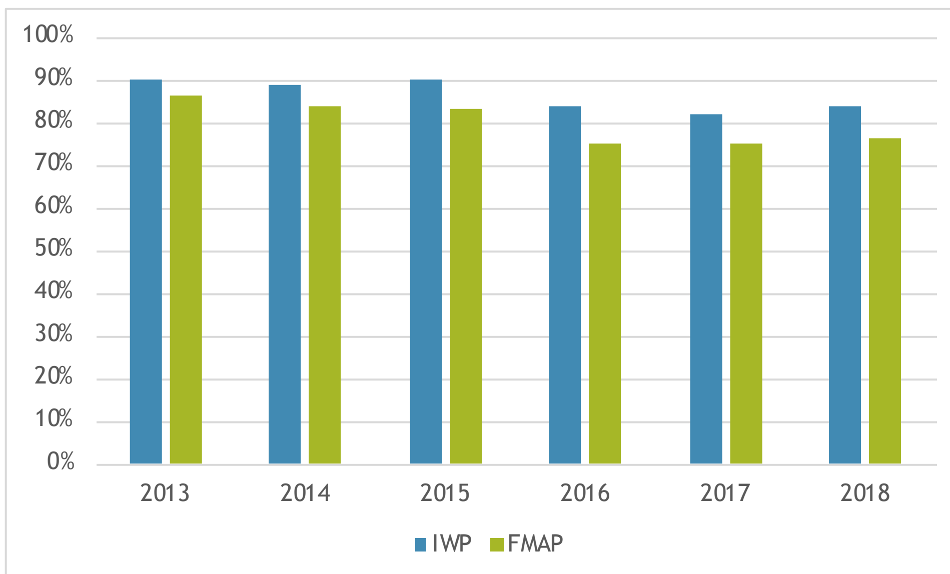


Figure 15. Proportion of population age 19-64 identified as having diabetes, and receiving a hemoglobin A1c test, CY 2013 – CY 2018



LDL-C Screening for People with Diabetes and Schizophrenia

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 modified from HEDIS 2018.

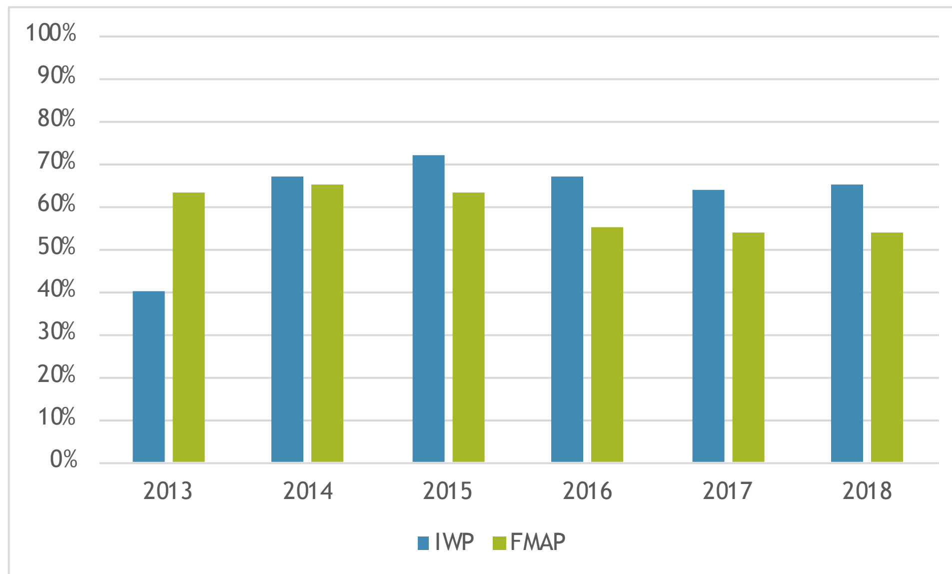
Results

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 over the years (Figure 16). Rates of LDL-C screening in IWP members with diabetes were higher than the rates for FMAP members with diabetes for all five years.

Table 10. Proportion of population age 19-64 identified as having diabetes with LDL-C screening, CY 2013 - CY 2018

	FMAP 2013	IC-> IWP 2013	FMAP 2014	IWP 2014	FMAP 2015	IWP 2015	FMAP 2016	IWP 2016	FMAP 2017	IWP 2017	FMAP 2018	FMAP 2018
Proportion with diabetes	4%	9%	5%	10%	5%	10%	7%	11%	8%	12%	7%	10%
LDL-C rate	63%	40%	65%	67%	63%	72%	55%	67%	54%	64%	54%	65%

Figure 16. Proportion of population age 19-64 identified as having diabetes with LDL-C screening, CY 2013 - CY 2018



Annual Monitoring for Members on Persistent Medication

Definition

This measure modified 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 IWP members who were in IowaCare in CY 2013, as the program did not provide prescription drug coverage.

Results

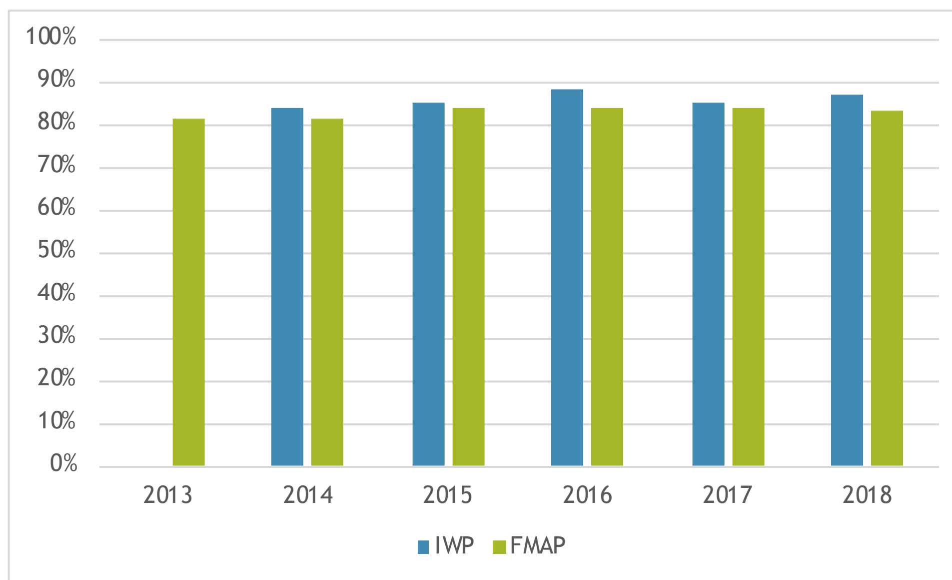
Table 11 and Figure 17 illustrate the proportion of members who were eligible for at least 11 months during the mea-

surement 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 five years.

Table 11. Proportion of population on diuretic medications screened for potassium and creatinine, CY 2013-CY 2018

	FMAP 2013	IC-> IWP 2013	FMAP 2014	IWP 2014	FMAP 2015	IWP 2015	FMAP 2016	IWP 2016	FMAP 2017	IWP 2017	FMAP 2018	IWP 2018
Proportion on diuretic	2%	N/A	2%	5%	2%	5%	4%	8%	2%	3%	1%	7%
Monitoring rate	81%	N/A	81%	84%	84%	85%	84%	88%	84%	85%	83%	87%

Figure 17. Proportion of population on diuretic medications monitored for changes in potassium and creatinine, CY 2013 – CY 2018



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 IHAWP, the numbers of non-emergent ED visits were consistently below those for FMAP members from CY 2014 – CY 2018 (Table 12).

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

Table 12. Number of non-emergent visits per 1,000 member months, CY 2013 - CY 2018

	FMAP 2013	IC-> IWP 2013	FMAP 2014	IWP 2014	FMAP 2015	IWP 2015	FMAP 2016	IWP 2016	FMAP 2017	IWP 2017	FMAP 2018	IWP 2018
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	22.5	16.4

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. An ED visit within the 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.

Results

The rates of ED visits and follow-up ED visits for IWP members are lower than for FMAP members for all five years, CY 2014-CY 2018 (Table 13). Though the proportion of members with an Index ED visits fell over time, the proportion of members that experienced at least one Index visit with a second visit within 30 days remained constant, indicating that ED follow-up care may not be improving. As CMS continues to encourage providers to utilize coding for transitional care from inpatient and ED services, these proportions may decrease.

Table 13. Proportion of members age 20-64 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 2018

	FMAP 2013	IC-> IWP 2013	FMAP 2014	IWP 2014	FMAP 2015	IWP 2015	FMAP 2016	IWP 2016	FMAP 2017	IWP 2017	FMAP 2018	IWP 2018
Proportion with index ED visit	68%	42%	67%	66%	71%	69%	49%	37%	44%	35%	43%	33%
Proportion with ED readmission	29%	19%	30%	24%	28%	23%	29%	27%	28%	26%	27%	25%

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 five years however, the rates for IWP members increased from CY 2014 – CY 2016 before dropping in CY 2017 and CY 2018 (Table 14). The ED rates/1,000 member months for FMAP members and IWP members began to converge in CY 2016 (Figure 18) and follow a similar pattern of decrease since then. 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 2018, while the rate of ambulatory care visits decreased for FMAP members (Figure 19). By CY 2016 and the rate of ambulatory care visits for IWP members is close to the rate for FMAP members (only 30 visit per 1,000 members months apart) and this difference persists through CY 2018.

Table 14. Number of ED visits and number of ambulatory care visits per 1,000 member months for members 20-64 years of age, CY 2013 - CY 2018

	FMAP 2013	IC-> IWP 2013	FMAP 2014	IWP 2014	FMAP 2015	IWP 2015	FMAP 2016	IWP 2016	FMAP 2017	IWP 2017	FMAP 2018	IWP 2018
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	88.6	66.7
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	368.6	334.1

Figure 18. ED visits per 1,000 member months, CY 2013 - CY 2018

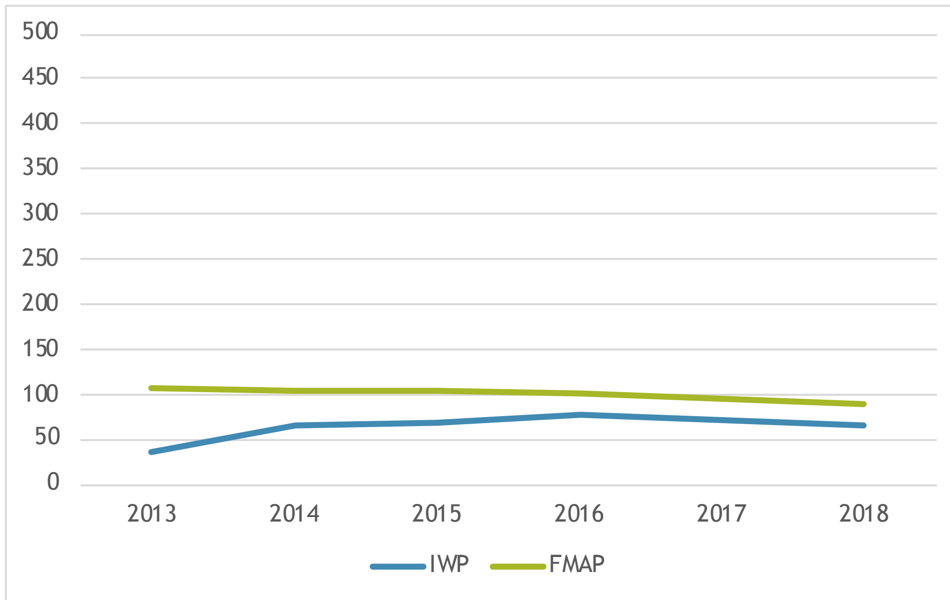
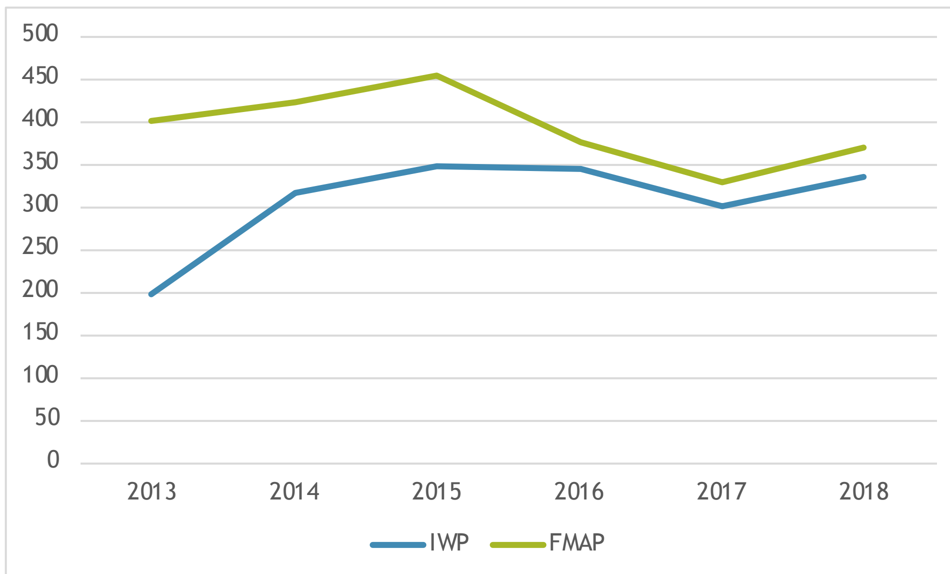


Figure 19. Ambulatory care visits per 1,000 member months, CY 2013 - CY 2017



Quality of care

Admission Rate for Chronic Obstructive Pulmonary Disease (COPD)/Asthma

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 through CY 2018, 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 all three years with the rate of admission being four times higher for IWP than for FMAP members in CY 2018. This may be expected due to the increased age of IWP members and the higher likelihood of chronic conditions in this group.

Table 15. COPD/asthma admission rate for members 19-64 years of age, CY 2016 – CY 2018

	FMAP 2016	IWP 2016	FMAP 2017	IWP 2017	FMAP 2018	IWP 2018
Members	26,411	100,377	25669	102715	31,703	122,240
Number of admissions	16	178	10	160	8	134
Admission rate/100,000	61	177	39	156	25	109

Admission Rate for Congestive Heart Failure (CHF)

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 all three years, over twice as high in CY 2018. As with the COPD/asthma admission rates, 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 16. CHF admission rate for members 19-64 years of age, CY 2016 – CY 2018

	FMAP 2016	IWP 2016	FMAP 2017	IWP 2017	FMAP 2018	IWP 2018
Members	26,411	100,377	25669	102715	31,703	122,240
Number of admissions	23	163	19	180	19	172
Admission rate/100,000	87	162	74	175	59	140

Well Adult Visit

Definition

The well adult visit measure calculates the percent of members eligible for at least 11 months in the measurement year with a well adult visit as defined by one of the following:

- Preventive exam CPT code (99385-99387, 99395-99397, 99401-99404, 99411, 99412, 99420, 99429) for the period CY 2013 through CY 2018
- Visit code (99201-99215) AND a preventive visit diagnosis code (V70.0, V70.3, V70.5, V70.6, V70.8, V70.9) for the period CY 2013 through 3rd quarter 2015
- Visit code (99201-99215) AND a preventive visit diagnosis code (Z00.00, Z00.01, Z00.121, Z00.129, Z00.5, Z00.8, Z02.0, Z02.1, Z02.2, Z02.3, Z02.4, Z02.5, Z02.6, Z02.71, Z02.79, Z02.81, Z02.82, Z02.83, Z02.89, Z02.9) for the period 4th quarter 2015 through CY 2018

A "well visit" within IWP may include a dental visit; however, we have limited the definition for the current measure to medical visits.

Results

Rates of well adult care are higher for IWP members than FMAP members across both age groups; however, the rates in both groups are low. These results indicate that the IWP members are more likely than FMAP members to receive preventive care, though only about 25% access these services in any given year (Table 17, Figure 20 and Figure 21).

Table 17. Adult well visit rates by program and age, CY 2013 - CY 2018

Age		FMAP 2013	IC-> IWP 2013	FMAP 2014	IWP 2014	FMAP 2015	IWP 2015	FMAP 2016	IWP 2016	FMAP 2017	IWP 2017	FMAP 2018	IWP 2018
20-44 years	# %	3,754 22%	1,695 10%	4,110 22%	6,164 28%	4,340 22%	8,587 23%	7,816 24%	17,021 25%	6,825 21%	16,155 23%	6,255 23%	17,989 23%
45-64 years	# %	249 14%	960 7%	413 17%	6,576 38%	515 19%	7,400 30%	1,046 22%	11,774 29%	1,062 22%	11,597 28%	1,044 25%	12,838 29%
Total	# %	**4,003** **21%**	**2,655** **9%**	**4,523** **21%**	**13,740** **31%**	**4,855** **22%**	**15,987** **26%**	**8,862** **23%**	**28,795** **26%**	**7,887** **21%**	**27,752** **25%**	**7,299** **23%**	**30,827** **25%**

Figure 20. Access to preventive/ambulatory health services for adults 20-44 years of age, CY 2013 - CY 2018

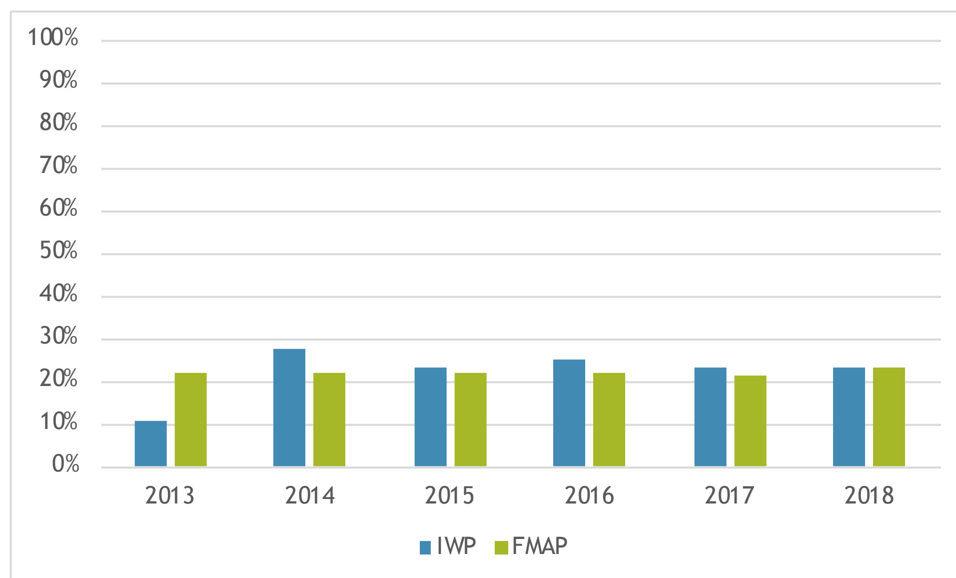
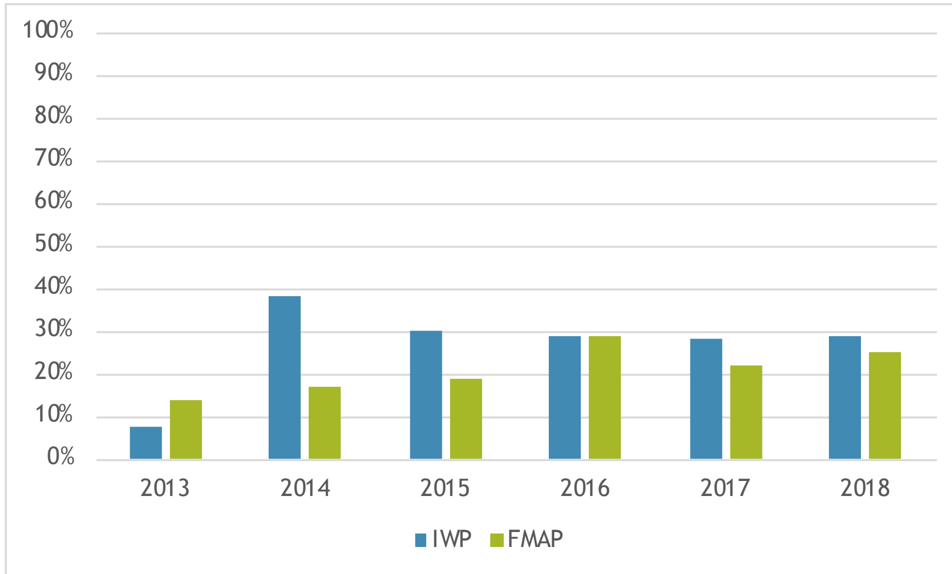


Figure 21. Access to preventive/ambulatory health services for adults 45-64 years of age, CY 2013 – CY 2018



Whether Member had Well Adult Visit

The analyses regarding whether a member had a well adult visit and the factors related to a well adult visit are covered in Healthy Behaviors Incentive program reports at http://ppc.uiowa.edu/health/study/healthy-behaviors-incentive-program.

APPENDIX A: EVALUATION CHANGES

Study Groups

In the original evaluation proposal Medicaid members who were eligible due to a disability determination were considered a comparison group. This group was chosen because IowaCare members, many of whom were to transition into IHAWP, were more likely to have chronic illness than members in Medicaid who were eligible primarily due to income. The disability determination group has been removed from the evaluation comparison groups because IHAWP eligible individuals have the option of requesting the designation “medically exempt” which allows them to remain in the IHAWP program but receive the same services and waiver options as members eligible through disability determination. Member deemed medically exempt will be analyzed separately for the 2018 report. We will utilize Medicaid members eligible due to a disability determination as the comparison group for those analyses.

Statistical Methods

Though we proposed means testing when comparing population-based rates and proportions in the evaluation proposal, we have chosen to present the numbers from the study populations without any adjustment or statistical testing. The numbers, rates and proportions presented in this report are based on the study populations which are very close, in demographic characteristics, to the actual IHAWP population, IowaCare and Family Medical Assistance Program membership. We have excluded members who have the preponderance of their eligibility in the Medicaid in programs with reduced coverage (i.e., Family Planning Waiver) or Medicare, which precludes us from accessing the majority of their health care utilization and cost experience through the Medicaid claims. Additionally, these numbers are compared over a three-year period, so though unadjusted means do not provide for an adequate cross-sectional comparison, we are more confident in the comparison of changes in trends over time.

Though we have begun the job of modelling outcomes to determine the factors related to members’ accessing services such as well adult care, we are still developing the approach that is best suited to the Iowa experience and data. The appropriate risk adjustment strategies and methods for incorporating monumental policy changes in the Medicaid program during the IHAWP demonstration period are two significant challenges. Risk adjustment strategies for a non-elderly, primarily healthy population are difficult to apply and interpret. We have formed a methods roundtable to address this issue for the final report.

Measures

A number of the measures originally proposed have been removed either due to the inability to meet the protocol requirements with the existing data or due to small numbers of members in the denominator or numerator leading to unacceptable variation in rates over time. These measures are listed below.

- Measure 1: Follow-up after hospitalization for mental illness (Measures 2A and 2B)

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. This result may be due to most members with mental illness severe enough to warrant hospitalization being moved into the medically exempt 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.

- 9B: Whether a women 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 11: Flu shots in past year (Measures 11A and 11B)

Measures 11A and 11B have been removed from the evaluation as data for these measures 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 2: Chlamydia screening in past year

This measure was removed due to the difficulty of reliably determining whether members were sexually active.

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

Both measure 17A and 17B have been removed from the evaluation due to most members with mental illness being moved into the medically exempt 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 35: Cholesterol management for patients with cardiovascular conditions (Measures 35A and 35B)

Measures 35A and 35B have been removed from the evaluation due to extremely low numbers of members who have cardiovascular conditions severe enough to be included in the measures.

- Measure 3: Admission rate for COPD, diabetes short-term complications, CHF, and asthma

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

- Measure 4: Admission rate for diabetes short-term complications (Measures 40A and 40B)

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

- Measure 5: Pharmacotherapy management of COPD exacerbation (Measures 34A and 34B)

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

- Measure 6: Mental health utilization (Measures 18A and 18B)

Removed due to the reduced numbers of members in this group as a result of the Integrated Health Home program.

- Measure 7: EPSDT utilization (Measures 24A and 24B)

Removed due to the small number of members eligible for IWP with EPSDT benefits and not in a transformational program.

- Measure 8: Avoidance of antibiotic treatment in adults with acute bronchitis

Removed due to difficulty with measure definition.

- Measure 9: Use of appropriate medications for people with asthma

Removed due to removal from HEDIS measures.

- Measure 10: Medication management for people with asthma

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

- Measure 11: Inpatient utilization-general hospital/acute care

Removed due time constraints.

- Measure 12: Plan "all cause" hospital readmissions

Removed as current HEDIS measures do not allow for risk adjustment.

Timeline

The original timeline for the evaluation had the provision of a survey report and provider network analysis as part of this evaluation report. Due to transition to managed care for all Medicaid members, including those in the expansion, into a managed care organization by January 1, 2016, there was a 12-month period of transition and uncertainty for members from October 2015 to September 2016. During this time, some IHAWP members were transitioned from the QHP to fee-for-service to an MCO. Surveying members during this transition is not a priority so the surveys were moved to the spring of 2017 in consultation with the Iowa Department of Human Services (IDHS) and Centers for Medicare & Medicaid Services (CMS). In addition, provider network analyses are not particularly useful during a time of transition due to the difficulty of determining which providers are active. We are in the process of acquiring and cleaning the MCO provider lists. If we are able to obtain accurate and verifiable provider lists, we will be able to complete the provider network analyses in the future.