# Iowa Health and Wellness Plan Selected Results

Suzanne Bentler
Elizabeth Momany
Peter Damiano
Dan Shane
Natoshia Askelson
Brad Wright

# IHAWP Evolution

| | |
|---|---|
| January 2014 | First IHAWP members enrolled |
| May 2014 | IHAWP members enrolled in Dental Wellness Plan with Delta Dental of Iowa |
| July 2014 | IHAWP members enrolled in the Healthy Behaviors Incentive Program |
| November 2014 | IHAWP members in CoOpportunity were moved to MediPASS (PCCM program), Meridian (HMO), or Coventry (QHP) |
| November 2015 | IHAWP members in Coventry were moved to MediPASS or Fee-for-service (MPC component dormant) |
| April 2016 | IHAWP members were moved to one of three MCOs- United Health Care, AmeriGroup or AmeriHealth Caritas |

# IHAWP evaluation

- Waiver of Non-emergency medical transportation (NEMT)
- Healthy Behaviors Incentive Program (HBI)
- Utilization outcomes

# Non-Emergency Medical Transportation

| | |
|---|---|
| January 2014 | Waiver of NEMT services for IHAWP members |
| October 2014 | IowaCare to IHAWP Transition Report released |
| January 2015 – July 2015 | NEMT waiver extended pending review of additional survey data (to field in fall/winter 2014-15) |
| April 2015 | IHAWP v MSP Member Experiences Report released; Result -- additional survey requested with bigger sample (to field in fall/early winter 2015-16) |
| August 2015 –March 2016 | Waiver extended |
| March 2016 | NEMT Report released |
| April 2016 – June 2016 | Waiver extended |
| June 2016 – December 2016 | Waiver extended & under review |

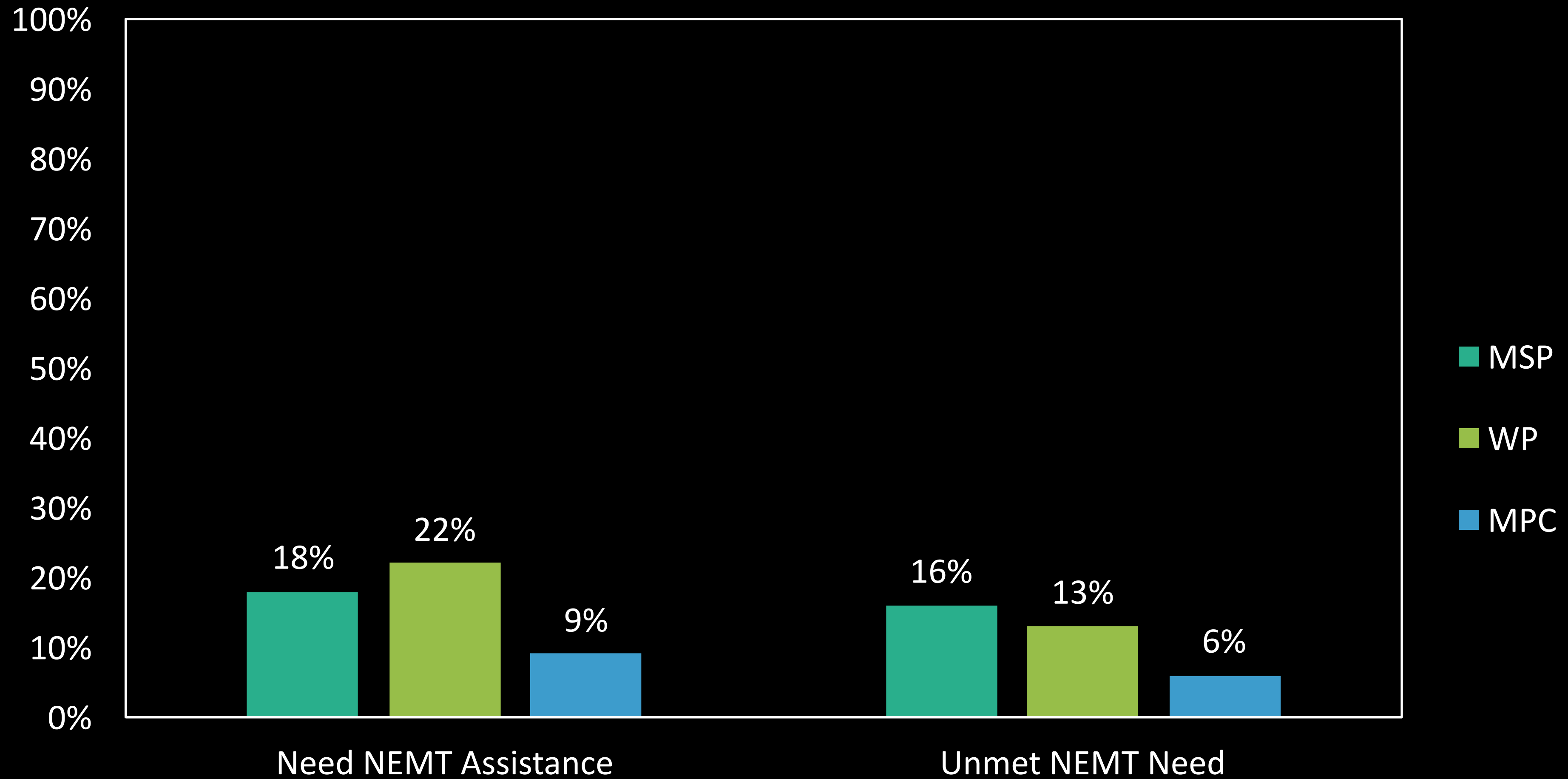
# Research Questions

1. Is there a difference in reported unmet NEMT need between IHAWP and MSP members?
2. Does plan type (IHAWP or MSP) and/or unmet NEMT need relate to obtaining particular health care services?

# Methods

- Transportation specific survey sent to 30,540 members (10,180 from each IHAWP-WP, IHAWP-MPC, MSP)
- In Field October 28, 2015 – January 15, 2016
- Overall adjusted response rate 30%
- Survey data combined with claims experience of care during the same 6 month look-back timeframe
- From claims – Well care visit (y/n), Acute care visit (y/n), ED visit (y/n)
- Descriptive statistics & logistic regression models

# Need and Unmet Need for NEMT




Statistically significant differences between MSP & WP (p<.01) and MSP & MPC (p<.01) for each of these factors

# Association with Health Care Visits

- Model 1. Well visits (WVs)
  - For those with an unmet NEMT need, those in WP had a 40% lower odds of a WV compared to MSP
- Model 2: Acute care visits (ACVs)
  - Unmet NEMT need not associated with ACVs
  - WP had 18% lower odds compared to MSP
- Model 3: Emergency department visits (EDVs)
  - Unmet NEMT need 55% greater odds of EDV
  - WP had 28% lower odds of EDV compared to MSP

All models adjusted for enrollment months, age, gender, race/ethnicity, education level, urban/rural residence, physical and mental health status, and distance to providers (PCP & ED)

# Conclusions

- More unmet NEMT need reported by those who have the benefit
  - *Why are those who have the benefit still experiencing unmet NEMT need?*
  - *Is ~15% unmet NEMT need acceptable?*
  - *Who is experiencing the need for NEMT services?*
- Some evidence to suggest that having an unmet NEMT need can affect health care utilization in potentially undesirable ways (i.e., ↓ well care visits, ↑ ED visits)
  - *More research needed to really tease this out*

# Healthy Behaviors Incentive Program

Main Characteristics of the Program

- Members complete a yearly wellness exam (WV) and Health Risk Assessment (HRA) to avoid paying a premium in the following year
- Provider receives additional payment to encourage HRA completion
- Member incentivized to engage in other healthy behaviors

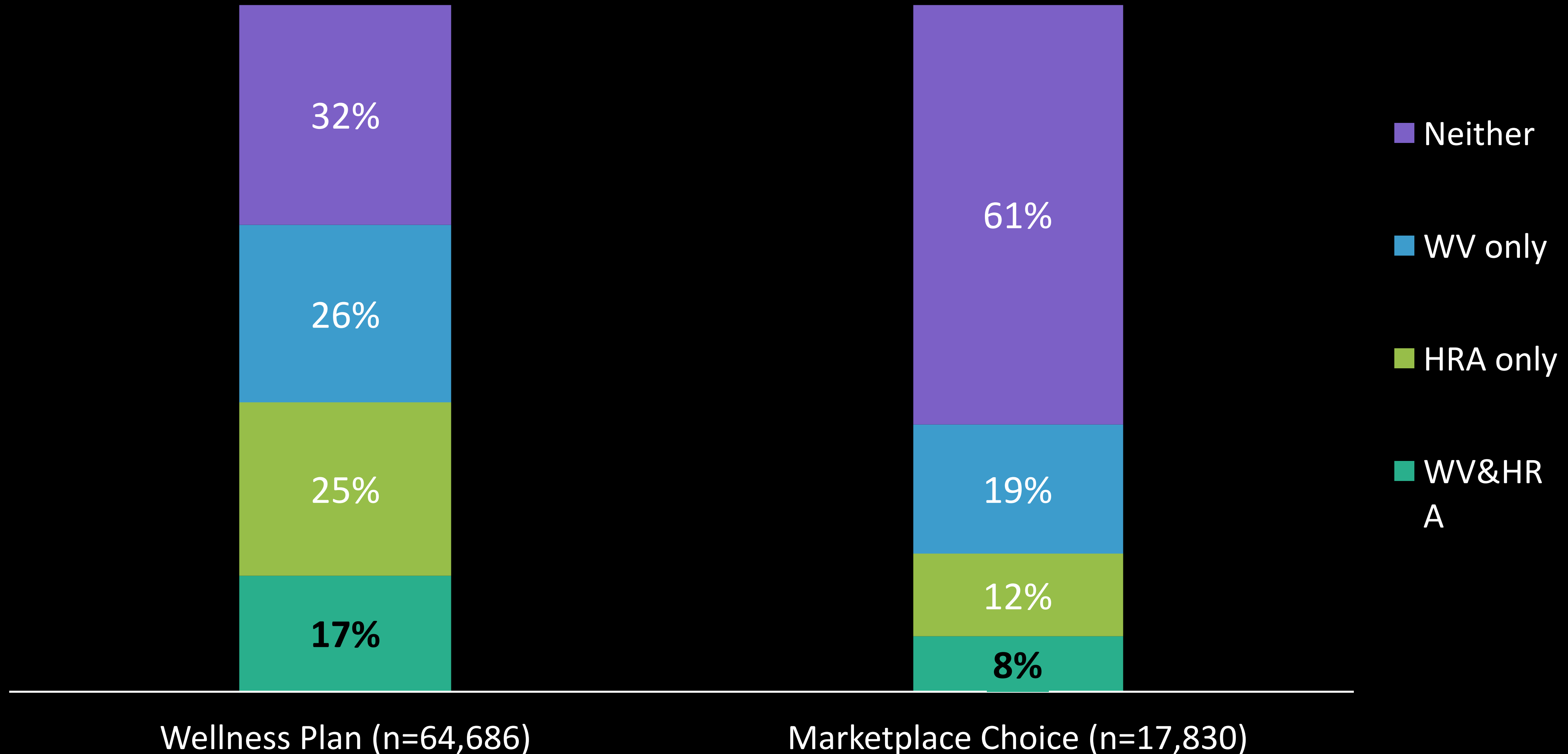
# Research Questions

1. How many completed the HBI requirements (well visit and HRA)?
2. Was the HBI program implemented as designed?
3. How well did members and providers understand the HBI program?
4. What were the barriers to member participation (completion of HBs)?

# Methods

- Q1: Interviews with HBI staff and document review
- Q2: Analysis of first year (2014) of enrollment and claims data
- Q3 & Q4: In-depth telephone interviews with clinic managers (n = 52) and enrollees (n = 152)

# HBI Completion



# Planned vs Actual Implementation

| Planned | Actual |
|---|---|
| Extensive communication effort to inform providers, clinics, & members | Letters to providers and members; Website with information for members and provider resources such as a toolkit and HRA Training Webinar |
| Evidence of Wellness Visit defined using specific CPT codes | Definition Expanded – Allowed self-reported visits and preventive dental exams to count |
| Evidence of HRA included completion by member online or with a health care provider | Definition Expanded – Allowed self-report of completion, regardless of evidence |
| Members who did not complete a wellness visit and HRA and who did not pay premiums would be disenrolled after Year 1 | Delayed Implementation – Disenrollment did not begin until the last quarter of Year 2 |
| Additional healthy behaviors would be encouraged through incentives | Not Implemented -- A vendor to carry this out was not identified |

# Why was the completion rate so low?

- *Low awareness/knowledge of the program* – members and clinic managers
- *Little or incorrect information about program* - members and clinic managers
- *Limited promotion of the program* – some clinics have some promotion efforts, many have none; few members received communication
- *Barriers to completion of HRA* – no or inadequate technology, poor communication about how to access it, issues with how to complete it, no interest, …
- *Barriers to completion of wellness visit* - appointment availability, scheduling challenges, providers not accepting insurance, transportation,…

# Utilization Outcomes

- Access to ambulatory care
- Hemoglobin A1c
- Well visits

# Outcomes – Access to ambulatory care

Adults' access to preventive/ambulatory health services by program and age for IHAWP members eligible >=11 months in CY 2014 and >=11 months in CY 2013
CY 2013 and CY 2014

| Age | | FMAP 2013 | FMAP 2014 | IowaCare 2013 | WP 2014 | IowaCare 2013 | MPC 2014 |
|---|---|---|---|---|---|---|---|
| **20-44 years** | % | 87% | 89% | 63% | 83% | 70% | 80% |
| | Members | 17,453 | 17,353 | 8,790 | 9,006 | 2,443 | 1,994 |
| **45-64 years** | % | 86% | 87% | 70% | 89% | 77% | 86% |
| | Members | 2,063 | 2,059 | 9,430 | 9,447 | 2,055 | 1,947 |
| **Total** | % | 87% | 89% | 66% | 86% | 73% | 83% |
| | Members | 19,516 | 19,412 | 18,220 | 18,453 | 4,498 | 3,941 |

# Outcomes – Hemoglobin A1c

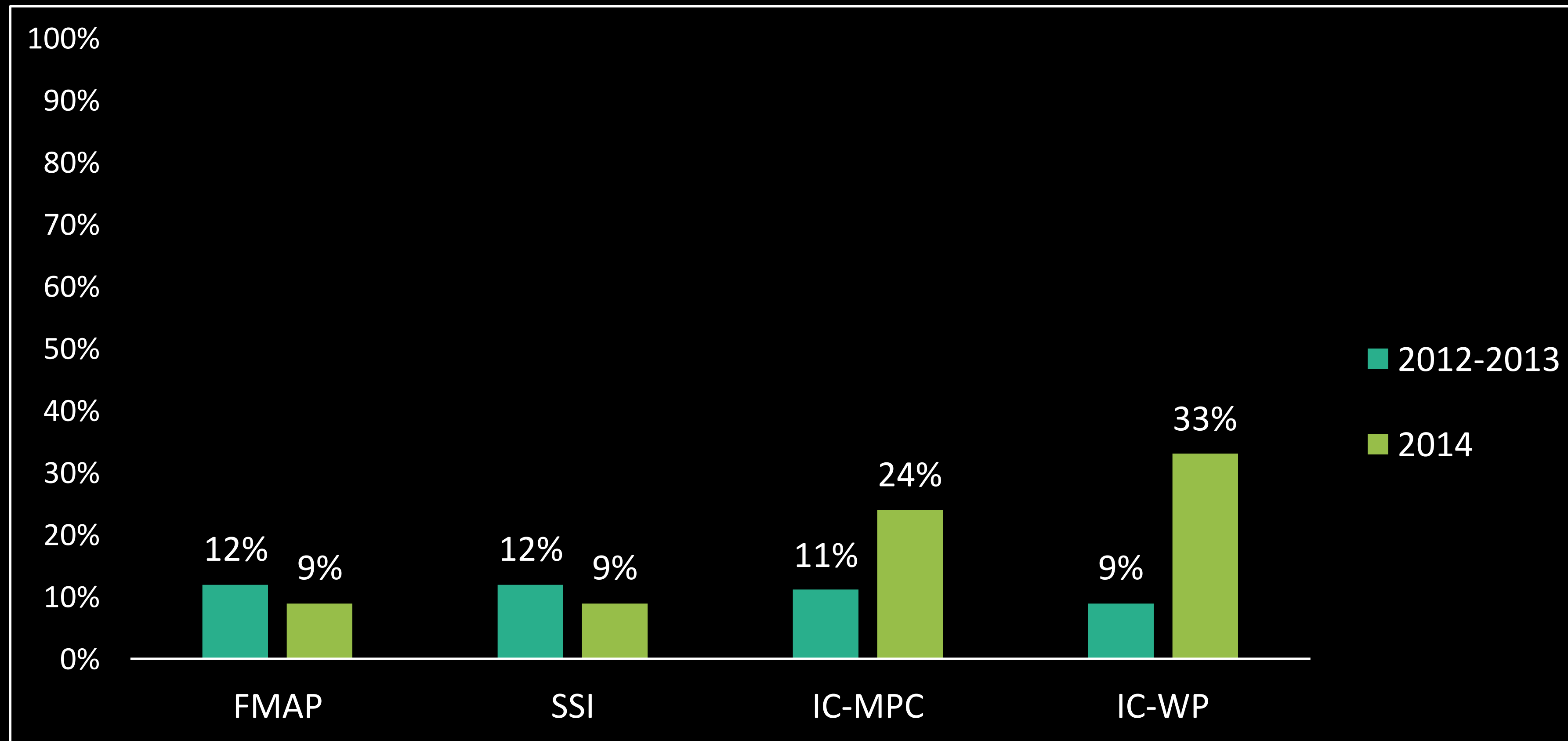
Proportion of population age 19-64 identified as having diabetes with a Hemoglobin A1c
CY 2013 and CY 2014

| **Age** | | **FMAP 2013** | **IowaCare 2013** | **FMAP 2014** | **WP 2014** | **MPC 2014** |
|---|---|---|---|---|---|---|
| **Members with diabetes** | Number | 1,661 | 4,851 | 2,055 | 4,472 | 1,108 |
| | Proportion | 5% | 9% | 6% | 10% | 8% |
| **Hemoglobin A1c rate** | | 74% | 82% | 75% | 87% | 79% |

# Well Visits Analysis: Data/Methods

- Focus on pre/post likelihood of well visit for group on limited pre-ACA coverage plan (IowaCare) that transitioned to IHAWP
- Straightforward diff-in-diff model using traditional Medicaid members as control group (subset that more closely matches IowaCare pop) and comparing 2012-2013 well visits with 2014 visits
- Additional perspective -- split IHAWP by plan: Wellness Plan & Marketplace Choice
- Results: +26pp overall; WP: +28pp, MC: +16pp
- Included numerous model sensitivity checks; robust results

# Outcomes – Wellness visit



# Going forward……or backward

- The private-option Medicaid expansion became a public expansion
- Instability of the covering entity introduces noise into the evaluation
- State Innovation Model activities complicate the evaluation of IHAWP
- Data sources are changing