Ohio Medicaid Group VIII Assessment

Methodology:
A Report to the Ohio General Assembly

The Ohio Department of Medicaid
John R. Kasich, Governor  Barbara R. Sears, Director
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I. Introduction

The Ohio Medicaid Group VIII Assessment (Group VIII Assessment) project examined how Medicaid expansion in Ohio has affected new enrollees with respect to access and utilization of health care, physical and mental health status, financial distress/hardship, and employment.

The phrase “Group VIII” refers to the section of the Social Security Act that sets requirements for Medicaid expansion eligibility and allowed most Ohioans aged 19 through 64 with incomes at or below 138% of the federal poverty level (FPL) to become eligible for Medicaid. Prior to January 1, 2014, Medicaid eligibility for adults was limited to those with certain qualifying characteristics such as parenthood or disability, and the income limitation for most Medicaid eligibility groups was lower than 90% of the FPL.

The Ohio Medicaid Group VIII Assessment Methodology Report describes the data collection activities that were used to generate information for the Ohio Medicaid Group VIII Assessment’s Statutory Report. Data collection was preceded by interviews with the Ohio Department of Medicaid (ODM), a literature review, and discussions within the research team concerning how best to conceptualize measuring the Ohio Medicaid expansion benefit. Once the conceptualization was set, background analyses using Ohio Medicaid administrative data and the Ohio Medicaid Assessment Survey were performed to refine topic selection. For question selection for the telephone survey, the research team primarily used pretested and reviewed questions, response options, and measures. Data collection started with the Group VIII Survey fielding in the spring 2016, and ended with stakeholder interviews in October 2016.

When appropriate, Group VIII enrollees were compared to those enrolled in Ohio Medicaid under pre-expansion eligibility rules (“pre-expansion enrollees”). The sample for the Ohio Medicaid Group VIII Assessment was obtained from ODM’s administrative records for the coverage periods of January 2013 through March 2016 for the pre-expansion eligible, and January 2014 through March 2016 for the Group VIII enrolled. To enable analytical comparison between Group VIII enrollees and the pre-expansion comparison group, the study excluded those enrolled as dual eligible, pregnant women, and those living in institutions or with less than 11 months continual enrollment. A comprehensive list of exclusions is described later in Section 2.1 of this document. Study participants were selected using stratified random sampling techniques. Greater detail relating to participant selection is contained in Section 2 of this Methodology Report.

The Ohio Medicaid Group VIII Assessment used the following six activities to collect data:

- A detailed telephone survey of 7,508 Group VIII and pre-expansion enrollees, including questions about access to care, health system utilization, physical and mental health, financial hardship, and employment (cooperation rate of 76.1%).

- A biometric screening of 886 respondents who completed the telephone survey, including both Group VIII and pre-expansion enrollees. The biometric screenings allowed for the systematic collection of comprehensive and verifiable health-related data (screening participation rate of 68%).

- A review of the medical records of 430 Group VIII enrollees who completed the telephone survey and biometric screening. Collected records spanned the time periods before and after Medicaid enrollment and enabled an assessment of how health care utilization, health status, and medical treatments changed after enrolling in Medicaid.
• An analysis of Medicaid administrative data for all Group VIII and pre-expansion enrollees eligible for the Group VIII Assessment. The review of administrative data was used to calculate measures of health care utilization, including preventive care and evidence-based care for chronic health conditions.

• Focus groups of 27 Group VIII enrollees who participated in the telephone survey at a minimum (some participants completed other components as well). Focus groups were designed to obtain more in-depth and personalized information about survey responses.

• Interviews with 10 Ohio Medicaid service providers and other key stakeholders. These interviews allowed for input from Medicaid stakeholders on the effects of Medicaid expansion.

The number of participants in each of the study phases was based on the evaluation goals for the study. Data from the Group VIII Survey were weighted to represent the total populations of Group VIII and pre-expansion enrollees who were eligible for the study. The biometric screening data were weighted to represent the population in the sample frame for the biometric screening. No other quantitative data were weighted. Medical records data were treated as a case study and the Medicaid administrative data were analyzed as a universe (see Section 7).

Data from the Group VIII Survey, the biometric screening, and the Medicaid administrative billing activities were linked into a single master file. Data from the medical records, from the responses of participant focus groups, and from interviews with health care providers and Medicaid stakeholders were set into independent data files.

Project analyses of all Group VIII Assessment data were performed by a research team with membership from the ODM, the Ohio Colleges of Medicine Government Resource Center (GRC), The Ohio State University (OSU) College of Public Health, Ohio University, and RTI International. Analyses included descriptive and modeled statistics, open-ended question coding, thematic coding for qualitative data, and Healthcare Effectiveness Data and Information Set (HEDIS) influenced analyses of Medicaid administrative data.

Project oversight was administered by the Ohio Group VIII Executive Committee with representation from the ODM, GRC, OSU, Ohio University, and RTI International. Additional study design assistance was provided by the State Health Access Data Assistance Center (SHADAC) and by the National Center for Health Statistics (NCHS).

Many statistics, charts, and tables not included in the Ohio Medicaid Group VIII Assessment's Statutory Report are included in the Ohio Medicaid Group VIII Assessment's Methodology Report, within the body of the Methodology Report as examples and in Appendices at the end of this Methodology Report.

For additional information concerning the Ohio Medicaid Group VIII Assessment Statutory Report or the Ohio Medicaid Group VIII Methods Report, contact the Ohio Department of Medicaid at Melissa.Ayers@medicaid.ohio.gov. For additional information from the web, see http://medicaid.ohio.gov.
II. Sampling Design

1. Target and Sampling Populations

Group VIII enrollees were the primary target population of interest. A Group VIII enrolled person was defined as a person enrolled under Affordable Care Act (ACA)-associated Medicaid Expansion and eligible for this study. Eligibility was determined by being in one of several Medicaid enrollment aid categories associated with Group VIII. Individuals became eligible for Group VIII under one of two major criteria:

1. monthly family income ≤ 138% of the federal poverty level (FPL) and no child in the family; or
2. family income > 90% to 138% of FPL and a Medicaid enrolled child in the family.

The comparison population comprised pre-expansion enrollees who were enrolled in Medicaid under pre-ACA rules for a period of at least 11 out of 12 months in 2015.

Excluded from the study population were:

- those previously, but not continuously, enrolled in Medicaid prior to ACA-associated Medicaid expansion;
- those on disability assistance;
- those in a family planning program;
- pre-expansion eligible pregnant women;
- those dual-enrolled in Medicaid and Medicare;
- those with third-party liability;
- nursing home participants;
- retroactive eligibility and backdated eligibility; and
- those enrolled via waiver programs.

Based on the March 2016 Medicaid Enrollment and Eligibility Database, there were 571,350 Group VIII enrollees and 929,449 pre-expansion enrollees in total. After applying the study’s exclusion criteria, the eligible Group VIII enrollee population consisted of 219,342 enrollees. The pre-expansion enrollee population consisted of 477,518 enrollees. The Group VIII Assessment had three quantitative data components, which built on one another:

- Telephone survey
- Biometric screening
- Medical records abstraction

1 Medicaid enrollment for recent months is not static because Medicaid, unlike private insurance, allows individuals to be retroactively enrolled for prior months if certain requirements are met. Therefore, Medicaid and Group VIII enrollment for the month of May, processed at the time the sample was drawn at the end of May (665,000), was significantly lower than enrollment for the month of May processed through November (702,000). For budgeting and other planning, the Ohio Department of Medicaid estimates unreported (future) retroactive and backdated enrollment for recent months based on historical patterns of retroactive and backdated enrollment. The Group VIII enrollment totals presented in this report include the ODM retroactive and backdated estimates to give a more complete representation of program participation and to be consistent with ODM’s Monthly Medicaid Caseload Report.
The telephone survey was administered to random samples of Group VIII and pre-expansion enrollees and was representative of the Ohio Medicaid population as defined by the study criteria. A random sample of telephone survey respondents were then asked to complete the biometric screening. Due to operational constraints and logistics, a subset of Ohio counties was purposefully selected for the biometric screening component, rather than including all 88 counties. Counties for the biometric subsample were selected based on their Medicaid enrollment, and to ensure that a reasonable number of counties within each targeted county type (metro, rural, and suburban) were included. Figures 1 and 2 show the Group VIII and pre-expansion enrollment in March 2016 by zip code, respectively, and highlight the 22 counties that were selected for the biometric screening component of the study. These 22 counties account for approximately 67% of the Group VIII population and 65% of the pre-expansion Medicaid population. The 22 counties are also listed in Table 1 by their county type. Biometric data were collected at 21 sites because respondents in Trumbull County were scheduled at the Mahoning County site.

Figure 1. Group VIII Enrollee Population Density by Zip Code with Biometric Screening Counties Highlighted
All Group VIII enrollees who completed the biometric screening were asked to participate in the medical records abstraction. Medical record abstraction was not conducted with any pre-expansion enrollees. The medical records abstraction component was limited to Group VIII enrollees because its intention was to compare utilization among people prior to having Medicaid coverage (2013) and post-enrollment into Medicaid (2015 and 2016). Pre-expansion enrollees, because they could have Medicaid during the full period of 2013–2016, should not have seen much difference in their utilization. Furthermore, Medicaid administrative data were
available during both periods for the assessment of any possible changes in utilization among pre-expansion enrollees. Group VIII enrollees did not have any Medicaid administrative data in 2013.

2. Sample Design

Telephone Survey

Sampling Frame

The sampling frame used to select eligible study members was the March 2016 Medicaid Eligibility and Enrollment File. The Enrollment File contained the following information about each Medicaid enrollee:

- First and Last Name
- Medicaid ID
- Phone number
- Street address
- City
- State
- Zip code
- County of residence
- Plan number
- Group VIII/Pre-expansion status
- Gender
- Age category (19–44, 45–64 years)

The Group VIII Assessment was also interested in gathering information about those that need/needed medical services the most (i.e., those with a chronic condition). Based on Medicaid administrative data, a person was deemed as having a chronic condition if that person had multiple billings for a single chronic condition or billings for a comorbidity due to multiple chronic conditions. The chronic condition criteria were based on the diagnosis code related to one or more of seven selected conditions. The seven chronic conditions were:

- Chronic obstructive pulmonary disease (COPD)
- Congestive heart failure (CHF)
- High cholesterol
- Diabetes
- Depression
- Substance abuse
- Hypertension

Persons enrolled in March 2016 who met the Group VIII Assessment eligibility criteria were included in the sampling frame. Table 2 presents the distribution of eligible enrollees for the Group VIII and pre-expansion populations by enrollee characteristic. In total, there were 219,342 Group VIII enrollees and 477,518 pre-expansion enrollees eligible for the study. Furthermore, the proportion of Medicaid enrollees who had at least one chronic condition was reasonably large (46.9% for Group VIII and 56.7% for pre-expansion enrollees). The proportion of Medicaid enrollees was higher in the metro counties (63.3% and 60.9% for Group VIII and pre-expansion enrollees, respectively), with a small proportion found in suburban counties (10.6% and 10.4% for Group VIII and pre-expansion enrollees, respectively).
Table 2. Distribution of Medicaid Population Eligible for Group VIII Assessment by Enrollment Type and Stratified by Enrollee Characteristics

<table>
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<th></th>
<th>Pre-expansion</th>
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<tr>
<td></td>
<td>Population Count</td>
<td>%</td>
<td>Population Count</td>
<td>%</td>
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<tr>
<td>Total</td>
<td>219,342</td>
<td>477,518</td>
<td></td>
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<tr>
<td>Gender</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Female</td>
<td>96,893  44.2</td>
<td>333,387  69.8</td>
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<td></td>
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<tr>
<td>Male</td>
<td>122,449  55.8</td>
<td>144,131  30.2</td>
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<tr>
<td>Chronic Condition</td>
<td></td>
<td></td>
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<td></td>
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<tr>
<td>Yes</td>
<td>102,972  46.9</td>
<td>270,566  56.7</td>
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<tr>
<td>No</td>
<td>116,370  53.1</td>
<td>206,952  43.3</td>
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<tr>
<td>Age</td>
<td></td>
<td></td>
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<tr>
<td>19–44 years</td>
<td>106,717  48.7</td>
<td>360,156  75.4</td>
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<tr>
<td>45–64 years</td>
<td>112,625  51.3</td>
<td>117,362  24.6</td>
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<tr>
<td>County Type</td>
<td></td>
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<tr>
<td>Metro</td>
<td>138,811  63.3</td>
<td>290,940  60.9</td>
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<tr>
<td>Rural</td>
<td>57,247   26.1</td>
<td>137,067  28.7</td>
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<tr>
<td>Suburban</td>
<td>23,284   10.6</td>
<td>49,511   10.4</td>
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**Design**

The telephone survey employed a stratified random sample design among the Group VIII and pre-expansion enrollees. Within each enrollment type, individuals were stratified by the following criteria:

- Sex (2 levels)
- Chronic condition status (2 levels: chronic condition or no chronic condition)
- Age category (2 levels: 19–44 years or 45–64 years of age)
- County type [25 levels: biometric screening counties (22), non-biometric metro (1), non-biometric suburban (1), and non-biometric rural counties (1)]

This resulted in 200 strata per Medicaid enrollment type (400 strata across the two enrollment types).

In general, stratification can be used for three purposes: (1) oversample a minority population, (2) explicitly allocate to a population to ensure representation, and (3) create homogeneous groups for analysis, which improves precision. For the Group VIII Assessment, stratification was used to achieve all three benefits. However, as Table 2 shows, for all characteristics other than county type, the population distribution was roughly equal. Oversampling was therefore only required for county type. Although having a chronic condition was not a rare event among Medicaid enrollees, it was determined to be an important factor for stratification to ensure
adequate representation of this key subpopulation in the biometric screening and medical records abstraction and to improve the precision during analysis.

**Sample Allocation**

The targeted number of completed interviews was allocated such that 50% of the sample was allocated to metro counties, 25% to rural counties, and 25% to suburban counties, and then proportionally within the other strata. This scheme achieved the analytic goal of having similar respondent sample sizes in each county type while only marginally impacting estimate precision.

**Starting sample size and selection of sample.** Because the response rate for the telephone survey was not known, rather than approximating it, a replicate design was used to release sample. In a replicate design, a larger than needed sample is drawn and randomly split into smaller samples (i.e., replicates). Replicates were produced within each stratum. For the telephone survey, a lower bound response rate of 20% was assumed to determine the starting sample size. **Table 3** presents the starting sample size by stratification characteristics that were selected and divided into replicates. Replicates were produced within each stratum and consisted of 10 sampled persons. Replicates were released until the marginal number of respondents was achieved. **Table 3** indicates the amount of sample in each marginal stratum that was released to achieve the desired number of respondents.\(^2\) Due to efficiencies realized in fielding, including the high cooperation rate and interviewer productivity, the total number of respondents exceeded the targeted sample sizes detailed in **Table 3**.

**Table 3. Number of Respondents, Targeted Sample Size, and Released Sample Size for Telephone Survey by Medicaid Enrollment Type and Stratified by Respondent Characteristics**

| Characteristic       | Group VIII |            | | Pre-expansion |            | |
|----------------------|------------|------------|----------------|--------------|-----------------|
|                      | Released Sample | Target Sample Size | Respondents | Released Sample | Target Sample Size | Respondents |
| **Total**            | 26,150     | 4,899      | 5,111         | 10,180       | 1,848          | 2,397          |
| **Gender**           |            |            |               |              |                |                |
| Male                 | 15,350     | 2,710      | 2,502         | 3,640        | 564            | 762            |
| Female               | 10,800     | 2,189      | 2,609         | 6,540        | 1,284          | 1,635          |
| **Chronic Condition**|            |            |               |              |                |                |
| Yes                  | 11,780     | 2,309      | 2,548         | 5,210        | 1,043          | 1,351          |
| No                   | 14,370     | 2,590      | 2,563         | 4,970        | 805            | 1,046          |
| **Age**              |            |            |               |              |                |                |
| 19–44 years          | 14,430     | 2,370      | 1,992         | 7,560        | 1,383          | 1,484          |
| 45–64 years          | 11,720     | 2,529      | 3,119         | 2,620        | 465            | 913            |
| **County Type**      |            |            |               |              |                |                |
| Metro                | 13,430     | 2,448      | 2,439         | 4,980        | 910            | 1,138          |
| Rural                | 6,260      | 1,225      | 1,389         | 2,700        | 482            | 691            |
| Suburban             | 6,460      | 1,226      | 1,283         | 2,500        | 456            | 568            |

\(^2\) As an evaluation study, the desired (targeted) number of respondents was based on the resources available for the study.
Because of the sensitive information contained in each sample record, the sample was selected and housed within an enhanced security network (ESN). No information containing personal identifying information (PII) about a selected person was removed from the ESN. Any sample-related information removed from the ESN was stripped of any PII prior to being taken out.

**Biometric Screening**

**Sample Coverage and Allocation**

**Sample coverage.** *Table 4* presents the Medicaid population and expected number of telephone survey respondents in the 22 biometric counties by Medicaid enrollment type. Given the study population of 219,342 Group VIII enrollees and 477,518 pre-expansion enrollees, the 22 selected counties covered 68% (=149,136/219,342) of Group VIII enrolled and 65% (=312,490/477,518) of pre-expansion enrolled persons. Furthermore, the 22 selected counties included 61% and 60% of Group VIII enrolled and pre-expansion telephone survey respondents, respectively.

### Table 4. Eligible Medicaid Population and Telephone Respondents in Selected Biometric Screening Counties by County Type and Medicaid Enrollment Type

<table>
<thead>
<tr>
<th>County Type</th>
<th>Group VIII</th>
<th>Pre-expansion</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Population</td>
<td>Telephone Respondents</td>
</tr>
<tr>
<td>Biometric</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Metro</td>
<td>125,022</td>
<td>83.8</td>
</tr>
<tr>
<td>Rural</td>
<td>15,950</td>
<td>10.7</td>
</tr>
<tr>
<td>Suburban</td>
<td>8,164</td>
<td>5.5</td>
</tr>
<tr>
<td>Total Biometric</td>
<td>149,136</td>
<td>68.0</td>
</tr>
<tr>
<td>Total Non-biometric</td>
<td>70,206</td>
<td>32.0</td>
</tr>
<tr>
<td>Total</td>
<td>219,342</td>
<td>—</td>
</tr>
</tbody>
</table>

**Sample allocation.** Moreover, as *Table 4* illustrates, the population and telephone respondent samples in the 22 biometric counties were skewed more toward the metro counties than the actual Medicaid population and desired respondent telephone respondent sample (see *Table 2*). Therefore, if a simple random sample of telephone respondents was selected in the 22 biometric counties, the biometric respondents would have heavily represented the metro areas. To reduce the skewness in the biometric screening respondent sample, the biometric screening was allocated such that 60% of respondents came from metro counties and 20% came from rural and suburban counties each. *Table 5* presents the targeted respondent allocation by county type. At the county type level, the biometric screening respondents were selected proportional to the number of telephone respondents in each county.
### Table 5. Biometric Screening Respondent Allocation by County Type

<table>
<thead>
<tr>
<th>County Type</th>
<th>Group VIII</th>
<th>Pre-expansion</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Sample</td>
<td>%</td>
</tr>
<tr>
<td>Metro</td>
<td>435</td>
<td>60.0</td>
</tr>
<tr>
<td>Rural</td>
<td>145</td>
<td>20.0</td>
</tr>
<tr>
<td>Suburban</td>
<td>145</td>
<td>20.0</td>
</tr>
</tbody>
</table>

**Sample Selection**

Within each biometric county, telephone survey respondents had a known probability of being asked to participate in the biometric screening process. The probability of being asked to participate in the biometric screening was the same for all people in a replicate, but could vary across replicates. Because the participation or “show up” rates for individuals were unknown, for counties with a large number of expected biometric screenings (i.e., 25 or more), the screenings were split across multiple screening periods approximately 6 weeks apart. This allowed for the participant “show up” rate to be estimated for the second and subsequent screenings. Counties with a small number of expected screenings only had one screening period. For counties that had later screening dates (either large counties for their second screening or small counties scheduled later in the screening period), empirical information about the “show up” rate was used to better decide how many screenings needed to be scheduled to meet the desired number of screenings in each county.

The starting assumption for the agreement rate (i.e., the rate at which telephone survey respondents agreed to participate in the biometric screening) was 30%, and the starting assumption for the “show up” rate was 70%. Given these assumptions, all initial telephone respondents were asked to participate in the biometric screening until more empirical data were known. The actual agreement and “show up” rates were similar to these starting assumptions—the agreement rates were 27.6% and 31.5% for Group VIII and pre-expansion telephone respondents, respectively; the “show up” rates were 69.6% and 63.9% for Group VIII and pre-expansion biometric participants, respectively. All telephone respondents throughout the data collection period were therefore asked to participate in the biometric screening.

Based on this design, **Table 6** presents the anticipated and actual number of respondents to the biometric screening by Medicaid enrollment type and stratified by respondent characteristics. The table shows that for the Group VIII enrollees, the actual number of respondents to the screening was lower than the targeted amount because of lower than expected participation from people who were younger, male, and living in metro counties. Overall, actual respondent totals in any demographic group could be higher or lower than the anticipated number due to differential nonresponse.
Table 6. Respondent Counts for the Biometric Screening by Medicaid Enrollment Type and Stratified by Respondent Characteristics

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Group VIII</th>
<th>Pre-expansion</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Respondents</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gender</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>408</td>
<td>283</td>
</tr>
<tr>
<td>Female</td>
<td>317</td>
<td>316</td>
</tr>
<tr>
<td>Chronic Condition</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>341</td>
<td>344</td>
</tr>
<tr>
<td>No</td>
<td>384</td>
<td>255</td>
</tr>
<tr>
<td>Age</td>
<td></td>
<td></td>
</tr>
<tr>
<td>19–44 years</td>
<td>362</td>
<td>178</td>
</tr>
<tr>
<td>45–64 years</td>
<td>363</td>
<td>421</td>
</tr>
<tr>
<td>County Type</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Metro</td>
<td>435</td>
<td>359</td>
</tr>
<tr>
<td>Rural</td>
<td>145</td>
<td>118</td>
</tr>
<tr>
<td>Suburban</td>
<td>145</td>
<td>122</td>
</tr>
</tbody>
</table>

Medical Records Abstraction

Selection of Respondents

All Group VIII enrollees who completed the biometric screening (725 projected; 599 completed screenings) were asked to participate in the medical records abstraction. Based on experience from similar studies (e.g., the Medical Expenditure Panel Survey [MEPS]), the following assumptions were used to estimate the sample yields for the medical records abstraction component: (1) an 80% participation rate of enrollees who completed the biometric screenings, providing signed authorization forms to their usual source-of-care (USOC)\(^3\) medical providers for release of their medical records; and (2) an 80% provider cooperation rate to provide the requested medical records. The medical records abstraction obtained records from two time periods: (1) 2013 and (2) 2015–2016.

Based on these assumptions and the projected biometric screening participants, it was expected that 580 biometric screening participants would sign the authorization form, and medical providers would cooperate in providing records for 464 of these. However, at the end of data collection, there were 430 enrollees who had signed authorization forms and whose medical provider had cooperated. Of these 430 enrollees, 174 had data in both 2013 and 2015 or 2016. Because medical records from both periods were needed to understand how

---

\(^3\) Determining whether the “usual source of care (USOC)” was a primary care provider or some other medical provider was left up to the respondent.
Group VIII enrollees’ medical conditions and diagnoses changed, only those with records in both periods were used in the case studies of the medical records. Enrollees for which medical records were not obtained in both periods predominantly did not have data from 2013; 92.6% of participants for whom data were received in only one period had data for 2015-2016 (most were uninsured during the earlier period and, therefore, did not see their provider). Table 7 presents the demographic characteristics of the 174 Group VIII enrollees with medical records abstraction data covering both the 2013 and 2015-2016 time periods.

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Number of Participants</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>174</td>
<td>100</td>
</tr>
<tr>
<td>Gender</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>65</td>
<td>37.4</td>
</tr>
<tr>
<td>Female</td>
<td>109</td>
<td>62.6</td>
</tr>
<tr>
<td>Chronic Condition</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>116</td>
<td>66.7</td>
</tr>
<tr>
<td>No</td>
<td>58</td>
<td>33.3</td>
</tr>
<tr>
<td>Age</td>
<td></td>
<td></td>
</tr>
<tr>
<td>19–44 years</td>
<td>39</td>
<td>22.4</td>
</tr>
<tr>
<td>45–64 years</td>
<td>135</td>
<td>77.6</td>
</tr>
<tr>
<td>County Type</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Metro</td>
<td>94</td>
<td>54.0</td>
</tr>
<tr>
<td>Rural</td>
<td>38</td>
<td>21.8</td>
</tr>
<tr>
<td>Suburban</td>
<td>42</td>
<td>24.2</td>
</tr>
</tbody>
</table>

For the subset of 174 patients with medical record information from their USOC for both the period in 2013 prior to enrolling in Medicaid and the period in 2015-2016 as Medicaid enrollees, these records were reviewed for information on health status, chronic disease diagnoses, preventive screenings, and medical treatments/prescriptions. This review enabled an assessment of health care utilization, treatment regimens and changes in the health status of a subset of Group VIII enrollees both before and after enrolling in Medicaid. Given the multiple levels of additional nonresponse (acquisition of authorization forms, obtaining provider cooperation to release the medical records) encountered subsequent to the biometric screenings and the limited number of patients with medical data for both time periods necessary to conduct the analysis, a case study model was applied to the medical records component. Under this model, the data were deemed best used in unweighted analysis. Consequently, no weights were created for the medical records abstraction respondents.
3. **Sample Results**

*Table 8* presents the targeted and actual number of telephone survey respondents and biometric screening participants by geographic stratum and Medicaid enrollment type. In total, 7,508 people responded to the telephone survey (5,111 Group VIII respondents and 2,397 pre-expansion respondents) and 886 people participated in the biometric screening (599 Group VIII participants and 287 pre-expansion participants).

*Table 9* shows the distribution of the telephone survey respondents and biometric, and medical records participants by Medicaid enrollment type. For both the Group VIII and pre-expansion enrollees, the targeted participant distributions by county type were achieved for both the telephone survey and biometric screening.

*Table 10* presents how the distribution of telephone and biometric participants by county type compared to the March 2016 Medicaid population that was eligible for this study. For both Group VIII and pre-expansion enrollees, as expected, the proportion of respondents in the rural and suburban counties was greater than the actual proportion of Medicaid enrollees in those county types.
Table 8. Telephone and Biometric Screening Target and Complete Participants by Region for Group VIII and Pre-expansion Enrollees

<table>
<thead>
<tr>
<th>Region</th>
<th>Group VIII</th>
<th></th>
<th></th>
<th>Pre-expansion</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Phone</td>
<td>Biometric</td>
<td></td>
<td></td>
<td>Phone</td>
<td>Biometric</td>
</tr>
<tr>
<td></td>
<td>Target</td>
<td>Complete</td>
<td>Scheduled</td>
<td>Target</td>
<td>Complete</td>
<td>Scheduled</td>
</tr>
<tr>
<td>Metro—Allen</td>
<td>34</td>
<td>42</td>
<td>6</td>
<td>6</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>Metro—Butler</td>
<td>121</td>
<td>113</td>
<td>26</td>
<td>24</td>
<td>18</td>
<td></td>
</tr>
<tr>
<td>Metro—Cuyahoga</td>
<td>662</td>
<td>599</td>
<td>188</td>
<td>129</td>
<td>114</td>
<td></td>
</tr>
<tr>
<td>Metro—Franklin</td>
<td>431</td>
<td>447</td>
<td>87</td>
<td>84</td>
<td>63</td>
<td></td>
</tr>
<tr>
<td>Metro—Hamilton</td>
<td>351</td>
<td>322</td>
<td>93</td>
<td>68</td>
<td>60</td>
<td></td>
</tr>
<tr>
<td>Metro—Lucas</td>
<td>189</td>
<td>204</td>
<td>43</td>
<td>37</td>
<td>29</td>
<td></td>
</tr>
<tr>
<td>Metro—Mahoning</td>
<td>83</td>
<td>75</td>
<td>20</td>
<td>16</td>
<td>12</td>
<td></td>
</tr>
<tr>
<td>Metro—Montgomery</td>
<td>207</td>
<td>242</td>
<td>52</td>
<td>40</td>
<td>35</td>
<td></td>
</tr>
<tr>
<td>Metro—Summit</td>
<td>157</td>
<td>161</td>
<td>36</td>
<td>31</td>
<td>24</td>
<td></td>
</tr>
<tr>
<td>Rural—Gallia</td>
<td>16</td>
<td>23</td>
<td>10</td>
<td>7</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>Rural—Hocking</td>
<td>14</td>
<td>12</td>
<td>2</td>
<td>6</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Rural—Jackson</td>
<td>17</td>
<td>20</td>
<td>8</td>
<td>7</td>
<td>8</td>
<td></td>
</tr>
<tr>
<td>Rural—Muscngum</td>
<td>38</td>
<td>52</td>
<td>19</td>
<td>17</td>
<td>14</td>
<td></td>
</tr>
<tr>
<td>Rural—Scioto</td>
<td>40</td>
<td>45</td>
<td>16</td>
<td>16</td>
<td>12</td>
<td></td>
</tr>
<tr>
<td>Rural—Trumbull</td>
<td>36</td>
<td>154</td>
<td>51</td>
<td>49</td>
<td>35</td>
<td></td>
</tr>
<tr>
<td>Rural—Washington</td>
<td>113</td>
<td>87</td>
<td>11</td>
<td>17</td>
<td>9</td>
<td></td>
</tr>
<tr>
<td>Rural—Marion</td>
<td>24</td>
<td>33</td>
<td>20</td>
<td>10</td>
<td>17</td>
<td></td>
</tr>
<tr>
<td>Rural—Wayne</td>
<td>39</td>
<td>60</td>
<td>21</td>
<td>16</td>
<td>16</td>
<td></td>
</tr>
<tr>
<td>Suburban—Fairfield</td>
<td>115</td>
<td>105</td>
<td>30</td>
<td>40</td>
<td>20</td>
<td></td>
</tr>
<tr>
<td>Suburban—Greene</td>
<td>109</td>
<td>125</td>
<td>47</td>
<td>38</td>
<td>38</td>
<td></td>
</tr>
<tr>
<td>Suburban—Licking</td>
<td>126</td>
<td>129</td>
<td>42</td>
<td>45</td>
<td>36</td>
<td></td>
</tr>
<tr>
<td>Suburban—Wood</td>
<td>64</td>
<td>72</td>
<td>33</td>
<td>22</td>
<td>28</td>
<td></td>
</tr>
</tbody>
</table>

(continued)
Table 8. Telephone and Biometric Screening Target and Complete Participants by Region for Group VIII and Pre-expansion Enrollees (continued)

| Region                | Group VIII | | | | | | Pre-expansion | | | |
|-----------------------|------------|------------------|------------------|-------|------------------|------------------|------------------|------------------|-------|------------------|------------------|------------------|-------|
|                       | Target    | Complete | Scheduled | Target | Complete | Target    | Complete | Scheduled | Target | Complete | Scheduled | Target | Complete |
| Nonbiometric—Metro    | 213       | 234      | —         | —      | —        | 97        | 163      | —         | —      | —        | —         | —      | —         |
| Nonbiometric—Rural    | 888       | 903      | —         | —      | —        | 336       | 423      | —         | —      | —        | —         | —      | —         |
| Nonbiometric—Suburban | 812       | 852      | —         | —      | —        | 294       | 384      | —         | —      | —        | —         | —      | —         |
| Total                 | 4,899     | 5,111    | 861       | 725    | 599      | 1,848     | 2,397    | 449       | 266    | 287      | —         | —      | —         |
Table 9. Distribution of Total Study Population, Telephone Respondents, Biometric Screening Assessment Participants, Medical Records Abstraction (MRA) Respondents by Medicaid Enrollment Type, Stratified by Population Characteristics

<table>
<thead>
<tr>
<th></th>
<th>Group VIII</th>
<th>Pre-expansion</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Population</td>
<td>Telephone</td>
</tr>
<tr>
<td></td>
<td>N</td>
<td>%</td>
</tr>
<tr>
<td>Total</td>
<td>219,342</td>
<td>100</td>
</tr>
<tr>
<td>Gender</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>122,449</td>
<td>55.8%</td>
</tr>
<tr>
<td>Female</td>
<td>96,893</td>
<td>44.2%</td>
</tr>
<tr>
<td>Chronic Disease Status</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chronic</td>
<td>102,972</td>
<td>46.9%</td>
</tr>
<tr>
<td>Non-Chronic</td>
<td>116,370</td>
<td>53.1%</td>
</tr>
<tr>
<td>Age Category</td>
<td></td>
<td></td>
</tr>
<tr>
<td>19–44 years</td>
<td>106,717</td>
<td>48.7%</td>
</tr>
<tr>
<td>45–64 years</td>
<td>112,625</td>
<td>51.3%</td>
</tr>
<tr>
<td>County Type</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Metro</td>
<td>138,811</td>
<td>63.3%</td>
</tr>
<tr>
<td>Rural</td>
<td>57,247</td>
<td>26.1%</td>
</tr>
<tr>
<td>Suburban</td>
<td>23,284</td>
<td>10.6%</td>
</tr>
</tbody>
</table>
**Table 10. Distribution of Total Study Population, Telephone Respondents, and Biometric Screening Assessment Participants by Medicaid Enrollee Type, Stratified by County Type and Biometric Screening Assessment Status**

<table>
<thead>
<tr>
<th>County Type</th>
<th>Group VIII</th>
<th>Pre-expansion</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Population</td>
<td>Telephone</td>
</tr>
<tr>
<td></td>
<td>N</td>
<td>%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>219,342</td>
<td>—</td>
</tr>
<tr>
<td><strong>Biometric</strong></td>
<td>149,136</td>
<td>100.0</td>
</tr>
<tr>
<td>Metro</td>
<td>125,022</td>
<td>83.8</td>
</tr>
<tr>
<td>Rural</td>
<td>15,950</td>
<td>10.7</td>
</tr>
<tr>
<td>Suburban</td>
<td>8,164</td>
<td>5.5</td>
</tr>
<tr>
<td><strong>Nonbiometric</strong></td>
<td>70,206</td>
<td>100.0</td>
</tr>
<tr>
<td>Metro</td>
<td>13,789</td>
<td>19.6</td>
</tr>
<tr>
<td>Rural</td>
<td>41,297</td>
<td>58.8</td>
</tr>
<tr>
<td>Suburban</td>
<td>15,120</td>
<td>21.5</td>
</tr>
</tbody>
</table>
III. Telephone Survey

1. Instrument Content

The telephone survey was administered to Group VIII and pre-expansion enrollees. The questionnaire consisted of separate sections focusing on topics including access to care, health system utilization, physical and mental health, financial hardship, and employment. Group VIII respondents also answered questions about their pathways to Medicaid coverage and were asked what gaining Medicaid coverage meant to them. Table 11 is a summary of each questionnaire section.

<table>
<thead>
<tr>
<th>Table 11. Summary of Questionnaire Sections</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Opening Section</strong></td>
</tr>
<tr>
<td>SECTION A Introduction</td>
</tr>
<tr>
<td>SECTION A Screener and Cell Phone Usage</td>
</tr>
<tr>
<td><strong>Limited Demographics</strong></td>
</tr>
<tr>
<td>SECTION B Gender, Age, and County of Residence</td>
</tr>
<tr>
<td><strong>Medicaid Coverage, Prior Coverage, Pathways to Coverage, and Health Status</strong></td>
</tr>
<tr>
<td>SECTION C Confirmation of Insurance Status and Prior Coverage for Group VIII</td>
</tr>
<tr>
<td>SECTION D Pathways to Medicaid Coverage (asked only of Group VIII Enrollees)</td>
</tr>
<tr>
<td>SECTION E Health Status and Health Conditions</td>
</tr>
<tr>
<td><strong>Health Care Utilization</strong></td>
</tr>
<tr>
<td>SECTION F Health Care Utilization and Usual Source of Care</td>
</tr>
<tr>
<td>SECTION G Health Care Access and Unmet Need</td>
</tr>
<tr>
<td><strong>Employment and Financial Hardships, Health Behaviors, and Demographics</strong></td>
</tr>
<tr>
<td>SECTION H Employment Status</td>
</tr>
<tr>
<td>SECTION I Financial Hardships</td>
</tr>
<tr>
<td>SECTION J Health Behaviors</td>
</tr>
<tr>
<td>SECTION J Demographics</td>
</tr>
<tr>
<td>SECTION K Perceived Value of Medicaid Coverage (asked only of Group VIII Enrollees)</td>
</tr>
<tr>
<td>SECTION L Recruitment for Biometric Screening</td>
</tr>
</tbody>
</table>

2. Survey Instrument Development

The Group VIII Executive Committee (EC) collaborated on the development of the survey questionnaire. The EC initiated the development process by reviewing the 2012–2015 Ohio Medicaid Assessment Survey and 2004–2010 Ohio Family Health Survey instruments to assess which items could be used for the Group VIII telephone survey. The EC then collaborated with agency stakeholders to identify what new items would be necessary to meet their current needs. The research team drafted new survey questions and revised existing questions to meet
these data needs. After the EC developed a working draft of the instrument, RTI assisted in finalizing the instrument and preparing for pilot testing. Staff examined the instrument for ease of administration and response, wording and response categories for new items, transitions and overall survey flow, skip patterns, and item-specific logic.

The pilot test survey instrument specifications were completed on February 16, 2016, with the goal of programming, testing, and finalizing the survey for a pilot test in April. After several iterations and discussions, on March 10, 2016 a final instrument was provided and the computer-assisted telephone interviewing (CATI) programming began. The survey was programmed and a pilot test initiated in April.

3. **Interviewer Training**

Survey interviewer training was conducted on April 19 and 20 at RTI’s Research Operation Center in Raleigh, NC. Eight experienced interviewers and four supervisors participated in the initial training. After the pilot study, an additional 16 interviewers were given the same training protocol for the full study.

Interviewers had to complete training and certification prior to beginning “live” calling. Experienced interviewers attended a 4-hour session of project training and 1 to 2 hours of mock interviewing. Topics covered during training focused on the survey’s background and structure, study-specific protocols and procedures, pronunciation, and answers to frequently asked questions (*Table 12*).

<table>
<thead>
<tr>
<th>Time (minutes)</th>
<th>Topic</th>
</tr>
</thead>
<tbody>
<tr>
<td>15</td>
<td>Welcome and Introduction</td>
</tr>
<tr>
<td>25</td>
<td>Survey Background, Purpose, and Structure</td>
</tr>
<tr>
<td>10</td>
<td>Roles and Responsibilities</td>
</tr>
<tr>
<td>10</td>
<td>General Contacting Procedures</td>
</tr>
<tr>
<td>15</td>
<td>Respondent Rights and Importance of Confidentiality</td>
</tr>
<tr>
<td>45</td>
<td>Review of Frequently Asked Questions (FAQs)</td>
</tr>
<tr>
<td>15</td>
<td>BREAK</td>
</tr>
<tr>
<td>20</td>
<td>Pronunciation Practice</td>
</tr>
<tr>
<td>75</td>
<td>Round-Robin</td>
</tr>
<tr>
<td>10</td>
<td>Q&amp;A Sessions</td>
</tr>
<tr>
<td></td>
<td><strong>Evening 2</strong></td>
</tr>
<tr>
<td>10</td>
<td>Q&amp;A/Review</td>
</tr>
<tr>
<td>30</td>
<td>Emotional Distress and Sensitivity</td>
</tr>
<tr>
<td>30</td>
<td>Refusal Avoidance</td>
</tr>
<tr>
<td>55</td>
<td>Paired Practice</td>
</tr>
<tr>
<td>15</td>
<td>BREAK</td>
</tr>
<tr>
<td>15</td>
<td>Review FAQs and Pronunciation</td>
</tr>
<tr>
<td>40</td>
<td>Individual Read-Through of Questionnaire</td>
</tr>
<tr>
<td>35</td>
<td>Certification</td>
</tr>
<tr>
<td>10</td>
<td>Q&amp;A/Final Review</td>
</tr>
</tbody>
</table>

During training, interviewers participated in round-robin mock interviews and paired-practice mock interviews, and completed individual survey practice exercises. Interviewer certification involved completing two oral quizzes as well as successfully attending and participating during training sessions and exercises. Interviewers were required to achieve 100% correct answers on both oral quizzes to become certified.
The 2016 Group VIII Survey training agenda included the items in Table 12.

4. **Pilot Test**

The primary objective and purpose of the pilot test was to replicate the conditions for full-scale survey data collection. The sample for the pilot was drawn in the same manner that was to be used to draw the final sample. However, there were several methodological differences between the implementation of the pilot and the ultimate fielding of the survey. For example, call attempt protocols were relaxed during the pilot in the number and timing of telephone attempts. Also, refusal conversion attempts and Spanish interviews were not conducted during the pilot. Pilot sample members also did not receive the prenotification letter that was mailed to all full sample members. Last, the final training protocol was modified based on observations from the pilot activities.

Interviewing for the pilot started on April 20, 2016, and continued through April 21, 2016, with the goal of completing 50 interviews. The interviewers made calls between the hours of 9:00 a.m. and 9:00 p.m. on weekdays. In total, RTI obtained 51 completed pilot survey interviews. Completed interviews were obtained with between one and three attempts per record; on average, two attempts had to be made to complete a survey.

5. **Disposition of Pilot Sample**

The pilot completed 51 interviews. Table 13 presents the final disposition for all 828 released sampled numbers.

For this survey, the results of each call attempt were assigned a disposition according to guidelines published by the American Association for Public Opinion Research (AAPOR). The final dispositions can be summarized as follows:

- **Eligible**
  - Completes and Partial Interviews (if applicable)
  - Refusals and Noncontacts

- **Ineligible**
  - Survey Ineligible = Person is determined to be 65 years of age or older, no longer has Medicaid, or has had Medicaid coverage for less than 1 year

- **Unknown**
  - Unknown Eligible (known person) = Confirmed correct person reached but did not establish survey eligibility
  - Unknown Person = Cannot confirm person and survey eligibility

Each sampled person’s history of attempted contacts was analyzed to determine the record’s final status. The final status was based on the contact attempt that provided the most information (e.g., a completed interview or a refusal). (For more information, see Table 13.)
### Table 13. Distribution of Disposition Codes for the Group VIII Survey Pilot

<table>
<thead>
<tr>
<th>Label</th>
<th>Total Number</th>
<th>% Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Completes (full interviews only)</td>
<td>51</td>
<td>6.2</td>
</tr>
<tr>
<td>Partial Complete</td>
<td>0</td>
<td>0.0</td>
</tr>
<tr>
<td>Refusals and Break-offs</td>
<td>41</td>
<td>5.0</td>
</tr>
<tr>
<td>Noncontact</td>
<td>256</td>
<td>30.9</td>
</tr>
<tr>
<td>No Eligible Respondent</td>
<td>16</td>
<td>1.9</td>
</tr>
<tr>
<td>Unknown Eligibility, Noninterview</td>
<td>381</td>
<td>56.0</td>
</tr>
</tbody>
</table>

### Timing

During the pilot, the mean interview time for all cases was 25.6 minutes, with a median time of 22.7 minutes. The minimum interview length was 17.2 minutes and the maximum interview time was 46.6 minutes.

*Table 14* shows the mean and median interview times for the overall instrument as well as by module.

### Table 14. Interview Time by Module in the Pilot Test

<table>
<thead>
<tr>
<th>Section</th>
<th>Mean Time (seconds)</th>
<th>Median (seconds)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Section A</td>
<td>115</td>
<td>74</td>
</tr>
<tr>
<td>Section B</td>
<td>25</td>
<td>22</td>
</tr>
<tr>
<td>Section C</td>
<td>56.8</td>
<td>41</td>
</tr>
<tr>
<td>Section D*</td>
<td>31.9</td>
<td>24</td>
</tr>
<tr>
<td>Section E</td>
<td>399.5</td>
<td>378</td>
</tr>
<tr>
<td>Section F</td>
<td>155.8</td>
<td>134</td>
</tr>
<tr>
<td>Section G</td>
<td>339.3</td>
<td>324</td>
</tr>
<tr>
<td>Section H</td>
<td>66.8</td>
<td>50</td>
</tr>
<tr>
<td>Section I</td>
<td>96.2</td>
<td>83</td>
</tr>
<tr>
<td>Section J</td>
<td>114.5</td>
<td>111</td>
</tr>
<tr>
<td>Section K*</td>
<td>85</td>
<td>89</td>
</tr>
<tr>
<td>Section L</td>
<td>101.1</td>
<td>84</td>
</tr>
</tbody>
</table>

* Sections D and K were administered to Group VIII enrollees only.

### 6. Cuts for Length

To bring the survey closer to the budgeted average of 20 minutes per adult respondent, questions were cut from and revised in the instrument. The EC developed guidelines for prioritizing questionnaire items to distinguish items that were critical to policy and program analyses from those that were less critical and could be deleted.
The guideline for deleted questions included time considerations (long banks of questions) and the degree to which a question was of importance to the Ohio Medicaid program and the requirements of the Statutory Report. Beyond deletions, the introduction, transition, and closing statements were revised to shorten the survey and reduce break-offs. Other minor text changes were made for clarity and flow purposes. Finally, a number of small logic errors were found and corrected.

The final version of the questionnaire with CATI specifications can be found in Appendix A.

7. **Data Collection Procedures**

RTI used the Voxco CATI software system to program and field the Group VIII Survey. This fully integrated program provided call management and replicate controls, multilingual interviewing capabilities, monitoring, and incidence tracking. The software automatically controlled skip and fill logic, and range checking for numeric data. The programming logic directed the questionnaire’s flow and prevented an interviewer from entering data in the wrong field. On any given screen of the questionnaire, the program only accepted a predetermined range or type of response.

**Implementation Protocol**

The Group VIII Survey followed a calling protocol adapted from that used in the 2015 Ohio Medicaid Assessment Survey. Initially, each sample member was sent a prenotification letter including information about the survey and a means to contact the project. Shortly after they received the letter (usually within 3–5 days), calls were made to attempt to complete interviews. The Group VIII Survey used a 10-attempt protocol for reaching listed sample members, with attempts distributed across days of the week, and parts of the day, and across six weeks of fielding, to maximize the possibility of reaching respondents when they were able to set aside time for the survey.

**Call Scheduling**

The target interviewing period was between 5 p.m. and 9 p.m. respondent time on weekdays, between 10 a.m. and 9 p.m. on Saturdays, and between 1 p.m. and 9 p.m. on Sundays. RTI’s Research Operations Center also scheduled shifts between 9 a.m. and 5 p.m. weekdays for up to a maximum of 40% of total session hours to reach respondents who worked or were otherwise unavailable in the evenings.

**Number of Attempts**

Interviewers made a minimum of 10 attempts to reach an eligible respondent. Each call attempt was given a minimum of five rings. The attempts were rotated through weekday day, weekday evening, Saturday day, and Sunday evening shifts to maximize coverage of the residential population. Persistent “ring no-answers” were attempted a minimum of four times and days of the week. If a respondent was contacted on the last call, and an interview could not be completed, another attempt was made. Lines with busy signals were called back a minimum of two times at 15-minute intervals. If the line was still busy after the third attempt, the number was attempted again on different calling time periods until the record was resolved.

**Callbacks**

A system-scheduled callback was assigned to a record that could not be given a specific date and time, and a scheduled callback was assigned for respondents who provided a definite appointment for re-contact.

Callbacks to specific respondents were entered into the computer by interviewers and handled automatically by the program. RTI’s system accommodated both general and specific callbacks. For a specific appointment, the
record waited until the designated time to be released. At this time, the system found the next available interviewer and delivered the record as the next call. The call history screen that accompanied each record informed the interviewer that the call was a definite appointment and described the circumstances of the original contact. General callbacks, where respondents requested that RTI try to reach them at a generally specified time of day (“I usually get home around 6 o’clock”), were sorted and allotted automatically by the system. They were held out of the sample until the appointed hour, when they were sent to a station with an open slot for that call. They had a higher system priority than returning no-answer and busy records, but lower priority than specific callbacks.

RTI’s system also accommodated the restarting of interrupted interviews. If a cooperative respondent had to terminate an interview, but wanted to finish at a later time, it was possible to set a definite callback for that time and resume the interview where it left off. If the interviewer who began the survey was available at the prescribed time, the system sent the call back to that station.

Respondent Selection
As a listed sample, the study assumed all those in the study were eligible to participate. In that administrative records are sometimes inaccurate, eligibility was verified; eligibility criteria included being 19 years through 64 years of age, currently on Medicaid, and having been on Medicaid for 1 or more years.

Sample Location Efforts
In some instances, the designated sample member was no longer at the phone number extracted from the Medicaid Eligibility and Enrollment data. In those cases, the interviewers attempted to get the most updated contact information from the individual who answered the phone. In addition, for the cases with outdated or inaccurate contact information, batch tracing was utilized to try to find the most updated information. Batch tracing involved providing the existing information to one of several vendors to obtain the most updated contact information.

Refusal Conversion
All interviewers calling on the Group VIII Survey were trained to avoid refusals. When respondents refused to participate, the interviewer left a note explaining what, if anything, had happened or had been said, and RTI’s refusal conversion specialists made at least one more contact. Exceptions were made for cases in which the person answering the phone said something indicating a callback would not be appropriate, such as making threats. This information was reviewed by staff just before calling the telephone number again. During nonresponse refresher trainings, supervisory staff compiled these cases and reviewed effective strategies for nonresponse avoidance and conversion.

Although a high response rate was important, the role of the interviewers was not to harass respondents into participating in either the selection process or the interview. Interviewers were trained to inform their supervisor about the following situations:

- If the respondent was verbally abusive or threatened litigation;
- if the respondent requested to be placed on a “do not call” list; or
- if the person who answered the phone refused to transfer the call to the selected respondent and stated that they would never allow the call to be passed to the selected respondent. These cases were called back at another day and time in an effort to contact the respondent.
These numbers were terminated and coded as final refusals not to be called back.

**Spanish Interviewing**

RTI conducted the telephone survey in English and Spanish. Of the 7,508 completed records in the final data file, 45 (.01%) were collected in Spanish. Spanish-speaking interviewers were associated with records flagged during initial contact as having reached a non-English speaking potential respondent. When a bilingual interviewer reached a Spanish-speaking respondent, the interviewer explained the survey in Spanish and continued directly into the interview without interruption. When a non–Spanish-speaking interviewer contacted a Spanish-speaking sample member, the record was coded for Spanish interviewing, and the system automatically routed the record to a bilingual interviewer for subsequent attempts.

**Methods Used to Increase Response Rates**

A variety of methods were implemented to maximize response rates for the Group VIII Survey, including:

- mailing a prenotification letter prior to calling;
- leaving messages on answering machines and privacy managers;
- providing toll-free verification numbers for the survey sponsor;
- employing special refusal conversion efforts;
- reattempting phone numbers on different days, and at different times of the day, to maximize chances to reach each household;
- conducting interviews in Spanish and English; and
- offering a $20 gift card incentive for respondents.

Each of these is described in detail below.

**Mailing a Prenotification Letter Prior to Calling**

For the main fielding, 4 a single-page lead letter was used to notify the designated sample members that someone would be attempting to reach them. The letter was mailed to the address included in Medicaid Enrollment and Eligibility data. Written in both English and Spanish, the letter informed the sample member of the nature of the survey, that they could be expecting a call within a few days of receiving the letter, and provided them with contact information, including a toll-free number, if they had any questions or concerns. Respondents who called the toll-free number were able to complete the survey at the time of their call, and many did so. A copy of the prenotification letter appears in **Appendix B**.

**Leaving Messages on Answering Machines**

Interviewing staff left messages on persistent “answering machine” and “privacy manager” dispositions, informing respondents of the study and scheduling another call attempt for the following day. The message stated that interviewers were calling on behalf of the Ohio Department of Medicaid and that a callback at their convenience would be appreciated. The toll-free telephone number was left on the answering machine. Messages were left on the first and fourth attempts to a sample member if an answering machine or privacy manager was

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4 A prenotification letter was not sent for the pilot test.
reached on these attempts. For privacy managers, if a message could not be left, the interviewers were instructed to enter the toll-free telephone number.

The text of the answering machine message was as follows:

“Hello, my name is ______________, from RTI International and we are conducting a survey about Medicaid Coverage and access to health care on behalf of the Ohio Department of Medicaid. Your name and contact information has been selected as someone who we would like to talk to about this important study. We would like to explain our survey to you. We will try to contact you again, however if you would like to reach us, you can call the Group VIII Study on our toll-free number at 1-866-406-7333.”

Survey Verification Toll-Free Number

A dedicated toll-free telephone number was established to receive respondent calls regarding the legitimacy and validity of the study. Contact information for GRC was made available to those respondents who wished to contact the survey sponsor directly. GRC took responsibility for responding to concerns about the survey effort and shared this information with ODM and RTI.

Refusal Conversion Efforts

Refusal conversation calls were made to all sample members who refused initial attempts. The calls were placed after a 7-day cooldown period by specifically trained refusal conversion specialists.

Reattempting Numbers

As discussed above in the Implementation Protocol, telephone numbers that did not initially result in a completed interview were contacted on different days, and at different times of the day, to maximize efforts to reach each sample member. The study protocol allowed calling over 6 weeks to ensure that respondents on vacation and those not at home during common calling hours could be reached.

Offering a Gift Card for Survey Completion

Respondents who completed the telephone interview were asked if they would like to receive a $20 Walmart gift card. For those who acknowledged that they would like to receive the card, their address was verified and a gift card was sent.

8. Response Rates

To affirm the representation of the target population in a study, researchers look to response rates as indicators of performance. There is no one agreed-upon standard response rate formula because each project lends itself to different measures of performance. Several of these performance measures are discussed below.

The results of each call attempt were assigned a disposition according to guidelines published by AAPOR. The final dispositions can be summarized as follows:

- Eligible
  - Completes and Partial Interviews (if applicable)
– Refusals and Noncontacts\(^5\)

- Ineligible
  - Survey Ineligible = Person is determined to be 65 years of age or older, no longer has Medicaid, or has had Medicaid coverage for less than 1 year

- Unknown

Each sampled person's history of attempted contacts was analyzed to determine the record's final status. The final status was based on the contact attempt that provided the most information (e.g., a completed interview or a refusal). In the Group VIII Survey, all persons who started the survey were required to finish for the survey to be considered completed. Therefore, there were no partial interviews for this study. (For more information, see Table 15.)

**Table 15. Distribution of Disposition Codes by AAPOR Response Category, for All Survey Respondents and Stratified by Group VIII and Pre-expansion Enrollee Respondents**

<table>
<thead>
<tr>
<th>AAPOR Group</th>
<th>Disposition</th>
<th>Total</th>
<th>Group VIII</th>
<th>Pre-expansion</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.1</td>
<td>Completes (full interviews only)</td>
<td>7,508</td>
<td>5,111</td>
<td>2,397</td>
</tr>
<tr>
<td>2.1</td>
<td>Refusals and Break-offs</td>
<td>2,365</td>
<td>1,634</td>
<td>731</td>
</tr>
<tr>
<td>4.7</td>
<td>No Eligible Respondent</td>
<td>1,617</td>
<td>1,334</td>
<td>283</td>
</tr>
<tr>
<td>3.0</td>
<td>Unknown Eligibility, Non-interview</td>
<td>24,850</td>
<td>18,071</td>
<td>6,769</td>
</tr>
</tbody>
</table>

**AAPOR Response Rates**

The response rates take into account the ability of the interviewing staff to establish contact with potentially eligible persons and to resolve the eligibility status of the sampled person. The Group VIII Survey utilized a list frame from a database of known eligible persons. Therefore, the only persons considered ineligible were those who had been incorrectly identified in the frame as being under 65 years of age and currently having Medicaid coverage for 1 year or longer. In other words, unlike a random digit dial (RDD) study, a bad phone number (e.g., fax line, business number) does not make a sampled person ineligible. However, people who could not be reached and have their eligibility status confirmed were considered to have unknown eligibility. In cases where resolution of a person's eligibility status was not achieved—that is, the telephone number provided did not allow the eligibility of the selected person to be determined—these response rates generally use an estimate of the rate at which telephone numbers ring into eligible persons to classify a fraction of these numbers of unknown disposition as eligible. Compared to the lower-bound, this approach increases the response rate calculation by not assuming that all unscreened numbers belonged to qualifying persons. In addition, some “adjusted” response rates assign cases to the denominator where the respondent was eligible but unable to complete the interview because of impairment or language difficulties.

\(^5\) As mentioned above in the pilot study discussion, all individuals were assumed to be eligible given they had a valid record in the Medicaid administrative data, unless RTI collected information on a call confirming they were ineligible.
One adjusted response rate, AAPOR’s response rate for mail and list telephone surveys, calculates the eligible persons by taking a proportion of the unresolved numbers and classifying them as eligible. Accordingly, the AAPOR response rate formula was used to measure the response rate across all sampled persons:

\[
RR3 = \frac{Completes}{Eligible + e_u \times Unknown},
\]

where

\[
e_u = \left( \frac{Eligible}{Eligible + Ineligible} \right)
\]

For this study, this calculation produced an AAPOR 3 response rate of 25.7% for the pre-expansion sample, 23.4% for the Group VIII sample, and 24.1% overall.

**Cooperation Rate**

The cooperation rate provides the percentage of respondents among those for which contact was made and eligibility was determined. The cooperation rate is a measure of interviewer performance and does not take into account sample quality (e.g., numbers that ring but are never answered) or a person’s behavior that prevents contact (e.g., privacy manager technology, screening calls using an answering machine). The formula is:

\[
Cooperation \ Rate = \frac{Completes}{Known \ Eligible}
\]

The upper-bound cooperation rate for this study was 76.6% for the pre-expansion sample, 75.8% for the Group VIII sample, and 76.1% overall.
IV. Biometric Screening

1. Biometric Screening

A subset of survey respondents was asked to participate in a biometric screening in order to supplement self-reported and clinical findings of consenting study members who have chronic conditions.

2. Biometric Screening Nurse Team

Data collection was conducted and managed by a team of experienced nurses affiliated with the Ohio State University Health Plan (OSUHP). A team of 15 nurses from OSUHP managed and performed the biometric screenings at locations across Ohio. Members of the nurse team were experienced registered nurses (RNs), skilled to conduct similar types of health screenings. This same team is responsible for conducting annual biometric screenings for all OSU employees.

3. Training

Nurses were skilled professionals knowledgeable with the setup and use of the diagnostic equipment used to collect the biometric measurements. Therefore, diagnostic equipment and biometric measurement training was not required. Training included project-specific administrative protocols and data quality procedures.

Project Training

An in-person project training was conducted in May 2016. Training focused on study-specific protocols and consistency when interacting with participants. Review and completion of forms, review of scripts, and biometric screening procedures were covered in detail. The Spanish biometric screening process was also reviewed in anticipation of a small number of Spanish-speaking participants.

Ongoing Training

Follow-up training was conducted as needed during the data collection period to ensure consistency in following administrative protocols and data quality procedures.

4. Field Period and Sessions

Recruitment of clinic locations included identifying potential biometric screening sites and securing their cooperation. The following section describes the process used to secure the biometric screening sites, and describes when and where the biometric screening sessions were conducted.

Session Scheduling

Biometric screening sites were located in 21 of the 88 Ohio counties due to resource and logistics constraints. A total of 32 sessions were scheduled across a 3-month period. Sessions were held on weekdays and primarily conducted in government-managed facilities (e.g., agriculture extension offices, local health departments, public libraries).

The first session was held on May 24 in Franklin County and the last session was held on August 19 in Mahoning County. In some larger metropolitan counties, multiple sessions were scheduled. In one county, biometric

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6 See Section 2.2 for a discussion of the rationale for selecting the 22 counties for biometric screening. Two counties, Mahoning and Trumbull, shared a site in Mahoning County, leading to a total of 21 sites.
screening sessions were held in two different locations to maximize participation. Table 16 lists all biometric screening session dates and county designations.

<table>
<thead>
<tr>
<th>Date</th>
<th>County</th>
<th>Date</th>
<th>County</th>
</tr>
</thead>
<tbody>
<tr>
<td>May-24</td>
<td>Franklin</td>
<td>Jul-12</td>
<td>Allen</td>
</tr>
<tr>
<td>May-25</td>
<td>Hocking</td>
<td>Jul-13</td>
<td>Lucas</td>
</tr>
<tr>
<td>May-26</td>
<td>Licking</td>
<td>Jul-15</td>
<td>Hamilton</td>
</tr>
<tr>
<td>May-31</td>
<td>Fairfield</td>
<td>Jul-18</td>
<td>Franklin</td>
</tr>
<tr>
<td>Jun-02</td>
<td>Marion</td>
<td>Jul-19</td>
<td>Wayne</td>
</tr>
<tr>
<td>Jun-07</td>
<td>Muskingum</td>
<td>Jul-20</td>
<td>Montgomery</td>
</tr>
<tr>
<td>Jun-10</td>
<td>Cuyahoga</td>
<td>Jul-25</td>
<td>Wood</td>
</tr>
<tr>
<td>Jun-14</td>
<td>Butler</td>
<td>Jul-26</td>
<td>Trumbull</td>
</tr>
<tr>
<td>Jun-16</td>
<td>Jackson</td>
<td>Jul-29</td>
<td>Cuyahoga</td>
</tr>
<tr>
<td>Jun-20</td>
<td>Franklin</td>
<td>Aug-01</td>
<td>Hamilton</td>
</tr>
<tr>
<td>Jun-21</td>
<td>Trumbull</td>
<td>Aug-02</td>
<td>Washington</td>
</tr>
<tr>
<td>Jun-28</td>
<td>Greene</td>
<td>Aug-03</td>
<td>Cuyahoga</td>
</tr>
<tr>
<td>Jun-30</td>
<td>Hamilton</td>
<td>Aug-08</td>
<td>Cuyahoga</td>
</tr>
<tr>
<td>Jul-05</td>
<td>Summit</td>
<td>Aug-10</td>
<td>Scioto</td>
</tr>
<tr>
<td>Jul-06</td>
<td>Gallia</td>
<td>Aug-12</td>
<td>Cuyahoga</td>
</tr>
<tr>
<td>Jul-08</td>
<td>Cuyahoga</td>
<td>Aug-19</td>
<td>Mahoning</td>
</tr>
</tbody>
</table>

5. Biometric Screening Protocol

During the CATI interview, a subset of survey respondents was asked to participate in a biometric screening (see Section 2.1 for sample selection criterion). If the survey respondent agreed, an appointment was set for them to complete the biometric screening in person. Participants were asked to bring contact information for their 2013 and 2015/2016 usual source of care (USOC) and personal identification to the screening appointment. Acceptable forms of identification included a Medicaid card, driver’s license, school ID, military ID, other photo ID, or recent utility bill with the participant’s name and address listed.

During the biometric screening, if eligible, participants were invited to participate in the MRA portion of the study (see Section 5).

Biometric Screening Process

The biometric screening focused on five biometric indicators of chronic disease risk: (1) body mass index (BMI); (2) blood pressure (BP); (3) pulse; (4) hemoglobin A1c; and (5) cholesterol. Biometric screening procedures included:

- checking the participant’s identity by examining their identification;
• obtaining informed consent for the biometric screening;
• collecting height, weight, BP, and pulse measurements;
• completing a blood spot collection including hemoglobin A1c, total cholesterol, high-density lipoprotein (HDL), and non-HDL measures;
• providing participants with a Biometric Results and Education Page that detailed their biometric measurements and explained what the measurements meant;
• confirming the USOC from the participant and obtaining consent for MRA (if eligible); and
• providing participants with a gift card incentive upon completion.

On average, biometric screenings took approximately 30 minutes.

Biometric measurements were collected with OSUHP diagnostic equipment, which included the Alere Afinion HbA1c used to screen for diabetes; Cholestech, which provided cholesterol count; a digital scale; a stadiometer; and a BP cuff.

In addition to the equipment, the nurse team had several hardcopy documents that were used for the biometric screening. These included:
• Biometric Session and Medical Abstraction Rosters (identified participants by session)
• Biometric Screening Informed Consent (see Appendix D)
• Medical Records Abstraction Informed Consent (see Appendix D)
• Biometric Screening Form (for recording measures taken) (see Appendix E)
• Biometric Screening and Medical Record Abstraction Incentive Receipts
• Biometric Results and Education Page (see Appendix G)
• Medicaid Provider Directory (see Section 5 for more information)

The biometric screening protocol appears in Appendix C, and the adverse event protocol is in Appendix F. To assess whether observed differences in the biometric screening between Group VIII enrollees and pre-expansion enrollees were due to demographic differences, a series of logistic regression models that predicted the likelihood of biometric risk indicators and adjusted for demographics were fit. These additional analyses can be found in Appendix N.

Spanish Language

Biometric screenings were conducted in both English and Spanish. Spanish language specialists served as translators, and all hard copy participant documents were available in both English and Spanish.

Incentives

Walmart gift cards were provided as incentives for the biometric screening and the MRA component. Participants received $100 for participating in the biometric screening and $50 for participating in MRA (if eligible).
6. **Data Quality**

Multiple steps were taken to ensure that all information obtained from the biometric screenings was of the utmost quality. These efforts ranged from onsite observations during the biometric screening sessions to a review of all hardcopy materials at multiple stages of the data collection process.

**Field Observations**

Field observations were conducted throughout the data collection period. Each observation consisted of an in-person presence during the biometric screening session to ensure that sessions were running as scheduled, and procedures and protocols were followed.

**Data Quality Review and Receipt of Hardcopy Materials**

All hardcopy forms collected during each session were reviewed for completeness and legibility. Once reviewed, all forms were securely stored. Data were then submitted to the RTI Sampling team for further review and analysis.

7. **Biometric Screening Participation Rates**

Throughout the data collection period, participation rates were closely monitored to ensure that the Ohio Medicaid Group VIII Assessment project met its goals not only for total number of completed biometric screenings, but also for completion rates that were acceptable across all counties and county types. The following section describes the rate in which eligible survey respondents participated in the biometric screening.

**Participant Participation Rates**

Overall, 67.6% of survey respondents who agreed to the biometric screening (n=886) attended a session and completed the screening (see Table 17). This included three Spanish-speaking participants who completed the biometric screening with the assistance of a translator (see Section 4.5). A total of 552 participants eligible to participate in the MRA chose to do so. Biometric screening participation rates varied by county, ranging from 100% to 50% (see Table 17). Participation was strongest in suburban counties and weakest in metropolitan counties; however, participation rates across the three types (i.e., metropolitan, suburban, and rural) were not drastically different (see Table 18). In terms of tenure in the Medicaid program, participation rates were higher for Group VIII enrollees than pre-expansion enrollees (see Table 19).

For one county where participation rates were low, RTI project staff reached out to respondents who initially refused to participate in the biometric screening or agreed and missed their scheduled appointment. Every effort was made to reschedule them for a later session. Ultimately, 27 participants who met this criteria were rescheduled for another appointment. Of those 27, 14 participants completed a biometric screening. In Tables 17, 18, and 19, these individuals are only included once in the “scheduled” column.
### Table 17. Biometric Screening Participation Rates by County

<table>
<thead>
<tr>
<th>County</th>
<th>Scheduled Participants</th>
<th>Completed Biometric Screenings</th>
<th>Participation Rate %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Allen</td>
<td>12</td>
<td>9</td>
<td>75.0</td>
</tr>
<tr>
<td>Butler</td>
<td>37</td>
<td>27</td>
<td>73.0</td>
</tr>
<tr>
<td>Cuyahoga</td>
<td>265</td>
<td>154</td>
<td>58.1</td>
</tr>
<tr>
<td>Fairfield</td>
<td>51</td>
<td>34</td>
<td>66.7</td>
</tr>
<tr>
<td>Franklin</td>
<td>137</td>
<td>95</td>
<td>69.3</td>
</tr>
<tr>
<td>Gallia</td>
<td>14</td>
<td>7</td>
<td>50.0</td>
</tr>
<tr>
<td>Greene</td>
<td>70</td>
<td>55</td>
<td>78.6</td>
</tr>
<tr>
<td>Hamilton</td>
<td>132</td>
<td>86</td>
<td>65.2</td>
</tr>
<tr>
<td>Hocking</td>
<td>4</td>
<td>3</td>
<td>75.0</td>
</tr>
<tr>
<td>Jackson</td>
<td>14</td>
<td>14</td>
<td>100.0</td>
</tr>
<tr>
<td>Licking</td>
<td>61</td>
<td>45</td>
<td>73.8</td>
</tr>
<tr>
<td>Lucas</td>
<td>74</td>
<td>49</td>
<td>66.2</td>
</tr>
<tr>
<td>Mahoning</td>
<td>32</td>
<td>22</td>
<td>68.8</td>
</tr>
<tr>
<td>Marion</td>
<td>31</td>
<td>25</td>
<td>80.6</td>
</tr>
<tr>
<td>Montgomery</td>
<td>82</td>
<td>53</td>
<td>64.6</td>
</tr>
<tr>
<td>Muskingum</td>
<td>31</td>
<td>23</td>
<td>74.2</td>
</tr>
<tr>
<td>Scioto</td>
<td>36</td>
<td>25</td>
<td>69.4</td>
</tr>
<tr>
<td>Summit</td>
<td>60</td>
<td>38</td>
<td>63.3</td>
</tr>
<tr>
<td>Trumbull</td>
<td>75</td>
<td>47</td>
<td>62.7</td>
</tr>
<tr>
<td>Washington</td>
<td>18</td>
<td>15</td>
<td>83.3</td>
</tr>
<tr>
<td>Wayne</td>
<td>32</td>
<td>24</td>
<td>75.0</td>
</tr>
<tr>
<td>Wood</td>
<td>42</td>
<td>36</td>
<td>85.7</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>1,310</strong></td>
<td><strong>886</strong></td>
<td><strong>67.6</strong></td>
</tr>
</tbody>
</table>

### Table 18. Biometric Screening Participation Rates by County Type

<table>
<thead>
<tr>
<th>Type</th>
<th>Scheduled Participants</th>
<th>Completed Participants</th>
<th>Participation Rate %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Metropolitan</td>
<td>831</td>
<td>533</td>
<td>64</td>
</tr>
<tr>
<td>Suburban</td>
<td>224</td>
<td>170</td>
<td>76</td>
</tr>
<tr>
<td>Rural</td>
<td>255</td>
<td>183</td>
<td>72</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>1,310</strong></td>
<td><strong>886</strong></td>
<td><strong>67.6</strong></td>
</tr>
</tbody>
</table>
Table 19. Biometric Screening Participation Rates by Group VIII and Pre-Expansion Enrollees

<table>
<thead>
<tr>
<th>Type</th>
<th>Scheduled Participants</th>
<th>Completed Participants</th>
<th>Participation Rate %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre-expansion</td>
<td>450</td>
<td>287</td>
<td>64</td>
</tr>
<tr>
<td>Group VIII</td>
<td>860</td>
<td>599</td>
<td>70</td>
</tr>
<tr>
<td>Total</td>
<td>1,310</td>
<td>886</td>
<td>67.6</td>
</tr>
</tbody>
</table>
V. Medical Record Abstraction

1. Medical Record Abstraction Process

During the biometric screening, participants signed an authorization form for RTI telephone specialists to contact the provider that they considered to be their usual source of care (USOC). Figure 3 describes the steps that the telephone specialist followed after gaining cooperation from the medical provider’s office. The medical records abstraction protocol is included in Appendix H.
Figure 3. Ohio Group VIII Medical Record Data Collection Case Flow
Field Period

The field period was July through December and included contacting medical providers, providing them with information about the study, determining how they would send medical records for the patients in the study, receiving and abstracting the records (Table 20).

<table>
<thead>
<tr>
<th>Data Collection Activity</th>
<th>Dates</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical Record—Telephone</td>
<td>July 1, 2016 to October 14, 2016</td>
</tr>
<tr>
<td>Medical Record—Abstraction of Records for Inclusion in the Statutory Report</td>
<td>July 29, 2016 to October 14, 2016</td>
</tr>
<tr>
<td>Medical Record—Abstraction of any Additional Records Received</td>
<td>October 15, 2016 to December 30, 2016</td>
</tr>
</tbody>
</table>

2. Training

Seven people were trained as record abstractors and four of those people were also trained as telephone specialists. In addition to the MRA task leader, another team member was trained on quality control assurance procedures. The staffing plans were designed to ensure that telephone specialists and abstractors were available and prepared to meet the projected workload. Members of RTI's current interviewer staff with experience working on the Medical Expenditure Panel Survey provider outreach component were recruited for both telephone and abstraction trainings. Each training class was led by project staff, with support from call center supervisors.

Telephone Specialist Training

Telephone specialist training was held for 1 day. Trainees received training materials including the agenda, a training manual, and a frequently asked questions sheet. An interactive approach was taken to ensure that all interviewers received ample instruction and practice with all data collection protocols and procedures. Training methods included lecture, demonstration of the provider contact and receipt software systems, round-robin exercises, and paired practice. This interactive approach allowed for questions to be asked during training and clarification points to be addressed.

Abstraction Training

Interactive abstraction training was held for 2 days. This approach allowed trainees to receive lecture material and the opportunity to practice abstracting information from records. Training focused heavily on the data elements that needed to be collected, as well as properly documenting the information and entering these items correctly into the system.

3. Data Collection Systems

The MRA component utilized a software-based case management system that provided the flexibility of making telephone calls and abstracting data for electronic data entry. The system was designed to support a diverse set of users ranging from data collectors, supervisors, data managers, analysts, and project managers. There were five core components to the system: sample management; data receipt; coding; data capture & quality control; and case management.
The control system allowed users to manage contact with medical providers and associated forms for call scheduling, contact information, appointment times, and event/status information. The web component provided the electronic forms for data entry.

**Contact Guides**
The contact guides were used by the telephone specialists to initiate contact with the provider. During initial contact, the telephone specialist introduced the Ohio Medicaid Group VIII Assessment study and identified the appropriate point of contact (POC), collected the contact information of the POC, and determined if the provider materials should be sent by fax or mail. Once the provider materials were sent, the telephone specialist used the contact guide to call back the POC to confirm receipt of materials and then determine when RTI could expect to receive the medical records.

**Medical Provider Materials**
Prior to receiving the medical records, the telephone specialists used the contact information collected from the provider during initial contact to send providers (by fax or mail) the following materials *(see Appendix J)*:

- Fax/mail cover sheet.
- Cover letter providing general information about the study from ODM.
- A confidential patient checklist of all participants who agreed to participate in the MRA component.
- An authorization form for each patient on the patient list.
- Document that addresses commonly asked questions about the Ohio Medicaid Group VIII Assessment study.
- Fax/mail return form to be used by the respondent so they could choose either to fax or mail their medical records to RTI for hardcopy abstraction. The fax return cover sheet contained preprinted information for faxing records to RTI. The mail return form included a preprinted mailing label for the provider to send records to RTI via mail.
- The authorization form packets also included an 800 number for them to call if they had questions.

**Event Forms**
Once records were received, the abstractor used event forms to collect data for each 2013, 2015, and 2016 dates of service. This information was abstracted onto an abstraction notes form and then keyed into the electronic event form. The abstraction notes form allowed the abstractor to confirm that they collected all abstraction data elements appropriately, and allowed supervisors to assess an abstractor’s work. The event forms were accessible to the telephone specialists and abstractors through the system.

**Data to Be Abstracted from Medical Records**
A large proportion of the individuals selected for the medical records component had one or more chronic conditions. Due to the limited sample size for the set of chronic conditions that received particular scrutiny (e.g., diabetes, heart disease, hypertension, depression, etc.), the study design anticipated that for analytic purposes, more aggregated analytical measures at the beneficiary level would be studied, where individuals would be pooled across diagnostic categories rather than analyzed separately by disease category. *Appendix I* is the
The hardcopy form that the abstractors used to capture this information. The information that was abstracted for all individuals, when available, was:

- Date of birth
- Temperature
- Dates of service
- Diagnoses
- Height
- Procedures
- Weight
- Medications
- BP
- Tests

**Medical Provider Payments**

Some medical providers required payment for the processing, printing, and/or shipping of medical records. Upon request or receipt of an invoice, providers were paid the requested amount for the participant's medical records.

**Data Quality**

The abstraction monitoring system was used to ensure that staff were abstracting all data elements accurately. Each abstractor had their first five events completely reviewed and re-abstracted by a monitor trained to re-abstract cases.

**4. Communication**

Regular communication with members of GRC, RTI, and the abstraction team were conducted by way of weekly and ad hoc project meetings and email correspondence.

**Project Meetings**

Weekly and ad hoc project meetings were conducted with members of GRC, RTI, and the abstraction team. Weekly meetings covered protocol changes, data collection activities, production, and data quality.

**5. Medical Provider Response Rates**

Throughout the data collection period, participation rates were closely monitored to ensure that the Ohio Medicaid Group VIII Assessment project met its goals not only for total number of medical providers contacted but also for the number of medical providers that sent back records or some form of communication. The following section describes the rate at which eligible medical providers participated in the medical records portion of this study.

**Medical Provider Participation Rates**

Group VIII enrollees who completed the biometric screening were asked to provide voluntary access to their medical records. Approximately 91% (545) of the Group VIII enrollee biometric screening participants signed at least one authorization form to give their medical providers permission to release their medical records for this study. Of the 480 medical provider groups determined to be associated with these Group VIII enrollees with signed authorization forms, 390 of these medical provider groups (81.3%) provided the requested medical records for at least one of their associated patients.

**Medical Records Received by Participant**

*Table 21* breaks down the three types of groups for which RTI received medical records. The first group comprised those participants who indicated during the biometric screening that they had the same provider in
2013 (pre-expansion) and 2015–2016 (post-expansion). The second group of participants indicated that they had different providers in 2013 and in 2015–2016. The third and final group comprised those participants who indicated that they had a different provider in 2013 and 2015–2016 but for whom RTI received a signed authorization form for only one of their medical providers. Overall, for the 545 Group VIII enrollee biometric screening participants who signed at least one authorization form, the medical records were abstracted for 430 of these enrollees (78.9%) for at least one of the eligible study time periods (2013 and 2015–2016). Medical records were obtained and abstracted for both time periods for 174 participants. These participants had sufficient data to conduct the analyses to assess changes in their medical care and health status over time.

<table>
<thead>
<tr>
<th>Patients Abstracted</th>
<th>2013–2016 (same provider) = 301 Participants</th>
<th>2013, 2015–2016 (multiple providers) = 141 Participants</th>
<th>2013, 2015–2016 (multiple providers) = 103 Participants</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Patients Abstracted</td>
<td>Patients Abstracted</td>
<td>Patients Abstracted</td>
</tr>
<tr>
<td>Both Periods Abstracted</td>
<td>114</td>
<td>Both Periods Abstracted</td>
<td>Both Periods Abstracted</td>
</tr>
<tr>
<td>2013 only</td>
<td>8</td>
<td>2013 only</td>
<td>2013 only</td>
</tr>
<tr>
<td>2015–2016 only</td>
<td>108</td>
<td>2015–2016 only</td>
<td>2015–2016 only</td>
</tr>
</tbody>
</table>

1 These individuals signed a form for a provider in 2013 and another form for a provider 2015–2016, and RTI received both forms.

2 These individuals indicated that they have multiple providers; however, RTI only received one signed form.
VI. Imputation and Weighting

1. Imputation

Imputation was conducted on survey variables needed for weighting as well as a few derived variables. All variables that were required in the weighting process had less than 5% missing data. Because of the low level of item nonresponse, a conditional stochastic imputation was conducted. Each variable imputed was conditioned on the age category and sex of the respondent. The following variables were imputed:

- Race
- Hispanic origin
- Marital status
- Education
- Chronic condition status
- Smoking status

2. Weighting

Telephone Survey

Base Weights. The telephone survey was selected using a stratified simple random sample. Table 22 lists the stratification characteristics. In all, there were 400 strata levels. The base weight was the inverse probability of selection within each stratum. In other words, if the probability of selection \( \pi_{ih} \) for person \( i \) in stratum \( h \) is \( \pi_{ih} = \frac{n_h}{N_h} \) where \( n_h \) is the sample size in stratum \( h \) and \( N_h \) is the population in stratum \( h \), then the design based weight (\( w_{ih1} \)) is the inverse probability of selection, which is defined as

\[
 w_{ih1} = \frac{1}{\pi_{ih}}
\]

Table 22. Sampling Strata for Telephone Survey

<table>
<thead>
<tr>
<th>Medicaid Status (Group VIII/Pre-expansion)</th>
<th>Age category (19–44 years/45–64 years)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Region(^1)</td>
<td>Chronic condition (yes/no)</td>
</tr>
<tr>
<td>Sex</td>
<td></td>
</tr>
</tbody>
</table>

\(^1\) Region has 25 levels based on the 22 counties used in the biometric screening plus one level for metropolitan, suburban, and rural county for the remaining 66 counties.

Nonresponse Adjustment. The nonresponse adjustment was conducted using an iterative raking model based on the sampling strata along with all possible interactions. The model contained the marginal effect plus two-way and three-way interactions with region (see Table 23). Given the large number of strata (400), some of which had very small respondent sample sizes, a full interaction model that would allow adjustments to take place within stratum was unlikely to fit. Therefore, collapsed strata (i.e., models with lower-level interactions) were used. Furthermore, a separate model was run for Group VIII and pre-expansion enrollees. For some interactions, the region variable was collapsed to allow model convergence (e.g., region may be collapsed to county type—metropolitan, suburban, and rural within the 22 biometric counties—for some interactions). The nonresponse weight (\( w_{ih2} \)) was equal to the design-based weight among respondents times the nonresponse adjustment. In other words,

\[
 w_{ih2} = w_{ih1} \times ADJ_{NRTi}
\]

where \( ADJ_{NRTi} \) is the telephone survey nonresponse adjustment for respondent \( i \).
**Coverage Adjustment.** The nonresponse adjusted weights were calibrated to the original Medicaid population totals (i.e., poststratification to known population totals to minimize coverage error). A separate calibration step was conducted for Group VIII and pre-expansion enrollees. The control totals were based on the Medicaid enrollment population used to select the sample—the March 2016 enrollment as provided by ODM.

The coverage adjusted weight \( w_{ih3} \) was computed as

\[
w_{ih3} = w_{ih2} \times ADJ_{PS_{Ti}}
\]

where \( ADJ_{PS_{Ti}} \) is the telephone survey calibration adjustment for respondent \( i \). **Table 24** presents the characteristics that were used in the calibration.

**Table 24. Main Effect and Interaction Characteristics Used in Calibration Model**

<table>
<thead>
<tr>
<th>Sex</th>
<th>Age category (19–44 years/45–64 years)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Region</td>
<td>Chronic condition (yes/no)</td>
</tr>
<tr>
<td>Region by sex</td>
<td>Region by age category</td>
</tr>
<tr>
<td>Region by chronic condition</td>
<td>Region by sex by age category</td>
</tr>
<tr>
<td>Region by sex by chronic condition</td>
<td>Region by age by chronic condition</td>
</tr>
<tr>
<td>Region by sex by age by chronic condition</td>
<td></td>
</tr>
</tbody>
</table>

**Unequal Weighting Effect.** **Table 25** details the unequal weighting effects (UWE) for the different stages of the weighting process.

**Table 25. UWE for the Telephone Survey by Group VIII and Pre-expansion Enrolled**

<table>
<thead>
<tr>
<th>Telephone Weights</th>
<th>Group VIII</th>
<th>Pre-expansion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Design-based</td>
<td>1.19</td>
<td>1.35</td>
</tr>
<tr>
<td>Nonresponse adjustment</td>
<td>1.22</td>
<td>1.29</td>
</tr>
<tr>
<td>Poststratification</td>
<td>1.28</td>
<td>1.34</td>
</tr>
</tbody>
</table>
Biometric Screening

**Nonresponse Adjustment.** For the biometric screening, a nonrespondent was defined as any eligible person in a biometric assigned replicate who did not participate in a biometric screening. This includes those who refused to participate in a screening and those who initially agreed to participate but failed to show up during the screening period for their Ohio county.

The biometric nonresponse adjustment used the telephone survey poststratified weight as the starting weight (i.e., $w_{ih3}$). An iterative raking model was used to assign the weight of nonresponding biometric screening individuals to the responding biometric screening individuals. The resulting biometric screening nonresponse weight ($w_{ih4}$) was defined as

$$w_{ih4} = w_{ih3} \times ADJ\_NR_{Bi}$$

where $ADJ\_NR_{Bi}$ is the biometric screening nonresponse adjustment for respondent $i$.

Because biometric screening response was dependent on telephone screening response, the demographic characteristics provided in the telephone survey—for which there was more information and more accuracy than in Medicaid administrative data—were used. **Table 26** presents the variables that were used in the nonresponse model.

**Table 26. Telephone Survey Characteristics Used in Biometric Screening Nonresponse Model**

<table>
<thead>
<tr>
<th>Sex</th>
<th>Age category (19-44 years/45-64 years)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Race/ethnicity</td>
<td>Marital status</td>
</tr>
<tr>
<td>Chronic condition</td>
<td>County</td>
</tr>
<tr>
<td>County type</td>
<td>County type by age category</td>
</tr>
<tr>
<td>County type by sex</td>
<td>County type by marital status</td>
</tr>
<tr>
<td>County type by race/ethnicity</td>
<td>County type by chronic condition</td>
</tr>
</tbody>
</table>

As with all survey data, some respondents did not provide responses to some of the characteristics listed in **Table 26**. However, a valid response was needed for each respondent for the nonresponse adjustment. In reviewing the telephone survey response, the level of missing data was less than 5% for all demographic characteristics. Because the level of missing data was so low, a simple stochastic imputation was used based on the distribution of respondents with valid responses prior to conducting the nonresponse adjustment.

**Coverage Adjustment.** Because only a subset of telephone survey replicates were used to select the biometric screening respondents, their telephone survey adjusted weights will only sum to a portion of the population in the 22 counties. Therefore, a coverage adjustment was conducted within each county to ensure that the weight totals equaled the population totals for each county. The coverage adjusted weight ($w_{ih5}$) was calculated as:

$$w_{ih5} = w_{ih4} \times ADJ\_PS_{Bi}$$

where $ADJ\_PS_{Bi}$ is the biometric screening calibration adjustment for respondent $i$. 

Coverage adjustment models were conducted by Group VIII and pre-expansion Medicaid status. Within each enrollment type, the weights were benchmarked to the frame population totals. **Table 27** presents the frame characteristics used in the calibration adjustment model.

**Table 27. Main Effect and Interaction Characteristics Used in Biometric Screening Calibration Model**

<table>
<thead>
<tr>
<th>Sex</th>
<th>Age category (19–44 years/45–64 years)</th>
</tr>
</thead>
<tbody>
<tr>
<td>County type</td>
<td>Chronic condition (yes/no)</td>
</tr>
<tr>
<td>County type by sex</td>
<td>County type by age category</td>
</tr>
<tr>
<td>County type by chronic condition</td>
<td>Sex by age category</td>
</tr>
<tr>
<td>Sex by chronic condition</td>
<td>Age by chronic condition</td>
</tr>
</tbody>
</table>

**Weight Extrapolation for the Entire Medicaid Population in Ohio.** While the 22 counties selected for the biometric screening were purposively chosen, they were selected in a manner that would: (1) maximize the coverage of the Medicaid population in the state and (2) be representative of Group VIII and pre-expansion Medicaid enrollees in accordance to the study criteria. As such, the biometric screening counties covered 68% of the entire Medicaid population in Ohio and included multiple counties in each county type (metropolitan, suburban, and rural). To verify how the 22 counties were representative of the entire Ohio Medicaid population, a new set of weights were created to ensure that the weight total matched the population total of the entire Medicaid population. This was done through the poststratification adjustment. The state-level biometric screening weight ($w_{i,h5-S}$) was computed as:

$$w_{i,h5-S} = w_{i,h5} \times ADJ_{PS_{BI-S}}$$

where $ADJ_{PS_{BI-S}}$ is the statewide biometric calibration adjustment for respondent $i$.

The poststratification adjustment ratio-adjusted the calibrated 22 county biometric screening weight to the state population totals controlling for the frame characteristics detailed in **Table 28**.

**Table 28. Main Effect and Interaction Characteristics Used in State-level Biometric Screening Calibration Model**

<table>
<thead>
<tr>
<th>Sex</th>
<th>Age category (19–44 years/45–64 years)</th>
</tr>
</thead>
<tbody>
<tr>
<td>County type</td>
<td>Chronic condition (yes/no)</td>
</tr>
<tr>
<td>County type by sex</td>
<td>County type by age category</td>
</tr>
<tr>
<td>County type by chronic condition</td>
<td>County type by sex by age category</td>
</tr>
<tr>
<td>County type by sex by chronic condition</td>
<td>County type by age by chronic condition</td>
</tr>
</tbody>
</table>

**Unequal Weighting Effect**

**Table 29** details the unequal weighting effects for the different stages of the weighting process.
Table 29. UWE for the Biometric Screening by Group VIII and Pre-expansion Enrolled

<table>
<thead>
<tr>
<th>Biometric Weights</th>
<th>Group VIII</th>
<th>Pre-Expansion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Design-based</td>
<td>1.32</td>
<td>1.40</td>
</tr>
<tr>
<td>Nonresponse adjustment</td>
<td>1.53</td>
<td>1.53</td>
</tr>
<tr>
<td>Poststratification</td>
<td>1.71</td>
<td>1.61</td>
</tr>
<tr>
<td>Statewide poststratification</td>
<td>1.53</td>
<td>1.76</td>
</tr>
</tbody>
</table>

3. Medical Records Abstraction

Due to the small sample sizes of the medical records abstraction, the data were deemed best used in unweighted analysis. Therefore, no weights were created for the medical records abstraction participants.
VII. Medicaid Administrative Data

Medicaid administrative data include Medicaid claims submitted by health care providers for services rendered to Medicaid enrollees and the eligibility records for those Medicaid enrollees.

Each claim was submitted in an electronic format either to the Medicaid health plan to which enrollees were assigned or directly to the ODM if the enrollees were in fee-for-service. The claim included information on the patient, the provider, the services that the patient received, the dates the services were delivered, as well as the amount billed and paid. There were different formats for submission of institutional (hospital) claims, pharmacy claims, and all professional claims.

Eligibility data included enrollee identifiers, demographics, eligibility categories, health plan identifiers, and the inclusive dates that enrollees were eligible.

Claims and eligibility data were extracted from the Medicaid Information Technology System (MITS) for this study, including dates of eligibility and dates of service from January 1, 2015 through December 31, 2015, the designated period of analysis for this study. The data were extracted for all records that appeared in MITS through August 31, 2016. The claims and eligibility data were matched against the population sampling frame for the study, including the Group VIII enrollees and the pre-expansion comparison group.

The utilization and HEDIS measures below were calculated for the entire population sampling frame of Group VIII (219,342) and pre-expansion eligible persons (477,518).

1. Health Care Utilization

The administrative data were used to calculate measures of health care utilization, including hospital admission, emergency department, primary care, and pharmacy utilization rates. Emergency department utilization was classified as emergent or nonemergent using the NYU ED Algorithm\(^7\) including preventive care and evidence-based care for chronic health conditions. Methods of analysis were derived from the National Center for Quality Assurance (NCQA) HEDIS. The HEDIS measures were calculated for the telephone survey sample as well as for the entire population of Group VIII (219,342) and pre-expansion enrollees (477,518) who were enrolled in Medicaid for at least 11 months in 2015.

2. HEDIS-based\(^8\) Measures

Medicaid administrative data were used to create measures of the provision of evidence-based preventive care and clinically effective-based care for chronic health conditions. Methods of analysis were derived from the NCQA HEDIS. The HEDIS measures are used as a standard to measure the effectiveness of all health plans in the United States, including Medicare, commercial, and Medicaid. The HEDIS measures include:

---

\(^7\) For further information on the NYU ED Algorithm, see [http://wagner.nyu.edu/faculty/billings/nyued-background](http://wagner.nyu.edu/faculty/billings/nyued-background)

\(^8\) The measures are HEDIS based, but not always exactly the HEDIS measures, as some of the measures require a lookback period of 1 to 2 years prior to the measurement year. For many of the Group VIII enrollees, 2015 was the first year of their Medicaid administrative data, so this study limited the lookback period to 2015 for the Group VIII enrollees and the pre-expansion comparison group.
- Adult BMI Assessment
- Breast Cancer Screening
- Cervical Cancer Screening
- Chlamydia screening in Women
- Colorectal Cancer Screening
- Comprehensive Diabetes Care
- Controlling High Blood Pressure
- Statin Therapy for Patients With Cardiovascular Disease
- Statin Therapy for Patients With Diabetes
- Antidepressant Medication Management

The summary figures for the HEDIS measures can be found in *Appendix N.*
VIII. Qualitative Interviews

1. Qualitative Coding of Open-Ended Group VIII Survey Question

The Group VIII Survey included an open-ended question (item K4) that was only administered to Group VIII enrollees. It read, “In your own words, describe in a sentence what getting Medicaid has meant to you.” A total of 5,051 individuals responded to this open-ended question. Interviewers administering the survey transcribed the responses verbatim.

Three researchers independently analyzed the responses for emerging themes to describe what Medicaid meant to them. After deriving these initial themes, each researcher analyzed 200 responses a week until the coding was completed on October 19, 2016.

In addition to these 200 responses, each researcher also independently coded the same 20 responses a week. These responses were used to compute weekly reliability statistics among the three researchers (using Krippendorf’s Alpha statistic). As a result of these reliability statistics, theme definitions were refined. Average alpha statistics were greater than 0.74, with 5 out of the 9 themes having alphas above 0.80 (two of the themes were so rare that there was never any variation during the reliability assessment). The theme “access to care” was completely redefined after approximately 1,600 responses had been coded. The original definition from which coders were working was deemed too ambiguous and thus had to be refined and clarified in order for coders to reliably code responses. Consequently, double-coding for this theme was performed for all 5,051 observations. Table 30 lists the themes, definitions, and percentage of quotes that referenced the specific theme. Qualitative coding instructions for question K4 can be found in Appendix M.

Table 30. Qualitative Coding of Group VIII Survey Question K4

<table>
<thead>
<tr>
<th>Code</th>
<th>Definition</th>
<th>% Quotes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Generally negative</td>
<td>General negative response about Medicaid or the government’s decision to fund Medicaid.</td>
<td>0.6</td>
</tr>
<tr>
<td>Generally positive</td>
<td>Only used if nothing else applies and the comment was positive about Medicaid or having insurance. For example, a general positive response about Medicaid or the government’s decision to fund Medicaid.</td>
<td>30.1</td>
</tr>
<tr>
<td>Don't know</td>
<td>Person did not know what to say.</td>
<td>0.3</td>
</tr>
<tr>
<td>Relief/less stress or worry</td>
<td>Response mentioned feeling relieved, secured, peace of mind, having less worry, less stress; feeling assured because of medical access.</td>
<td>27.9</td>
</tr>
<tr>
<td>Costs—positive</td>
<td>Response mentioned cost savings or that Medicaid will cover medical bills.</td>
<td>22.7</td>
</tr>
<tr>
<td>Access to care</td>
<td>Response explicitly mentioned the ability to access medical care or see a doctor. Coded yes if person talked about being able to go to the doctor, get medical care, go to the hospital, get prescriptions, and/or get dental or vision care.</td>
<td>31.3</td>
</tr>
<tr>
<td>Health</td>
<td>Mentioned the health benefits of having Medicaid, both physical and mental health. Talked about health improvements.</td>
<td>10.1</td>
</tr>
<tr>
<td>Code</td>
<td>Definition</td>
<td>% Quotes</td>
</tr>
<tr>
<td>----------------------</td>
<td>-----------------------------------------------------------------------------</td>
<td>----------</td>
</tr>
<tr>
<td>Knowledge</td>
<td>Response indicated that person knows more about health now that Medicaid is available. Or, the person said that he/she has a better understanding of health or health problems.</td>
<td>1.0</td>
</tr>
<tr>
<td>Cost/access—negative</td>
<td>Any negative mention of costs or limited access, costs still incurred; costs person had to pay for before Medicaid.</td>
<td>1.9</td>
</tr>
<tr>
<td>Medical debt</td>
<td>Any specific mention of medical debt.</td>
<td>1.3</td>
</tr>
<tr>
<td>No fine</td>
<td>Any mention of getting Medicaid to avoid receiving a fine.</td>
<td>1.2</td>
</tr>
</tbody>
</table>

2. **Focus Group Discussions**

*Participants*: Individuals who completed the Group VIII telephone survey (and possibly the biometric screening and medical record review) and resided in Cuyahoga County, Hamilton County, or Muskingum/Licking counties were invited to participate in a focus group discussion. Discussions occurred in downtown Cleveland (September 20, 2016), Zanesville (September 24, 2016), and Cincinnati (October 1, 2016). RTI provided GRC staff with a list of potentially eligible focus group participants, and GRC staff called these individuals until at least 12 had signed up for a focus group discussion. A total of 27 individuals participated in a focus group discussion.

*Procedures*: Prior to starting the focus group discussion, participants were asked to complete a short survey for basic demographic items and basic information about Medicaid enrollment (see Table 31). After the surveys were completed, the focus group discussion began. Two OSU researchers conducted all three focus group discussions (one GRC staff member was present for one focus group discussion). All discussions were audio-taped and participants received a $50 Walmart card.

**Table 31. Information Gathered by Survey Before Focus Groups Were Conducted**

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Statistic</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age (Mean [SD])</td>
<td>47.8 (14.0)</td>
</tr>
<tr>
<td>Gender</td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>9 (33.3%)</td>
</tr>
<tr>
<td>Female</td>
<td>18 (66.7%)</td>
</tr>
<tr>
<td>Household Size</td>
<td></td>
</tr>
<tr>
<td>Adults (Mean [SD])</td>
<td>1.6 (0.9)</td>
</tr>
<tr>
<td>Children (Mean [SD])</td>
<td>1.0 (1.4)</td>
</tr>
<tr>
<td>Marital Status</td>
<td></td>
</tr>
<tr>
<td>Single</td>
<td>14 (51.9%)</td>
</tr>
<tr>
<td>Married or living with partner</td>
<td>6 (22.2%)</td>
</tr>
<tr>
<td>Divorced/separated/widowed</td>
<td>7 (25.9%)</td>
</tr>
<tr>
<td>Characteristic</td>
<td>Statistic</td>
</tr>
<tr>
<td>----------------</td>
<td>-----------</td>
</tr>
<tr>
<td><strong>Educational Attainment</strong></td>
<td></td>
</tr>
<tr>
<td>Less than high school</td>
<td>4 (15.4%)</td>
</tr>
<tr>
<td>High school/GED</td>
<td>12 (46.2%)</td>
</tr>
<tr>
<td>More than high school</td>
<td>10 (38.5%)</td>
</tr>
<tr>
<td><strong>Time in Medicaid</strong></td>
<td></td>
</tr>
<tr>
<td>Less than 1 year</td>
<td>1 (3.85%)</td>
</tr>
<tr>
<td>1–4 years</td>
<td>20 (76.9%)</td>
</tr>
<tr>
<td>More than 4 years</td>
<td>5 (19.2%)</td>
</tr>
</tbody>
</table>

*Measures*: The semistructured script included questions about use of health care services, impact on financial situation, and impact on health.

The focus group script can be found in *Appendix L*.

### 3. Stakeholder Interviews

**Participants**: ODM identified key stakeholders to contact for the qualitative interviews. These stakeholders comprised provider groups, such as long-term care groups, pharmacy groups, and medical service groups. Ten individuals completed interviews.

**Procedures**: Stakeholders were contacted via e-mail and asked to participate in a 30-minute phone interview. Three Group VIII researchers (two from OSU and one from GRC) conducted the interviews. All interviews were audio-taped and participants were offered a $50 Walmart card for completing the interview.

**Measures**: The semistructured script included questions about how Medicaid expansion affected the organization, the participant’s job, and the demand and supply on providers. Respondents were also asked if there were any surprises related to Medicaid expansion, what they were hearing about expansion from providers and others outside of the organization, and what the benefits/challenges are to clients.

Stakeholder interview questions appear in *Appendix K*. 
Appendix A:
Group VIII Telephone Survey Instrument
Group VIII Telephone Survey Instrument

Prepared by
RTI International
3040 Cornwallis Road
Research Triangle Park, NC 27709
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Notes to Group VIII Methods reviewers:

E1. Throughout sections of the survey, you will see “since getting Medicaid coverage/in the last 2 years.” The first clause refers to Group VIII enrollees and the second clause refers to pre-expansion enrollees.
Section A: Introduction and Screener

A1. Hello, may I please speak with {FILL SAMPLE MEMBER NAME}?

1  YES
2  NOT AVAILABLE RIGHT NOW—SET CALL BACK
3  NO, DOES NOT LIVE HERE ANYMORE (TRY TO LOCATE)
4  NO→ REFUSED
5  LANGUAGE BARRIER—GO TO END SCREEN
6  SAMPLE MEMBER INCAPABLE (PHYSICALLY/MENTALLY INCAPABLE)—GO TO END SCREEN

(INTERVIEWER: IF ASKED WHY CALLING SAY:
I'm calling to speak to {FILL SAMPLE MEMBER NAME} about a survey that the Ohio Department of Medicaid is doing with people who are enrolled in Medicaid to find out about their experiences with that program. Is {FILL SAMPLE MEMBER NAME} available?)

(INTERVIEWER: IF THEY SAY SAMPLE MEMBER IS NOT INTERESTED SAY:
{FILL SAMPLE MEMBER NAME} will receive $20 for completing the survey.)

A2. (Hello, this is ________________). I'm calling on behalf of the Ohio Department of Medicaid, which is doing a survey to find out about your experience with Medicaid. This is an evaluation only. A couple of weeks ago, you should have received a letter about this survey. You will receive a $20 gift card for completing this survey. I am hoping you will have a few minutes to complete it now.

01 CONTINUE

A3. Are you currently covered by Medicaid? You may also know the program as {FILL SPECIFIC MANAGED CARE PLAN NAME}.

(IF NECESSARY: You may also know the program as Healthy Families or MBIWD.)

01 YES
02 NO—TERMINATE
98 DK—TERMINATE
99 REF—TERMINATE

A4. Before we begin, have I reached you on a cell phone or a landline phone?

01  CELL PHONE
02  LANDLINE PHONE

//IF A4 = 01//
A5. Are you driving or doing anything that requires your full attention right now?

01  YES
02  NO (GO TO A7)
03  NOT A CELL PHONE (GO TO A7)

A6. When would be a better time to call you?

(INTERVIEWER: IF RESPONDENT INDICATES THAT THEY ARE WILLING TO TALK NOW SAY:
   I´m sorry, but for your safety we´re not able to do the interview while you´re driving.
   When would be a better time to call you?)

01  SET CALL BACK

A7. Now, I would like to ask a few general questions about you and your experience with Medicaid. Before we start the survey, the Ohio Department of Medicaid would like me to tell you that the interview will last approximately 20 minutes, your participation is voluntary, you do not have to answer any question you do not want to, and everything you say will be kept confidential. If you choose not to participate in this survey, you will not be penalized or lose your Medicaid benefits. May we begin?

(INTERVIEWER: IF THE R SAYS NO, CLICK BREAK TO SET AN APPOINTMENT OR CODE A REFUSAL)

01  YES
02  NO
99  REF
Section B: Limited Demographic Information

These first few questions are about you.

B1. What is your gender?

(INTERVIWER: READ ANSWER OPTIONS IF NECESSARY)

01 MALE
02 FEMALE
97 OTHER
99 REFUSED

B2. Please tell me how old you were on your last birthday.

(IF NECESSARY: Your best guess is fine.)

RECORD AGE (RANGE 019-125)
998 DK (GO TO B3)
999 REFUSED (GO TO B3)


//IF B2=998,999//

B3. On your last birthday would you say that you were...

(IF NECESSARY: Your best guess is fine.)

01 19-24 years old
02 25-34 years old
03 35-44 years old
04 45-54 years old
05 55-64 years old
06 65 years or older

98 DK
99 REFUSED

//IF B3=6, 98, 99 –TERMINATE//

//DO NOT ASK IF COUNTY NAME IS MISSING//

B4. To confirm, do you live in <COUNTY NAME> county?

(IF NECESSARY: Is this the county you live in most of the time?)

01 YES
02 NO
98 DK
99 REF

//ASK IF B4=02, 98, 99 OR IF COUNTY NAME IS MISSING//

B5. In what county in the State of Ohio do you live?

(If NECESSARY: Which county do you live in most of the time?)

(Interviewer Note:
  - Find the county respondents name in the list and code accordingly.
  - If respondent says more than one county name, code only the one respondent lives in most of the time is most sure of.)
<table>
<thead>
<tr>
<th>County</th>
<th>Code</th>
<th>County</th>
<th>Code</th>
<th>County</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>ADAMS</td>
<td>001</td>
<td>HAMILTON</td>
<td>061</td>
<td>NOBLE</td>
<td>121</td>
</tr>
<tr>
<td>ALLEN</td>
<td>003</td>
<td>HANCOCK</td>
<td>063</td>
<td>OTTAWA</td>
<td>123</td>
</tr>
<tr>
<td>ASHLAND</td>
<td>005</td>
<td>HARDIN</td>
<td>065</td>
<td>PAULDING</td>
<td>125</td>
</tr>
<tr>
<td>ASHTABULA</td>
<td>007</td>
<td>HARRISON</td>
<td>067</td>
<td>PERRY</td>
<td>127</td>
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<tr>
<td>ATHENS</td>
<td>009</td>
<td>HENRY</td>
<td>069</td>
<td>PICKAWAY</td>
<td>129</td>
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<tr>
<td>AUGLAIZE</td>
<td>011</td>
<td>HIGHLAND</td>
<td>071</td>
<td>PIKE</td>
<td>131</td>
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<tr>
<td>BELMONT</td>
<td>013</td>
<td>HOCKING</td>
<td>073</td>
<td>PORTAGE</td>
<td>133</td>
</tr>
<tr>
<td>BROWN</td>
<td>015</td>
<td>HOLMES</td>
<td>075</td>
<td>PREBLE</td>
<td>135</td>
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<td>BUTLER</td>
<td>017</td>
<td>HURON</td>
<td>077</td>
<td>PUTNAM</td>
<td>137</td>
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<td>CARROLL</td>
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<td>JACKSON</td>
<td>079</td>
<td>RICHLAND</td>
<td>139</td>
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<tr>
<td>CHAMPAIGN</td>
<td>021</td>
<td>JEFFERSON</td>
<td>081</td>
<td>ROSS</td>
<td>141</td>
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<tr>
<td>CLARK</td>
<td>023</td>
<td>KNOX</td>
<td>083</td>
<td>SANDUSKY</td>
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<td>LAKE</td>
<td>085</td>
<td>SCIOTO</td>
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<td>087</td>
<td>SCIOCA</td>
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<td>LOGAN</td>
<td>091</td>
<td>STARK</td>
<td>151</td>
</tr>
<tr>
<td>CRAWFORD</td>
<td>033</td>
<td>LORAIN</td>
<td>093</td>
<td>SUMMIT</td>
<td>153</td>
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<tr>
<td>CUYAHOGA</td>
<td>035</td>
<td>LUCAS</td>
<td>095</td>
<td>TRUMBULL</td>
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<td>MADISON</td>
<td>097</td>
<td>TUSCARAWAS</td>
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<tr>
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<td>039</td>
<td>MAHONING</td>
<td>099</td>
<td>UNION</td>
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<td>DELAWARE</td>
<td>041</td>
<td>MARION</td>
<td>101</td>
<td>VAN WERT</td>
<td>161</td>
</tr>
<tr>
<td>ERIE</td>
<td>043</td>
<td>MEDINA</td>
<td>103</td>
<td>VINTON</td>
<td>163</td>
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<tr>
<td>FAIRFIELD</td>
<td>045</td>
<td>MEIGS</td>
<td>105</td>
<td>WARREN</td>
<td>165</td>
</tr>
<tr>
<td>FAYETTE</td>
<td>047</td>
<td>MERCER</td>
<td>107</td>
<td>WASHINGTON</td>
<td>167</td>
</tr>
<tr>
<td>FRANKLIN</td>
<td>049</td>
<td>MIAMI</td>
<td>109</td>
<td>WAYNE</td>
<td>169</td>
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<tr>
<td>FULTON</td>
<td>051</td>
<td>MONROE</td>
<td>111</td>
<td>WILLIAMS</td>
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<td>GALLIA</td>
<td>053</td>
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<td>WOOD</td>
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</tr>
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<td>055</td>
<td>MORGAN</td>
<td>115</td>
<td>WYANDOT</td>
<td>175</td>
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<tr>
<td>GREENE</td>
<td>057</td>
<td>MORROW</td>
<td>117</td>
<td></td>
<td></td>
</tr>
<tr>
<td>GUERNSEY</td>
<td>059</td>
<td>MUSKINGUM</td>
<td>119</td>
<td></td>
<td></td>
</tr>
<tr>
<td>998</td>
<td></td>
<td>DK</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>999</td>
<td></td>
<td>REFUSED</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Section C: Confirmation of Insurance Status and Prior Coverage

IF NEWLY ELIGIBLE
Throughout this survey I will be asking about your experiences before having Medicaid and while having Medicaid. When I say “Medicaid” I am referring to your current plan, {FILL SPECIFIC MANAGED CARE PLAN NAME}, and any previous Medicaid coverage you had just before this plan.

IF OLDLY ELIGIBLE
Throughout this survey I will be asking about your experiences while having Medicaid. When I say “Medicaid” I am referring to your current plan, {FILL SPECIFIC MANAGED CARE PLAN NAME}, and any previous Medicaid coverage you had just before this plan.

C1. How long have you had your Medicaid coverage? Would you say...

(IF NECESSARY: You should consider the total amount of time you have had Medicaid, including any managed care plans and not just how long you have had your current plan.

(IF NECESSARY: You should not count periods where you have lost Medicaid for one month or less.)

01 Less than one year (END SURVEY, TELL PARTICIPANT THAT SURVEY IS FOR PEOPLE WITH MEDICAID FOR ONE OR MORE YEARS)
02 One to two years
03 More than two to three years
04 More than three years
98 DK
99 REF

ASK OF ALL NEWLY ELIGIBLES//

C2. Just prior to your current Medicaid coverage, were you covered by any health insurance plan?

01 YES
02 NO
98 DK (GO TO D1)
99 REF (GO TO D1)

IF C2 = 1//

C3. Just prior to your current Medicaid coverage, were you covered by a health insurance plan obtained through an employer or union?

(IF NECESSARY:
• Either through your own or someone else’s employment.
• Include retiree coverage and COBRA.
• Do not include Medicare or Medicaid coverage.)

01 YES
C4. Why did your previous employer health insurance end? For each statement I read, please tell me yes or no.

- C4a. The employer stopped offering insurance.
- C4b. The employer’s health insurance cost too much.
- C4c. You thought Medicaid was a better option than the employer’s health insurance.
- C4d. You or a family member stopped working at the job that provided health insurance.
- C4e. You were no longer eligible for the employer’s health insurance.

DO NOT RANDOMIZE STATEMENT ORDER

01 Yes
02 No
98 DK
99 REF

C5. Just prior to your current Medicaid coverage, were you covered by any other insurance that you or your family paid for completely, including insurance purchased through the Ohio Health Care Exchange or a healthcare.gov insurance plan?

(IF NECESSARY: The Ohio Health Care Exchange and healthcare.gov are part of the new health care law with gold, silver, and bronze plans.)

01 YES
02 NO
98 DK
99 REF

C6. Just prior to your current Medicaid coverage, for how long did you have this insurance coverage?

(IF NECESSARY: Your best guess is fine.)

C6_VALUE

DK
REF
C6_UNITS

01 DAYS
02 WEEKS
03 MONTHS
04 YEARS
DK
REF

//IF C2=2//

C7. For how long were you uninsured?

(IF NECESSARY: Your best guess is fine.)

C7_VALUE

______________

DK
REF

C7_UNITS

01 DAYS
02 WEEKS
03 MONTHS
04 YEARS
DK
REF
Section D: Pathways to Medicaid Enrollment

//ONLY ASK IF NEWLY ELIGIBLE//

This next question is about how you enrolled in the Medicaid program.

D1. How did you sign up for Medicaid? Did you sign up...
   01 Online?
   02 At a county or government office?
   02 At a medical center or doctor’s office when you went there to get health care?
   03 Or some other way?
   98 DK
   99 REF

   (INTERVIEWER NOTE: IF RESPONDENT SAYS ‘NURSING HOME’ OR “HOSPITAL” THEN CODE AS ‘03’)
Section E: Health Status and Health Conditions

Now I am going to ask you about your health and certain medical conditions.

E1. In general, would you say that your health is excellent, very good, good, fair, or poor?
   01 EXCELLENT
   02 VERY GOOD
   03 GOOD
   04 FAIR
   05 POOR
   98 DK
   99 REF

E2. <Since getting Medicaid coverage/In the last 2 years>, would you say your health is better, worse, or about the same?
   01 BETTER
   02 WORSE
   03 ABOUT THE SAME
   98 DK
   99 REF

Hypertension

E3. Have you ever been told by a doctor or other health professional that you had hypertension, also called high blood pressure?

   (INTERVIEWER NOTE: IF RESPONDENT SAYS ‘BORDERLINE’, “PRE-HYPERTENSION” OR “HIGH NORMAL” THEN CODE AS ‘02’)

   01 YES
   02 NO
   98 DK
   99 REF

   //FOR NEWLY ELIGIBLE ONLY: ASK IF E3 = 1//

E4. Were you first told that you had hypertension or high blood pressure before or after you got your current Medicaid coverage?

   01 BEFORE
   02 AFTER
   98 DK
   99 REF
   //IF E3 = 1//
E5. Are you **now** taking any medicine prescribed by a doctor for your high blood pressure?

01 YES
02 NO
98 DK
99 REF

//IF E5 = 1//

E6. For about how long have you been taking medicine for your high blood pressure? Has it been...

01 Less than 1 year
02 1 year but less than 2 years
03 2 years but less than 5 years, or
04 5 years or more
98 DK
99 REF

//ONLY FOR NEWLY ELIGIBLES ASK IF E4 = 1//

E7. Since getting your Medicaid coverage, has managing your high blood pressure gotten easier, harder, or has it stayed the same compared to before you had Medicaid coverage?

01 EASIER
02 HARDER
03 STAYED THE SAME
98 DK
99 REF

**High Cholesterol**

E8. Have you **ever** been told by a doctor or other health professional that you had high cholesterol?

01 YES
02 NO
98 DK
99 REF

//FOR NEWLY ELIGIBLE ONLY ASK IF E8 = 1//

E9. Were you **first** told that you had high cholesterol before or after you got your current Medicaid coverage?

01 BEFORE
02 AFTER
98 DK
99 REF

//IF E8 = 1//
E10. Are you now taking any medicine prescribed by a doctor to help lower your cholesterol?

   01 YES
   02 NO
   98 DK
   99 REF
   //IF E10 = 1//

E11. For about how long have you been taking medicine to help lower your cholesterol? Has it been...

   01 Less than 1 year
   02 1 year but less than 2 years
   03 2 years but less than 5 years, or
   04 5 years or more
   98 DK
   99 REF

   //ONLY FOR NEWLY ELIGIBLES ASK IF E9=1//

E12. Since getting your Medicaid coverage, has managing your high cholesterol gotten easier, harder, or has it stayed the same compared to before you had Medicaid coverage?

   01 EASIER
   02 HARDER
   03 STAYED THE SAME
   98 DK
   99 REF

Diabetes

E13. [Other than during pregnancy], have you ever been told by a doctor or other health professional that you had diabetes or sugar diabetes?

   (DIABETES: dahy-uh-bee-teez)

   (INTERVIEWER NOTE: IF RESPONDENT SAYS ‘BORDERLINE’ OR “PRE-DIABETES” THEN CODE AS ’02’)

   01 YES
   02 NO
   98 DK
   99 REF
   //FOR NEWLY ELIGIBLE ONLY: ASK IF E13 = 1//

E14. Were you first told that you had diabetes or sugar diabetes before or after you got your current Medicaid coverage?

   01 BEFORE
   02 AFTER
E15. Are you now taking insulin or diabetic pills to lower your blood sugar?

   IF NECESSARY: Diabetic pills are sometimes called oral agents or oral hypoglycemic agents.

   01 YES
   02 NO
   98 DK
   99 REF

   //IF E15=1//

E16. For how long have you been taking insulin or diabetic pills to lower your blood sugar? Has it been...

   IF NECESSARY: What is the longest amount of time you have been taking either insulin or diabetic pills?

   01 Less than 1 year
   02 1 year but less than 2 years
   03 2 years but less than 5 years, or
   04 5 years or more
   98 DK
   99 REF

   //ONLY FOR NEWLY ELIGIBLES: ASK IF E14=1)

E17. Since getting your Medicaid coverage, has managing your diabetes gotten easier, harder, or has it stayed the same compared to before you had Medicaid coverage?

   01 EASIER
   02 HARDER
   03 STAYED THE SAME
   98 DK
   99 REF

Other Chronic Conditions

Has a doctor or other health professional ever told you that you had any of the following? For each, tell me Yes, No, or you’re not sure.

(INTERVIEWER: READ INTRODUCTION FIRST TIME AND THEN AS NEEDED)
(Has a doctor or other health professional ever told you that you had any of the following?)
E18. Coronary heart disease?

(CORONARY: KAWR-E-NEREE)

01 YES
02 NO
98 DK
99 REF

E19. A heart attack (also called a myocardial infarction)?

(MYOCARDIAL: mahy-uh-kahr-dee-uh-l)

(INFARCTION: in-fahrk-shuhn)

01 YES
02 NO
98 DK
99 REF

E20. Congestive heart failure?

(CONGESTIVE: KUN-JES-TIV)

01 YES
02 NO
98 DK
99 REF

E21. A stroke?

01 YES
02 NO
98 DK
99 REF

E22. Emphysema?

(EMPHYSEMA: em-fuh-see-muh)

01 YES
02 NO
98 DK
99 REF

E23. Chronic obstructive pulmonary disease, also called COPD?

01 YES
02 NO
98 DK
99 REF
E24. Chronic bronchitis?
(BRONCHITIS: brong-**kahy**-tis)

01 YES
02 NO
98 DK
99 REF

E25. Cancer?

01 YES
02 NO
98 DK
99 REF

//FOR NEWLY ELIGIBLE ONLY ASK IF E18 = 1//

E26. Were you **first** told that you had coronary heart disease before or after you got your current Medicaid coverage?

(CORONARY: KAWR-E-NEREE)

01 BEFORE
02 AFTER
98 DK
99 REF

//FOR NEWLY ELIGIBLE ONLY ASK IF E19 = 1//

E27. Were you **first** told that you had a heart attack or myocardial infarction before or after you got your current Medicaid coverage?

(MYOCARDIAL: mahy-uh-kahr-dee-uh-I)

(INFARCTION: in-fahrk-shuhn)

01 BEFORE
02 AFTER
98 DK
99 REF

//FOR NEWLY ELIGIBLE ONLY ASK IF E20 = 1//

E28. Were you **first** told that you had congestive heart failure before or after you got your current Medicaid coverage?

(CONGESTIVE: KUN-JES- TIV)
E29. Were you first told that you had a stroke before or after you got your current Medicaid coverage?

01 BEFORE
02 AFTER
98 DK
99 REF

//FOR NEWLY ELIGIBLE ONLY ASK IF E21 = 1/

E30. Were you first told that you had emphysema before or after you got your current Medicaid coverage?

(EMPHYSEMA: em-fuh-see-muh)

01 BEFORE
02 AFTER
98 DK
99 REF

//FOR NEWLY ELIGIBLE ONLY ASK IF E22 = 1/

E31. Were you first told that you had chronic obstructive pulmonary disease, also called COPD, before or after you got your current Medicaid coverage?

01 BEFORE
02 AFTER
98 DK
99 REF

//FOR NEWLY ELIGIBLE ONLY ASK IF E23 = 1/

E32. Were you first told that you had chronic bronchitis before or after you got your current Medicaid coverage?

(BRONCHITIS: brong-kahy-tis)

01 BEFORE
02 AFTER
98 DK
99 REF

//FOR NEWLY ELIGIBLE ONLY ASK IF E25 = 1//
E33. Were you **first** told that you had cancer before or after you got your current Medicaid coverage?

- 01 BEFORE
- 02 AFTER
- 98 DK
- 99 REF
Functional Status

E34. Now, thinking about your physical health, which includes physical illness and injury, for how many days, during the past 30 days did a physical health condition keep you from doing your work or other usual activities?

(INTERVIEWER: IF RESPONDENT SAYS "NO", PROBE FOR THE EXACT NUMBER OF DAYS.

IF THE RESPONDENT SAYS "NONE," ENTER 0.)

_______

DK

REF

E35. Now, thinking about your mental health, which includes stress, depression, and problems with emotions or substance abuse, for how many days during the past 30 days did a mental health condition or emotional problem keep you from doing your work or other usual activities?

(INTERVIEWER: IF RESPONDENT SAYS "NO", PROBE FOR THE EXACT NUMBER OF DAYS.

IF THE RESPONDENT SAYS "NONE," ENTER 0.)

_______

DK

REF
**Mental Health**

Over the last 14 days, how often have you been bothered by any of the following problems?

(INTERVIEWER: FOR FIRST QUESTION READ THE CATEGORIES OF RESPONSE AND IF NECESSARY ON SUBSEQUENT QUESTIONS).

**E36. Feeling nervous, anxious or on edge.**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>00</td>
<td>0 to 1 days</td>
</tr>
<tr>
<td>01</td>
<td>2 to 6 days</td>
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<tr>
<td>02</td>
<td>7 to 11 days</td>
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<tr>
<td>03</td>
<td>12 to 14 days</td>
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<td>98</td>
<td>DK</td>
</tr>
<tr>
<td>99</td>
<td>REF</td>
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</tbody>
</table>

**E37. Not being able to stop or control worrying.**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
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</thead>
<tbody>
<tr>
<td>00</td>
<td>0 to 1 days</td>
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<tr>
<td>01</td>
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<td>02</td>
<td>7 to 11 days</td>
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<td>12 to 14 days</td>
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<td>98</td>
<td>DK</td>
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<td>99</td>
<td>REF</td>
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</tbody>
</table>

**E38. Little interest or pleasure in doing things.**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
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<tbody>
<tr>
<td>00</td>
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<td>12 to 14 days</td>
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<td>98</td>
<td>DK</td>
</tr>
<tr>
<td>99</td>
<td>REF</td>
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</tbody>
</table>

**E39. Feeling down, depressed, or hopeless.**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>00</td>
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<td>2 to 6 days</td>
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<tr>
<td>02</td>
<td>7 to 11 days</td>
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<tr>
<td>03</td>
<td>12 to 14 days</td>
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<tr>
<td>98</td>
<td>DK</td>
</tr>
<tr>
<td>99</td>
<td>REF</td>
</tr>
</tbody>
</table>
Section F: Healthcare Utilization and Usual Source of Care

I would now like to ask about your use of health care services.

//ASK IF NEWLY ELIGIBLE//

F1. Since getting Medicaid coverage, have you been a patient in the hospital emergency room more often, less often, or about as often compared to before you had Medicaid coverage?

01 MORE OFTEN
02 LESS OFTEN
03 ABOUT AS OFTEN
98 DK
99 REF

(INTERVIEWER NOTE: IF RESPONDENT. IF A RESPONDENT SAYS “I NEVER GO THE EMERGENCY ROOM” OR “I’VE NEVER BEEN HOSPITALIZED” STATE “THE OPTION ‘ABOUT THE SAME’ CAN ALSO MEAN THAT YOU DID NOT GO BEFORE MEDICAID AND YOU HAVE NOT GONE SINCE GETTING MEDICAID COVERAGE.”)

//IF F1 = 2//

F2. What is the main reason you are going to the hospital emergency room less often? Is it because...

01 You now have a regular doctor you can go to
02 You now go to urgent care instead of the hospital emergency room
03 You are healthier now and no longer need to go as often
04 Or some other reason?
98 DK
99 REF

//IF F1 = 1//

F3. What is the main reason you are going to the hospital emergency room more often? Is it because...

01 You no longer have a regular doctor
02 You are sicker now than you used to be
04 You had an illness or injury that required immediate attention
05 You now have health insurance
03 Or some other reason?
98 DK
99 REF
//ASK OF NEWLY ELIGIBLES ONLY//
F4. For this next question, I want you to think about times you have been admitted to the hospital for overnight or longer. Since getting Medicaid coverage, have you been admitted to the hospital more often, less often, or about as often compared to before you had Medicaid coverage?

01 MORE OFTEN
02 LESS OFTEN
03 ABOUT AS OFTEN
98 DK
99 REF

(INTERVIEWER NOTE: IF RESPONDENT. IF A RESPONDENT SAYS “I NEVER GO THE EMERGENCY ROOM” OR “I’VE NEVER BEEN HOSPITALIZED” STATE “THE OPTION ‘ABOUT THE SAME’ CAN ALSO MEAN THAT YOU DID NOT GO BEFORE MEDICAID AND YOU HAVE NOT GONE SINCE GETTING MEDICAID COVERAGE.”)

//ASK OF EVERYONE//
F5. Is there one place that you usually go to when you are sick or you need advice about your health?

(IF NECESSARY: this can include an ER.)
(If necessary: We are interested in whether you have one place you usually go to seek medical care, not whether you have been there recently.)

01 YES
02 NO
03 YES, VOLUNTEERED THAT THERE IS MORE THAN ONE PLACE
98 DK
99 REFUSE

//IF F5=02, 98, 99//
F6. Just to be sure, is it that there is no place at all that you usually go to when you are sick or you need advice about your health, or is it that you go to more than one place?

01 NO PLACE AT ALL
02 MORE THAN ONE PLACE
98 DK
99 REFUSED
F7. What are the reasons you do not have a place where you usually go for care? For each statement I read, please tell me yes or no. You...

   F7a. Do not know where to go for care.
   F7b. Cannot find a provider who takes your Medicaid coverage.
   F7c. Think that health care providers are too expensive.
   F7d. Do not have a way to get to a provider's office.
   F7e. Seldom or never get sick.

01 YES
02 NO
98 DK
99 REFUSED

F8. Is this place where you usually go for care

   01 a doctor’s office or health center?
   02 a hospital emergency room?
   03 an urgent care center?
   04 or some other place?
   98 DK
   99 REFUSED

F9. What is the main reason you usually go to the hospital emergency room/urgent care center? Is it that you...

   01 Cannot afford to go elsewhere?
   02 Think hospital emergency rooms/urgent care centers are convenient?
   03 Think hospital emergency rooms/urgent care centers are the best place to get care?
   04 Have no regular doctor?
   05 Or have some other reason I have not mentioned?
   98 DK
   99 REFUSED

ASK OF EVERYONE/

F10. Just before getting Medicaid coverage/Two years ago, did you have one place where you usually went when you were sick or you needed advice about your health?

01 YES
02 NO
98 DK
99 REF
IF (F5 = 01, 03 or F6 = 02) AND F10 = 01/
F11. Has the place where you usually go to when you are sick or you need advice about your health changed since getting Medicaid coverage/within the last two years?

01 YES
02 NO
98 DK
99 REF

IF F11 = 01/
F12. Was the place where you usually went for care before getting Medicaid coverage/two years ago

01 a doctor’s office or health center?
02 a hospital emergency room?
03 an urgent care center?
04 or some other place?
98 DK
99 REFUSED

IF F6=01 AND F10 = 01/
F13. Was the place where you usually went for care before getting Medicaid coverage/two years ago

01 a doctor’s office or health center?
02 a hospital emergency room?
03 an urgent care center?
04 or some other place?
98 DK
99 REFUSED

IF (F5 = 01, 03 or F6 = 02/
F14. A personal doctor or nurse is a health professional who knows you well and is familiar with your health history. This can be a general doctor, a specialist doctor, a nurse practitioner, or a physician’s assistant. Do you have one or more persons you think of as your personal doctor or nurse?

(INTerviewer: IF R IS NOT CLEAR WHETHER THEY SEE ONE PERSON OR MORE THAN ONE PERSON ASK: Do you have one person or more than one person you think of as your personal doctor or nurse?)

01 YES, ONE PERSON
02 YES, MORE THAN ONE PERSON
03 NO
98 DK
99 REFUSED

IF F14 = 01, 02/
F15. In the past 12 months, have you seen your personal doctor or nurse?
01 YES
02 NO
98 DK
99 REFUSED

//IF NEWLY ELIGIBLE/
F16. Did you have a personal doctor or nurse just before getting Medicaid coverage?

01 YES
03 NO
98 DK
99 REFUSED
Section G: Healthcare Access and Unmet Need

Did any of the following things happen to you <since getting Medicaid coverage/in the last 2 years>?

G1. <Since getting Medicaid coverage/In the last 2 years>, did you have any major medical costs?

   (IF NECESSARY: Including co-pays)
   (IF R ASKS WHAT IS MEANT BY “MAJOR”, SAY: Whatever it means to you.)

   01 YES
   02 NO
   98 DK
   99 REFUSED

//ASK OF NEWLY ELIGIBLES ONLY//

G2. Since getting Medicaid coverage, have you had more or fewer major medical costs compared to before you had Medicaid coverage?

   (IF NECESSARY: Including co-pays)
   (IF R ASKS WHAT IS MEANT BY “MAJOR”, SAY: Whatever it means to you.)

   01 MORE MEDICAL COSTS
   02 FEWER MEDICAL COSTS
   03 R OFFERED THAT COSTS HAVE NOT CHANGED
   98 DK
   99 REFUSED

//IF G2 = 01//

G3. Why have you had more major medical costs? For each statement I read, please tell me yes or no.

   G3a. You could not find a health care provider who accepts your Medicaid coverage.
   G3b. Medicaid does not cover the care that you need.
   G3c. Your health got worse since you got Medicaid coverage.

RANDOMIZE G3a through G3c

   01 YES
   02 NO
   98 DK
   99 REFUSED
G4. <Since getting Medicaid coverage/In the last 2 years>, did you delay or avoid getting care?

(IF NECESSARY: “Care” means any health care, including prescription drugs.)

01 YES
02 NO
98 DK
99 REFUSED

//IF G4 = 01//

G5. Why did you delay or avoid getting care? For each statement I read, please tell me yes or no.

G5a. You thought it would cost too much.
G5b. You did not have transportation.
G5c. The provider was not available when you needed to go.
G5d. You could not find a provider who took your Medicaid coverage.

RANDOMIZE G5a through G5d.

01 YES
02 NO
98 DK
99 REF

//IF NEWLY ELIGIBLE//

G6. In the year before you got Medicaid coverage, did you delay or avoid getting care?

(IF NECESSARY: “Care” means any health care, including prescription drugs.)

01 YES
02 NO
98 DK
99 REFUSED

G7. <Since getting Medicaid coverage/In the last 2 years>, did you have any problems getting the care you needed?

(IF NECESSARY: “Care” means any health care, including prescription drugs.)

01 YES
02 NO
98 DK
G8. In the year before you got Medicaid coverage, did you have any problems getting the care you needed?

(IF NECESSARY: “Care” means any health care, including prescription drugs.)

01 YES
02 NO
98 DK
99 REFUSED

My next questions are about times when you may have needed healthcare but could not get it.

G9. *Since getting Medicaid coverage/In the last 2 years*, was there a time when you needed dental care but could not get it at that time?

01 YES
02 NO
98 DK
99 REFUSED

//IF G9 = 01//

G10. Why could you not get the dental care you needed? For each statement I read, please tell me yes or no.

G10a. You thought it would cost too much.
G10b. You did not have transportation.
G10c. The dentist was not available when you needed to go.
G10d. Medicaid would not pay for the dental care you needed.
G10e. You could not find a dentist who would take your Medicaid coverage.

RANDOMIZE G10a through G10e

01 YES
02 NO
98 DK
99 REFUSED
G11. <Since getting Medicaid coverage/In the last 2 years>, was there a time when you needed vision care or eye glasses but could not get it at that time?

01 YES
02 NO
98 DK
99 REFUSED

//IF G11 = 01/

G12. Why could you not get the vision care or eye glasses you needed? For each statement I read, please tell me yes or no.

G12a. You thought it would cost too much.
G12b. You did not have transportation.
G12c. The vision care provider was not available when you needed to go.
G12d. Medicaid would not pay for the vision care or eye glasses you needed.
G12e. You could not find a vision care provider who would take your Medicaid coverage.

RANDOMIZE G12a through G12e

01 YES
02 NO
98 DK
99 REFUSED

G13. <Since getting Medicaid coverage/In the last 2 years>, was there a time when you needed mental health care or counseling services but could not get it at that time?

01 YES
02 NO
98 DK
99 REFUSED

//IF G13 = 01/

G14. Why could you not get the mental health care or counseling services you needed? For each statement I read, please tell me yes or no.

G14a. You thought it would cost too much.
G14b. You did not have transportation.
G14c. You did not know where to go to get care.
G14d. The mental health care provider was not available when you needed to go.
G14e. Medicaid would not pay for the mental health care or counseling services you needed.
G14f. You could not find a mental health care provider who would take your Medicaid coverage.

RANDOMIZE G14a through G14f
G15. <Since getting Medicaid coverage/In the last 2 years>, have you not filled a prescription? This includes refills.

01 YES
02 NO
98 DK
99 REFUSED

//IF G15 = 01//

G16. Why did you not fill a prescription? For each statement I read, please tell me yes or no.

G16a. You thought it would cost too much.
G16b. You did not have transportation to the pharmacy.
G16c. Medicaid would not pay for the prescription.
G16d. You did not think you needed the prescription.
G16e. You do not like taking medicine.
G16f. You could not find a pharmacy that would take your Medicaid coverage.

RANDOMIZE G16a through G16f

01 YES
02 NO
98 DK
99 REFUSED

G17. <Since getting Medicaid coverage/In the last 2 years>, was there a time when you needed any other health care, such as a medical exam or medical supplies, but could not get it at that time?

01 YES
02 NO
98 DK
99 REFUSED

G18. For this next question, please think about all possible unmet health needs, including unmet dental, vision, mental health, prescription, medical exam, and medical supply needs. <Since getting Medicaid coverage/Compared to 2 years ago>, do you have fewer, more, or about the same number of unmet health needs?
01 FEWER
02 MORE
03 SAME
04 RESPONDENT VOLUNTEERED THAT THEY DIDN'T HAVE ANY UNMET HEALTH NEEDS
98 DK
99 REF

G19. <Since getting Medicaid coverage/Compared to 2 years ago>, is getting the medical care you need easier, harder, or has it stayed the same?

(IF NECESSARY: “Care” means any health care, including prescription drugs.)

01 EASIER
02 HARDER
03 STAYED THE SAME
98 DK
99 REFUSED

//IF G19 = 01//
G20. Why is getting the medical care you need easier? For each statement I read, please tell me yes or no.

G20a. You have fewer out-of-pocket costs.
G20b. It is easier to get a provider to see you.
G20c. You have more providers to choose from.
G20d. Your family situation has improved.

//ONLY ASK G20e OF THE NEWLY ELIGIBLES//
G20e. You now have insurance coverage or your Medicaid coverage is better than your prior insurance coverage.

RANDOMIZE G19a through G19e

01 YES
02 NO
98 DK
99 REFUSED

//IF G19 = 02//
G21. Why is getting the medical care you need harder? For each statement I read, please tell me yes or no.

G21a. You have more out-of-pocket costs.
G21b. It is harder to get a provider to see you.
G21c. You have fewer providers to choose from.
G21d. Your family situation has gotten worse.

//ONLY ASK G21e OF THE NEWLY ELIGIBLES//

G21e. Your Medicaid coverage is worse than your prior insurance coverage.

RANDOMIZE G20a through G20e

01 YES
02 NO
98 DK
99 REFUSED

G22. **Since getting Medicaid coverage/Compared to 2 years ago**, is getting the dental care you need easier, harder, or has it stayed the same?

01 EASIER
02 HARDER
03 STAYED THE SAME
04 R SAID CARE WAS NOT NEEDED
98 DK
99 REFUSED

G23. **Since getting Medicaid coverage/Compared to 2 years ago**, is getting the vision care or eye glasses you need easier, harder, or has it stayed the same?

01 EASIER
02 HARDER
03 STAYED THE SAME
04 R SAID CARE WAS NOT NEEDED
98 DK
99 REFUSED

G24. **Since getting Medicaid coverage/Compared to 2 years ago**, is getting the mental health care or counseling services you need easier, harder, or has it stayed the same?

01 EASIER
02 HARDER
03 STAYED THE SAME
04 R SAID CARE WAS NOT NEEDED
98 DK
99 REFUSED
G25. <b>Since getting Medicaid coverage/Compared to 2 years ago</b>, is filling the prescriptions you need easier, harder, or has it stayed the same?

01 EASIER
02 HARDER
03 STAYED THE SAME
04 R SAID CARE WAS NOT NEEDED
98 DK
99 REFUSED

G26. <b>Since getting Medicaid coverage/Compared to 2 years ago</b>, is getting any other health care you need, such as a medical exam or medical supplies, easier, harder, or has it stayed the same?

01 EASIER
02 HARDER
03 STAYED THE SAME
04 R SAID CARE WAS NOT NEEDED
98 DK
99 REFUSED
Section H: Employment Status

These next questions are about your current employment status.

H1. **Last week** did you have a job either full or part-time?

   (IF NECESSARY: Include any job from which you were temporarily absent.
   IF NECESSARY: The sponsors want to know whether it is difficult it is for people with Medicaid to find and keep jobs.)

   01 YES
   02 NO
   98 DK
   99 REFUSED

//IF H1 = 01//

H2. Does your employer or union offer a health insurance plan to any of its employees?

   (INTERVIEWER: IF RESPONDENT HAS MORE THAN ONE JOB, ASK RESPONDENT TO CONSIDER THE JOB WHERE (HE/SHE) WORKS THE MOST HOURS.
   INTERVIEWER: THIS QUESTION REFERS TO INSURANCE OFFERED BY THE EMPLOYER, NOT NECESSARILY INSURANCE THE RESPONDENT HAS.)

   01 YES
   02 NO
   98 DK
   99 REFUSED

//IF H2 = 01//

H3. Are you currently eligible to participate in your employer or union health plan?

   (INTERVIEWER: IF RESPONDENT STATES THAT THEY ARE IN A WAITING PERIOD, THEY ARE NOT CURRENTLY ELIGIBLE.
   INTERVIEWER: IF RESPONDENT HAS MORE THAN ONE JOB, ASK RESPONDENT TO CONSIDER THE JOB WHERE (HE/SHE) WORKS THE MOST HOURS.)

   01 YES
   02 NO
   98 DK
A-38 Ohio Medicaid Group VIII Assessment Methodology

99 REFUSED

//IF NEWLY ELIGIBLE AND H1 = 01//

H4. Did getting Medicaid coverage make it easier for you to get a job or continue working?

01 YES
02 NO
98 DK
99 REFUSED

//IF H1 = 02//

H5. When did you last work at a job or business? Was it...

01 Within the last 12 months
02 More than 12 months ago, or
03 Or you have never worked
98 DK
99 REF

//IF H1 = 02//

H6. Do you have a disability that prevents you from accepting any kind of work during the next six months?

01 YES
02 NO
98 DK
99 REFUSED

H7. Are you currently looking for work?

01 YES
02 NO
98 DK
99 REFUSED

//ASK OF NEWLY ELIGIBLE ONLY: IF H1 = 02 & H7=1//

H8. Does having Medicaid coverage make it easier or harder to look for work?

01 EASIER
02 HARDER
98 DK
99 REFUSED
//IF H1 = 01//

H9. Altogether, how many jobs or businesses do you currently have?

01 1 JOB  
02 2-3 JOBS  
03 4 OR MORE JOBS  
98 DK  
99 REF

//IF H1 = 01//

H10. Do you usually work 35 hours or more per week <at your job/at all your jobs combined>?

01 YES  
02 NO  
03 R SAID THAT HOURS VARY  
98 DK  
99 REF

//IF H10 = 02 or 03 //

H11. Do you want to work a full time work week of 35 hours or more per week?

01 YES  
02 NO  
03 REGULAR HOURS ARE FULL TIME  
98 DK  
99 REF

//IF H10 = 02 or 03 AND H11 ne 03//

H12. Some people work part time because they cannot find full time work or because business is poor. Others work part time because of family obligations or other personal reasons. I am going to read several reasons why you may be working part time. For each, please tell me yes or no.

H10a. You could only find part-time work  
H10b. You are caring for a family member  
H10c. You have health or other limitations  
H10d. You are going to school  
H10e. You are concerned you will no longer qualify for your Medicaid coverage or other benefits if you work full time  
H10f. You only want to work part time

RANDOMIZE H10a through H10f
<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>01</td>
<td>YES</td>
</tr>
<tr>
<td>02</td>
<td>NO</td>
</tr>
<tr>
<td>98</td>
<td>DK</td>
</tr>
<tr>
<td>99</td>
<td>REFUSED</td>
</tr>
</tbody>
</table>
Section I: Financial Hardship

These next questions are about your financial situation.

I1. <Since getting Medicaid coverage/In the last 2 years>, has your financial situation been getting better, worse, or has it stayed the same?

01 BETTER
02 WORSE
03 STAYED THE SAME
98 DK
99 REFFUSED

I2.

//QUESTION STEM FOR NEWLY ELIGIBLES//

I want you to consider your financial situation now compared to your financial situation before you had Medicaid. For each question please say yes or no. Since getting Medicaid coverage, is it easier to...

//QUESTION STEM FOR OLDLY ELIGIBLES//

I want you to consider your financial situation over the last 2 years. For each question please say yes or no. In the last 2 years, is it easier to...

I2a. Buy food for your family or household?
I2b. Pay your rent or mortgage?
I2c. Pay off any debt that you had <before getting Medicaid>?

RANDOMIZE I2a THROUGH I2c

01 YES
02 NO
03 RESPONDENT SAID THEY DID NOT HAVE THIS
98 DK
99 REF

These next few questions are about medical debt. Medical debt includes unpaid hospital bills, doctor bills, or any other bills that you acquired while getting medical care.

//ASK OF NEWLY ELIGIBLE//

I3. Before getting Medicaid coverage, did you acquire any medical debt?
(IF NECESSARY: Medical debt includes unpaid hospital bills, doctor bills, or any other bills that you acquired while getting medical care.)

01 YES
02 NO
98 DK
99 REFUSED

//IF I3 = 01//

I4. Are you still paying off your medical debt?

01 YES
02 NO
98 DK
99 REFUSED

//IF I4 = 01//

I5. About how much medical debt do you still owe? Your best guess is fine.

___ENTER DOLLAR AMOUNT
DK
REFUSED

//ASK IF I5=DK OR REFUSED//

I6. Which category best represents the total amount of medical debt that you still owe?

01 Less than $1,000
02 $1,000 to $10,000
03 More than $10,000 to $30,000, or
04 More than $30,000
98 DK
99 REF

//IF I3 = 01//

I7. For this next set of items, I want you to think about the medical debt you acquired before getting Medicaid coverage. Did you ever do any of the following or have any of the following happened as a result of the unpaid medical bills or medical debt you acquired before getting Medicaid coverage? For each statement I read, please tell me yes or no.

I7a. Borrowed money from friends or relatives.
I7b. Taken a loan of any kind.
I7c. Filed for or taken bankruptcy.
I7d. Fallen behind in paying bills.
I7e. Had a creditor call or come to see you to demand payment.
I7f. Had your wages attached or garnisheed by a creditor.

RANDOMIZE I7a THROUGH I7f

01 YES
02 NO
98 DK
99 REF

I8. <Since getting Medicaid coverage/in the last 2 years>, have you acquired medical debt?

(IF NECESSARY: Medical debt includes unpaid hospital bills, doctor bills, or any other bills that you acquired while getting medical care.)

01 YES
02 NO
98 DK
99 REFUSED

//IF I8 = 01/

I9. About how much medical debt have you acquired <since getting Medicaid coverage/in the last 2 years>?
Your best guess is fine.

___ENTER DOLLAR AMOUNT
DK
REFUSED

//ASK IF I9=DK OR REFUSED//

I10. Which category best represents the total amount of medical debt that you have acquired <since getting Medicaid coverage/in the last 2 years>?

01 Less than $500
02 $500 to $1,000
03 More than $1,000 to $5,000, or
04 More than $5,000
98 DK
99 REF
Section J: Health Behaviors and Additional Demographics

These next few questions are about your experiences with tobacco and alcohol.

J1. Have you smoked at least 100 cigarettes in your entire life?

(If NECESSARY: 5 packs contain 100 cigarettes. This does not include smoking pipes, cigars, and electronic cigarettes or e-cigarettes.)

01 YES
02 NO
98 DK
99 REFUSED

//IF J1 = 01//

J2. Do you smoke cigarettes every day, some days, or not at all?

01 EVERY DAY
02 SOME DAYS
03 NOT AT ALL
98 DK
99 REFUSED

//IF J2=3//

J3. How long has it been since you quit smoking cigarettes? Would you say...

01 Less than 1 year ago
02 1 year but less than 2 years ago
03 2 years but less than 5 years ago, or
04 5 years or more ago
98 DK
99 REF

J4. During the past 30 days, considering all types of alcoholic beverages, on how many days, if any, did you have <4 (WOMEN) / 5 (MEN)> or more drinks on an occasion?
(INTERVIEWER: IF RESPONDENT SAYS "NO", PROBE FOR THE EXACT NUMBER OF DAYS.

IF THE RESPONDENT SAYS "NONE," ENTER 0)

______(Number of days 0-30)
98   DK
99   REFUSED

The next few questions are for general classification purposes.

J5. How many children 18 years of age or younger live in your household?

(IF NECESSARY:
  o For purposes of this survey, "household" is defined differently from "family". Household refers to all of the people who are living in your house, apartment, or mobile home where we reached you.)

00   NO CHILDREN
01   1 CHILD
02   2 CHILDREN
03   3 CHILDREN
04   4 CHILDREN
05   5 CHILDREN
06   6 CHILDREN
07   7 CHILDREN
08   8 CHILDREN
09   9 CHILDREN
10   10 CHILDREN
11   11 CHILDREN
12   12 OR MORE CHILDREN
98   DK
99   REFUSED

J6. Are you...

01 married
02 divorced
03 widowed
04 separated
05 never married, or
06 a member of an unmarried couple?
98 DK
99 REFUSED

//IF J7 = 01 or 06//

J7. Is your spouse or partner currently employed?

01 YES
02 NO
98 DK
99 REFUSED

J8. What is the highest level of school you have completed or the highest degree received?

(INTERVIEWER NOTE: IF RESPONSE IS:
"HIGH SCHOOL", ASK “Does this mean “some high school” or “high school graduate”
“COLLEGE”, ASK “Does this mean “some college” or “four year college graduate”
“DEGREE”, ASK “what type of degree”)

01 LESS THAN FIRST GRADE
02 FIRST THROUGH 8TH GRADE
03 SOME HIGH SCHOOL, BUT NO DIPLOMA
04 HIGH SCHOOL GRADUATE OR EQUIVALENT (GED/VOCATIONAL/TRADE SCHOOL GRADUATE)
05 SOME COLLEGE, BUT NO DEGREE
06 ASSOCIATE DEGREE (1-2 YEAR OCCUPATIONAL, TECHNICAL OR ACADEMIC PROGRAM)
07 FOUR YEAR COLLEGE GRADUATE/BACHELOR’S DEGREE
08 ADVANCED DEGREE (INCLUDING MASTER’S, PROFESSIONAL DEGREE, OR DOCTORATE)
98 DK
99 REFUSED

J9. Are you of Hispanic or Latino origin?

01 YES
02 NO
98 DK
99 REFUSED
J10. Which one or more of the following would you say is your race? Are you White, Black or African American, Asian, Native American, American Indian, or Alaskan Native, Native Hawaiian or Pacific Islander, or some other race I have not mentioned?

01 WHITE
02 BLACK OR AFRICAN AMERICAN
03 ASIAN
04 NATIVE AMERICAN, AMERICAN INDIAN, OR ALASKAN NATIVE
05 NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER
06 HISPANIC, LATINO, SPANISH
97 OTHER (DO NOT COLLECT AS OPEN-ENDED)
98 DK
99 REFUSED
Section K: Importance of Medicaid

These last questions are about your experiences since getting Medicaid.

//ASK NEWLY ELIGIBLE ONLY//

K1. **Since getting Medicaid coverage** do you worry about paying medical bills less often, more often, or about as often compared to before you had Medicaid coverage?

   01 LESS  
   02 MORE  
   03 ABOUT THE SAME  
   98 DK  
   99 REF

K2. **Since getting Medicaid coverage** do you worry about getting sick and going to the doctor less often, more often, or about as often compared to before you had Medicaid coverage?

   01 LESS  
   02 MORE  
   03 ABOUT THE SAME  
   98 DK  
   99 REF

K3. **Since getting Medicaid coverage** do you worry about getting injured and going to the doctor less often, more often, or about as often compared to before you had Medicaid coverage?

   01 LESS  
   02 MORE  
   03 ABOUT THE SAME  
   98 DK  
   99 REF

In your own words, describe in a sentence what getting Medicaid has meant to you.

OPEN-ENDED RESPONSE; INTERVIEWER SHOULD TYPE VERBATIM IF POSSIBLE
Section L: Final Script, Including Incentive and Recruitment for Biometric Screening

Thank you for answering our questions. We want to reassure you that your responses will be kept strictly confidential.

SKIP TO INCENT FOR THOSE NOT SELECTED FOR BIOMETRIC SCREENING/
ASK IF SELECTED FOR BIOMETRIC SCREENING/

Survey respondents are being asked to participate in a quick health assessment that will help us learn more about the current health status of those enrolled in Medicaid. You will receive $100 for your time. A registered nurse will check your blood pressure, height, and weight, and use a finger prick to measure your blood sugar and cholesterol. The visit will take no more than 30 minutes. If you are interested, we can schedule the assessment right now?

(IF NECESSARY: Your participation in the health assessment is completely voluntary. The information we gather is confidential and will be used only to learn about the health profiles of those in the Medicaid program. Your information will not be shared with anyone outside of the research team and you will get the results of your health assessment.)

(IF RELUCTANT: Do you have any questions or thoughts about participating in this health assessment? We can schedule the assessment right now and you will receive a reminder call from us prior to the appointment.)

01 YES
02 NO
03 NOT SURE (re-contact)

ASK IF YES, BIOMET=01/
We currently have dates and times available on ....
SELECT BIOMETTIME/
VERIFY TIME/

We want to thank you for agreeing to participate in the Ohio Medicaid Group VIII health assessment. Your appointment is scheduled on TIME/DATE at LOCATION. You are required to bring personal identification (ID) to this health assessment. This ID could be your Medicaid benefit card, an Ohio Driver’s License, a school ID, a military ID, another photo ID, or a recent utility bill with your name and address listed. You are also encouraged to bring with you the contact information for your primary health care provider or the place you usually go for health care services.

We would like to send you an e-mail reminder for your appointment. What is your e-mail address?
_INSERT EMAIL ADDRESS/

INTERVIEWER:
YOU ARE REQUIRED TO READ BACK THE EMAIL ADDRESS CHARACTER BY CHARACTER
IF R DOESN’T HAVE AN EMAIL ADDRESS, ENTER 96 NO EMAIL ADDRESS
To thank you for your participation in the survey, we would like to verify your address to send you a gift card for $20. The gift card may take 3 to 4 weeks to reach you.

I have your name and address as: READ AND SPELL NAME AND ADDRESS. CORRECT CHANGES AS NEEDED.

I would like to thank you again for your participation on this important project. Have a nice (day/evening).

(IF NECESSARY, If you would like to speak to someone about the survey please or if you have questions about your rights as a study participant please call RTI at 1-866-406-7333).
Appendix B: Group VIII Telephone Survey
Prenotification Letter
Dear <<Respondent Name>>:

Your name has been selected to participate in a survey by the Ohio Department of Medicaid that asks about your experiences with Medicaid. This important telephone survey is your opportunity to assist the Ohio Department of Medicaid to evaluate the State’s Medicaid program.

The Ohio State University and the survey company RTI International has been selected to help the Ohio Department of Medicaid conduct this study. In the coming week representatives of RTI will try to reach you by phone to give you an opportunity to share your experiences. Those who are eligible to participate in the study will receive a $20 gift card for doing so.

Your participation is very important because you are part of a scientific sample representing communities in the State of Ohio. The survey will ask a few general questions about you and your experiences with Medicaid. If you choose not to participate, you will not be penalized or lose your Medicaid benefits.

Thank you for your help and please be assured that we are not selling anything or asking for money. You can also call us toll-free at 866-406-7333 to update your contact information or ask any questions about the survey.

Sincerely,

Dr. Mary S. Applegate
Medical Director
The Ohio Department of Medicaid
50 West Town Street, Suite 400
Columbus, Ohio 43215
Estimado Participante de Encuesta,

La presente es para informarle, que el Departamento de Medicaid de Ohio está llevando a cabo una encuesta sobre la calidad del programa. Su nombre ha sido seleccionado al azar por Medicaid de Ohio, para participar en ésta importante encuesta. La encuesta hace preguntas sobre las experiencias que usted ha tenido con los cuidados y servicios proporcionados por Ohio Medicaid. Esta encuesta, es su oportunidad para ayudarle a Ohio Medicaid a mejorar los servicios que provee.

RTI internacional es la firma independiente que la cual está ayudándonos a conducir esta encuesta. La próxima semana, una persona de RTI lo llamará por teléfono para hacerle las preguntas relacionadas con la encuesta. Si usted es elegible y decide participar recibirá una tarjeta de compras por un valor de $20 dólares.

¡Su participación es muy importante para nosotros! Usted pertenece a un pequeño grupo, seleccionado entre todos los usuarios de Medicaid, por esta misma razón le pido que nos ayude. Sus respuestas serán confidenciales y solamente serán vistas por el equipo de investigación. Esta encuesta es voluntaria. Si usted decide no participar, no perderá ninguno de los beneficios ofrecidos por Medicaid.

Por favor, llame RTI al número gratuito 1-866-406-7333 para poner al día su información y para responder cualquier pregunta que usted tenga, relacionada con esta encuesta.

Gracias por su ayuda con esta importante encuesta.

Sinceramente,

Dr. Mary S. Applegate
Directora Médica
Departamento de Medicaid de Ohio
50 West Town Street, Suite 400
Columbus, Ohio 43215
Appendix C:
Group VIII Biometric Screening Protocol
Ohio Medicaid Group VIII Study - Data Collection Checklist

Roster Receipt

- Seven days prior to clinic session date, RTI will upload Clinic Session Roster and Medical Records Abstraction Roster to FTP site.
- OSUHP POC will be notified by RTI via email when rosters are uploaded to FTP site.
- OSUHP will download the rosters provided by RTI prior to clinic session date.

Data Quality Review

- As health screenings are completed, nurses will bring completed forms by participant to the OSUHP Clinic Session POC who will review all forms for completeness and legibility to ensure all issues are resolved while participant is present.
  - Each nurse will also complete an individual gift card transmittal form as they pay their assigned participants for completing the health screening. They will review this form at the end of the day for completeness and provide the form to the OSUHP POC.
- Clinic Session Roster completion (OSUHP Clinic Session POC)
  - Confirm roster is complete and participant’s status is indicated (Complete, No-show).
  - Confirm all forms marked as receipted on the Clinic Session Roster are present.
  - Paper clip documents together, by participant.
- Gift card transmittal form completion (OSUHP Clinic Session POC)
  - Complete the transmittal form, and confirm the number of cards distributed at the session matches the number of completed health screenings, and Medical Record Abstraction participants.
- Forms review, by OSUHP POC post-clinic session
  - Confirm per completed Clinic Session Roster that required forms are present, complete, and legible.
  - Confirm per Gift card Transmittal Form that gift card reconciliation is accurate for clinic session.
  - Resolve any discrepancies with OSUHP Clinic Session POC prior to shipping hard copy session materials to RTI.
- If Adverse Event Reports were submitted for session, review for completeness and retain original copy.
- OSUHP POC will copy the adverse event forms and ship a copy to RTI along with the clinic session materials. OSUHP will keep the originals.
Shipping Materials to RTI

- Once all steps above have been completed, place the completed Clinic Session Roster and gift card transmittal form in the clinic session envelope.

- Retain yellow copies of forms that were duplicates and place originals in clinic session envelope (paper clipped by participant) and seal. Complete the clinic session label on envelope (if not already done).

- Place sealed clinic session envelope in an RTI-provided FedEx Envelope. The FedEx envelope will have a pre-filled, pre-paid label already attached. Make a note of the FedEx tracking number.

- Arrange for FedEx pick-up or take it to a FedEx location.

- Ship all session envelopes together weekly, after last session of the week is completed.

- Send an email to RTI regarding shipment - include the Clinic Session ID numbers of sessions included in the package, along with the FedEx tracking number and ship date. Include the following RTI Staff on the email:
  
  - Amy Kowalski - akowalski@rti.org
  - Edrina Burnette - eburnette@rti.org
  - Mallory Grammar - mgrammar@rti.org
  - Milton Cahoon - mcahoon@rti.org
Appendix D:
Group VIII Medical Records Authorization Informed Consent & Authorization Forms
Consent to Be Part of a Research Project

We are inviting you to take part in a research project. This consent form will help you decide if you want to be in the study. Please read this form carefully, and ask study staff to explain anything you do not understand. You will have a chance to ask questions before you decide whether to be in the study.

Description and Purpose of the Ohio Medicaid Group VIII Study (Ohio Group VIII): The Ohio Group VIII will study Medicaid quality, Medicaid Health Homes, and how the Affordable Care Act might change how Medicaid is used.

The study is being conducted by the Ohio State University Medical Center and nurses at the Ohio State University Health Plan. RTI International is a research organization that will help with the health screenings. The screenings include a short physical health screening and blood spot collection.

Health Screening:

- **Screening.** A nurse will conduct a short (10 to 15 minute) health screening. The nurse will measure your height, weight, and blood pressure. You might be asked to remove certain pieces of clothing, like a jacket or shoes, to make it easier for the nurse to give you the health screening. After the health screening, the nurse will tell you what your measurements are.

- **Blood spot.** A nurse will take a small blood sample from one of your fingers. The nurse will place a few drops of blood into a machine for testing. It will take 3 to 5 minutes for the machine to run the tests. The blood will be tested for blood sugar and certain types of fats that are in the blood. The nurse will tell you your test results after the tests are done.

Award for being in the Study: It will cost you no money to be in the Ohio Group VIII study. We will give you a $100 Walmart gift card for completing the health screening. It is recommended that you not use the gift card for the purchase of alcohol, tobacco, firearms or ammunition.

You Are Free to Decide: Your decision to be a part of the Ohio Group VIII is up to you. You can refuse any part of the health screening. You can change your mind and quit the study at any time.

Your Privacy Is Protected: We will keep your health screening results private. We will not report your name, or any other information that says who you are (address or other personal information), to anyone outside our organization. The people in charge of this study are committed to protecting your privacy, and have signed a pledge that they will never give your test results to any other organization. The people doing the research will store your test results in very secure computer files. Only certain people with secret passwords can see this information. All paper forms will be handled very carefully, and will be destroyed at the end of the study period.

Benefits and Risks:

You will be helping us in our health research if you agree to be a part of our study. You can refuse to be in the study. If you do not want to be in the study, you will never lose any of your rights to receive healthcare under your Medicaid plan. While there is a very small chance for loss of personal information, this is highly unlikely to happen because we keep your information safe. The blood test is very safe, but it could cause a small bruise on your finger. You can tell us if you do not wish to have any part of the health screening, and you may take a break at any time.

Further Questions: If you have any questions about the research now or in the future, or about your rights as part of this study, you can contact the project's toll-free phone number at 1-866-406-7333.

My Consent: I read this Ohio Group VIII consent form (or the form has been read to me) and I understand it. I know that I can help the study by being a part of it. I also understand that there are some very small risks in being part of the study. All my questions have been answered. I know that any future questions that I may have will also be answered. I freely agree to be part of the Ohio Group VIII. I understand that by signing, I am not giving up any of my legal rights. I will be given a copy of this statement.

I have signed below to show that I agree to be part of the Ohio Group VIII Health Screening.

---

Printed Name of Participant | Signature of Participant | Date
---

Printed Name of Nurse | Signature of Nurse | Date
AUTHORIZATION FOR THE RELEASE OF MEDICAL RECORDS FOR THE
OHIO MEDICAID GROUP VIII STUDY
CASE ID: XXXXXXXX-X

Patient Name: ____________________________________________________________

Date of Birth: _______ / _______ / _______

Other Names Under Which Records May be Filed (ex: maiden name, surname, etc.):
____________________________________________________________________
____________________________________________________________________
____________________________________________________________________

I agree to be in the Ohio Medicaid Group VIII Study. I allow you, my doctor or clinic, to give the study the health records they ask for. Ohio State University Medical Center (OSUMC) and RTI International are doing this study. They will need medical records about all health services that I received from you from January 1, 2013 through September 30, 2016. This includes care from any staff (such as doctors or nurses).

I understand that the Health Insurance Portability and Accountability Act of 1996 (HIPAA) keeps my health records private. My records can only be given out if I agree to it. I freely signed this form (or copy of this form) to allow you to share my health records. I also understand that I will always be able to get the health care that I need under Medicaid, even if I do not sign this form.

I agree that my records will only be used for this study. After my records are given to the study, I know that they will no longer be covered under HIPAA, but will be covered by the Public Health Service Act. The Public Health Service Act says that you cannot let anyone know who I am, unless I agree to it. My name, social security number, or other personal data must be kept safe by all study staff. Also, the study cannot give out the names of the doctor or clinic who gave me medical care, unless they agree to it.

The study can use information I have given in the survey to help you put together my health records. I know that I can change my mind at any time. If I change my mind about being part of the study, I will call or write a study staff member to let them know I changed my mind. I understand that I cannot ask you to take back any records that you already gave to the study before I changed my mind about being part of it. This form will be good for 30 months from the date I sign it.

Medical Provider and/or Medical Group Name:
____________________________________________________
_____________________________________________________________________________________________

Street Address: _____________________________

Suite: _____________________________

City: _____________________________ State: _______ Zip: ____________

Telephone: _______ _______ - _______ (For Internal Use Only) Records to be Located

Area Code

Patient’s Signature _____________________________ Date Signed ____________

2013

2013-2016

2015-2016
# Biometric Screening Form

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<tr>
<th>Component</th>
<th>Reading</th>
<th>Notes</th>
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<td>Self-Reported</td>
</tr>
<tr>
<td>Weight (to nearest .1 kg)</td>
<td>☐</td>
<td>Self-Reported</td>
</tr>
<tr>
<td>1st Pulse (beats/min.)</td>
<td></td>
<td></td>
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<tr>
<td>1st Blood Pressure (Systolic/Diastolic)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2nd Pulse (beats/min.)</td>
<td></td>
<td></td>
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<tr>
<td>2nd Blood Pressure (Systolic/Diastolic)</td>
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<td></td>
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Write “REF” in the Reading column if the measure was refused. Write “UTC” if unable to capture.

## Finger Stick Results:

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<td></td>
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<tr>
<td>Non-HDL</td>
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Write “REF” in the Reading column if the measure was refused. Write “UTC” if unable to capture.

## Summary:

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<th>Complete</th>
<th>Refused</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health Screening</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Blood Tests</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical Records Abstraction</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Note. Place an X in the appropriate column for each component.
Appendix F:
Group VIII Biometric Screening Adverse Event Protocol
## 2016 Ohio Medicaid (Group VIII) Adverse Event Protocol

### Screening for High Blood Pressure

<table>
<thead>
<tr>
<th>Action</th>
<th>Systolic BP &gt; 180</th>
<th>Diastolic BP &gt; 110</th>
</tr>
</thead>
<tbody>
<tr>
<td>With symptoms such as chest pain, slurred speech, mentation changes, visual changes, facial drooping, headache</td>
<td><strong>Emergent</strong> - Take BP 2x.</td>
<td></td>
</tr>
<tr>
<td>Asymptomatic</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Action**

- Call 911 or to ED for immediate care
- Refer to Urgent Care or PCP for same day appointment. Participant to call PCP first and call Urgent Care if PCP can’t see them on the same day

| Abnormal^ | Systolic ≥ 140 | Diastolic ≥ 90 |
|-----------|----------------|
| Current symptoms such as mentation changes, visual changes, or headache and BP 160-179 / 100-109 |  |
| Asymptomatic |

**Action**

- Same Day Urgent Care or PCP for same day appointment. ED if necessary due to emergent symptoms
- Recommend follow-up with PCP in 1-2 weeks

**Normal**

- Systolic BP < 140
- SBP < 150 if age ≥ 60
- Diastolic BP < 90

**Action**

- Recommend yearly BP check

### Screening for Type 2 Diabetes Mellitus

<table>
<thead>
<tr>
<th>Action</th>
<th>Diabetes (diagnosed or potential new diagnosis)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hgb A1c ≥ 6.5%</td>
<td>Symptomatic</td>
</tr>
</tbody>
</table>

**Action**

- Call 911/refer to ED/Urgent Care/PCP - symptoms drive urgency.
- Recommend follow-up with PCP in 1-2 weeks

<table>
<thead>
<tr>
<th>Abnormal (Pre-Diabetes 5.7% - 6.4%)</th>
<th>Hgb A1c ≥ 5.7%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Asymptomatic</td>
<td></td>
</tr>
</tbody>
</table>

**Action**

- Recommend follow-up with PCP in 1-2 weeks

<table>
<thead>
<tr>
<th>Normal</th>
<th>HgbA1c &lt; 5.7%</th>
</tr>
</thead>
</table>

**Action**

- Recommend screening every 5 years

### Screening for Obesity

<table>
<thead>
<tr>
<th>Action</th>
<th>Abnormal (Overweight/Obesity)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Obese: BMI ≥ 30.0 kg/m²</td>
<td>Recommend follow-up with PCP for annual PE</td>
</tr>
<tr>
<td>Overweight: BMI 25-29.9</td>
<td></td>
</tr>
</tbody>
</table>

**Normal**

- BMI 18.5 kg/m² - 24.9 kg/m²

**Action**

- Recommend follow-up with PCP for annual PE

### Screening for Lipid Disorders

<table>
<thead>
<tr>
<th>Action</th>
<th>Abnormal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-HDL &gt; 130 mg/dL</td>
<td>Recommend follow-up with PCP for Annual PE</td>
</tr>
<tr>
<td>HDL &lt; 40 mg/dL (men) or &lt; 50 mg/dL (women)</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Normal</th>
<th>Non-HDL &lt; 130 mg/dL</th>
</tr>
</thead>
</table>

**Action**

- Recommend screening every 5 years
Indicators of Possible Distress

The following table provides some guidance as to what behaviors might indicate that a participant is under distress. Note that this is not an exhaustive list.

<table>
<thead>
<tr>
<th>LEVEL OF DISTRESS</th>
<th>SIGNS OR INDICATORS OF POSSIBLE DISTRESS</th>
</tr>
</thead>
<tbody>
<tr>
<td>MILD</td>
<td>• Change in voice tone or volume.</td>
</tr>
<tr>
<td></td>
<td>• Hesitancy to answer questions.</td>
</tr>
<tr>
<td></td>
<td>• Use of inappropriate language/cursing.</td>
</tr>
<tr>
<td></td>
<td>• Provides non-relevant answers to questions asked.</td>
</tr>
<tr>
<td></td>
<td>• Displays an unwillingness or hesitancy to continue.</td>
</tr>
<tr>
<td>MODERATE</td>
<td>• Displays signs of distress that may include long pauses, or sighing</td>
</tr>
<tr>
<td></td>
<td>• Sobbing, weeping, and/or crying.</td>
</tr>
<tr>
<td></td>
<td>• Displays flat voice tones.</td>
</tr>
<tr>
<td></td>
<td>• Being non-responsive.</td>
</tr>
<tr>
<td></td>
<td>• Provides nonsensical/bizarre answers.</td>
</tr>
<tr>
<td>SEVERE</td>
<td>• Talks about passive or active suicidal thoughts with or without a plan.</td>
</tr>
<tr>
<td></td>
<td>• Talks about wishing another person was dead with or without a plan to kill the person.</td>
</tr>
<tr>
<td></td>
<td>• Respondent asks for immediate help from emergency services or 911.</td>
</tr>
<tr>
<td></td>
<td>• Respondent poses an immediate threat to themselves or someone else.</td>
</tr>
</tbody>
</table>

If participant exhibits a distressed behavior, provide the hotline number to the Ohio Department of Mental Health and Addiction Services @ 1-877-275-6364. Complete an Adverse Event Form describing the distressed behavior (see Exhibit 1), and alert the OSUHP Clinic Session POC, who will then alert the OSUHP POC as soon as possible.

Similarly, in the unlikely event that a participant exhibits severe distress by expressing thoughts/intentions of suicide, encourage the participant to call the National Suicide Hotline @ 1-800-273-8255 (TALK). Detailed comments about any case involving suicidal thoughts/intentions should be reported to the OSUHP Clinic Session POC immediately, and recorded on an Adverse Event Form (see Exhibit 1). The OSUHP Clinic Session POC will then alert the OSUHP POC as soon as possible.
Exhibit 1. Adverse Event Form

Ohio Medicaid Group VIII Study
Adverse Event Form

<table>
<thead>
<tr>
<th>Participant Name (Print)</th>
<th>Case ID</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nurse Name (Print)</td>
<td>Date of Event</td>
</tr>
</tbody>
</table>

**Event Classification (e.g., High Blood Pressure, Type 2 Diabetes)**

**Event Description:**

**Resolution/Action Taken:**

Once complete, submit this form to your OSUHP Clinic Session POC
Appendix G:
Group VIII Biometric Screening Participant Results Form
Ohio Medicaid Group VIII Study - Health Screening and Blood Test Findings

The health screening was not a full exam and should not take the place of visits to your doctor. Feel free to share the results with your doctor. Below is the information we collected and what it means for your general health. If you have any questions, you may call 1-866-406-7333.

<table>
<thead>
<tr>
<th>Name (Print)</th>
<th>Date</th>
</tr>
</thead>
</table>

Your physical measurements were:

- Height (inches)
- Weight (pounds)

Your Body Mass Index (BMI) is:

- BMI

Your blood test results were:

- Hemoglobin A1c
- Total Cholesterol
- HDL
- Non-HDL

Your pulse readings were:

- 1st Reading BPM
- 2nd Reading BPM

Your blood pressure readings were:

<table>
<thead>
<tr>
<th>1st Systolic Blood Pressure</th>
<th>mmHg</th>
<th>2nd Systolic Blood Pressure</th>
<th>mmHg</th>
</tr>
</thead>
<tbody>
<tr>
<td>1st Diastolic Blood Pressure</td>
<td>mmHg</td>
<td>2nd Diastolic Blood Pressure</td>
<td>mmHg</td>
</tr>
</tbody>
</table>

Follow-up Recommendation:

- TODAY/IMMEDIATELY
- Within One Month
- Routine Healthcare

Notes:

Signature | Date/Time
---|---
Improving Your Numbers

How to Maintain a Healthier Body Weight - Avoid sugar sweetened beverages; drink water throughout the day. Follow a well-balanced, portion-controlled diet. Aim for a weight reduction of 1 to 2 pounds per week. Work with a health coach or dietitian to improve chances for success. Follow the same recommendations for reducing cholesterol.

Classification of Overweight/Obesity by BMI and Associated Disease Risk Relative to Normal Weight*

<table>
<thead>
<tr>
<th>BMI (kg/m²)</th>
<th>Obesity Class</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt; 18.5</td>
<td><strong>Underweight</strong></td>
</tr>
<tr>
<td>18.5 – 24.9</td>
<td><strong>Normal</strong></td>
</tr>
<tr>
<td>25.0 – 29.9</td>
<td><strong>Overweight</strong></td>
</tr>
<tr>
<td>30.0 – 34.9</td>
<td><strong>Obesity</strong></td>
</tr>
<tr>
<td>35.0 – 39.9</td>
<td>I</td>
</tr>
<tr>
<td>≥ 40</td>
<td>III</td>
</tr>
</tbody>
</table>

* Disease risk for type 2 diabetes, hypertension, and CVD.

How to Reduce Blood Glucose/A1c - Follow a well-balanced diet, and reduce portion sizes of carbohydrates and simple sugars. Avoid sugar sweetened beverages. Maintain a healthy body weight. Check with your doctor about increasing your physical activity to accumulate at least 150 minutes of moderate activity broken up over a week’s time. Schedule an appointment to follow-up with your doctor.

How to Reduce Cholesterol - Eat foods free of trans-fat (partially hydrogenated oil), low in saturated fat, and cholesterol. Eat fish, skinless chicken, skim milk, and legumes such as beans. Eat more fruits, vegetables, and whole grains. Use healthier cooking methods (baking, broiling, steaming, or grilling). Maintain a healthy body weight. Check with your doctor about increasing your physical activity with a goal of 150 minutes of moderate intensity physical activity broken up over a week’s time. Schedule an annual physical exam.

How to Increase High-density Lipoprotein (HDL) - Starting an aerobic exercise program may help increase your HDL by as much as 5% - check with your doctor. Weight loss can help increase HDL. Follow the same nutrition recommendations for reducing cholesterol. If you smoke, quitting all forms of tobacco can increase your HDL by 10%.

How to Reduce Blood Pressure - Eat foods with low or no added salt. Limit the number of processed or pre-prepared meals (canned foods and fast food) that you eat. Limit alcohol intake (1 drink/day for women and 1–2 drinks/day for men). Begin a tobacco-cessation program. Learn how to manage stress more effectively. Follow the same recommendations for reducing cholesterol and maintaining a healthier body weight.

Sources

- Information adapted from The American Diabetes Association – Standards of Medical Care in Diabetes
Appendix H:
Group VIII Medical Records Abstraction Protocol
Ohio Medicaid Group VIII
Medical Records Abstraction Protocol

A. Overview and Objectives

The primary analytic objectives of the Ohio Medicaid Group VIII Study are to determine the impact of the ACA Medicaid Expansion in Ohio for the newly enrolled Medicaid beneficiaries in the areas of 1) access to health care; 2) health care utilization; 3) health status; 4) financial hardship; 5) health risk behaviors; 6) employment opportunities; 7) health care compliance; and 8) pathways to enrollment.

A core survey questionnaire is under development that will be administered to a representative sample of both newly and pre-expansion Medicaid enrollees to address these issues. In addition to information on the newly eligible Medicaid enrollees collected for the targeted time period in 2015-2016, it will be necessary to assess their health status and health care experiences in 2013 (analyses pre and post the ACA expansions). The design will be supplemented with 1) the administration of a biometric screening for a representative subsample of newly eligible survey respondents to obtain clinical data on their health status in 2016 and 2) the collection of medical records information for a subset of these newly eligible Medicaid enrollees that:

a) participate in the biometric screening protocol;
b) give permission and provide the necessary identifying information to contact their targeted in-scope medical providers; and
c) whose providers agree to participate in the study and provide access to the clinical information that is requested.

The data obtained from the Medical Records Component of the Group VIII Study will serve to inform and supplement study analyses related to health care utilization, health status and health care compliance.

B. Targeted Medical Providers In-Scope for the Medical Records Component

Clinical measures to be obtained from the medical records could include patient assessments; diagnoses; frequency of visits over the eligible time frame. The data should provide information on undiagnosed cases of diabetes, hypertension, etc. and help inform assessments of changes in health status and health care utilization pre and post the Medicaid expansions.

The request of the respondent’s usual source of care (USOC) will help identify those cases where the respondent, during the core questionnaire, did not mention being a diabetic, having hypertension, heart disease, or suffer from depression. The biometric screenings will occur post the initial interview and will identify several of these conditions.

At this stage, much greater specificity as to the content to be acquired from the medical records need to be provided by the Group VIII study clinicians and analytic team, in addition to the planned formal analyses that will be conducted with the data that are obtained. Explicit specifications of study hypotheses to be tested and clarification of what medical record data will be required to facilitate these analyses have been formalized and are discussed below.

C. Medical Record Abstraction Recommendation

Given the difficulty in getting the eligible survey participants that consent to the biometric screening to also identify all the providers they have had encounters with during the study time frame in 2013 and 2015-2016; to provide signed permission to contact them and the necessary locating information; and to gain the medical providers cooperation and access to the necessary clinical information, it is essential to minimize the complexity of the design in order to achieve analytic objectives. A design that requires complete information on all eligible medical providers will result in an inefficient use of study resources, as study participants with abstracted data from only a subset of the set medical providers will be viewed as incomplete (not obtaining a full benefit from the costs of acquiring the incomplete information).
Consequently, the design would significantly benefit by

1) restricting the medical records acquisitions to a single provider per individual, preferably their usual source of care (USOC); and

2) restricting the number of events during the time period for which we abstract the data from the medical records.

Under this protocol, the following option is recommended:
For the time period 2015-2016, acquire the medical record information for the first, the last, and an additional subsample of all encounters with the USOC; and for the time period pre ACA, acquire the medical record information for the most recent encounter in 2013 and an additional subsample of all encounters with the USOC in that year.

Operationalization: For the process of requesting the permission from the Medicaid enrollee for the acquisition of medical record data from their medical provider(s), the request should cover the entire study eligible time period. On occasion, it will be easiest from the provider’s perspective to just send RTI all the records within the approved time period. We would then have flexibility in doing the streamlined data abstraction and data entry once the medical records are receipted.

D. Identifying the Usual Source of Care (USOC) for 2013 and 2015-2016

During the biometric screening, eligible survey participants will be asked to give their consent for RTI to contact their medical provider where they received their usual source of care. Upon consent, the nurse will ask the participant to recall their usual source of care in 2013 and who their usual source of care for 2015-2016. For 2013, survey participants will be asked to provide their usual source of care, address and telephone number. The on-site nurse will probe as necessary if the survey participant is having difficulties with recalling who their USOC. For 2015-2016, survey participants will again be asked to provide their usual source of care, address and telephone number. If the participant is unable to recall who their usual source of care is, the nurse on-site will provide the usual source of care for the Medicaid data.

If the survey respondent is still having difficulty identifying their usual source of care, the nurse will ask them to consider identifying the provider or location they most frequently have sought medical care from during the eligible time frames. It is possible that a subsample of the newly eligible Medicaid enrollees will have the same medical provider as their usual source of care pre and post the ACA Medicaid Expansions. This will not always be the case and for a subset, their most frequent site of medical care in 2013 will be a clinic or an ER.

In order to improve the capacity to identify the usual source of care these newly eligible Medicaid enrollees sought treatment from in 2013 and 2015-2016, the on-site nurse will have access to a full list of all providers in the state of Ohio use of to look up provider information. This would be available at the time of the biometric screening, when provider contact permission forms are signed.

E. Elements of Data to be Abstracted from Medical Record

A large proportion of the individuals selected for the Medical Records component will have one or more chronic conditions. Due to the limited sample size for the set of chronic conditions that will receive particular scrutiny (e.g. diabetes, heart disease, hypertension, depression, etc.), the study design anticipates that for analytic purposes, more aggregated analytical measures at the beneficiary level will be studied, where individuals will be pooled across diagnostic categories rather than analyzed separately by disease category. The information that will be abstracted for all individuals, when available, are:

- DOB
- Dates of Service
- Height
- Weight
• Blood Pressure
• Temperature
• Diagnoses
• Procedures
• Medications
• Tests

With this information Group VIII analysts would have the capacity to assess changes in health status overall and by demographic subgroups (pooling across individuals with chronic diseases). With respect to the measurement of health care utilization, household reports of the frequency of medical events are subject to significant recall error which expands in concert with the length of the recall period, the counts of encounters available in the medical recorders should improve assessments of utilization and may also provide additional information of other sources of medical care received by the patient.
Appendix I:
Group VIII Medical Records Abstraction Form
Abstraction Notes Form

<table>
<thead>
<tr>
<th>EVENT DATE OF SERVICE</th>
<th>TOTAL DATES OF SERVICE FOR THE YEAR</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2 0</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>BIOMETRICS</th>
<th>Height: _____ / _____</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Weight: ____________</td>
</tr>
<tr>
<td></td>
<td>BP: _______ / _______</td>
</tr>
<tr>
<td></td>
<td>Temperature: ________</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>ICD9 or ICD10/DIAGNOSES</th>
<th>__      _____       __       __         __</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>□ ICD-10 checkbox □ ICD-10 checkbox □ ICD-10 checkbox □ ICD-10 checkbox □ ICD-10 checkbox</td>
</tr>
<tr>
<td></td>
<td>Descriptions: __________________________________</td>
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<td>______________________________________________</td>
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<td>______________________________________________</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>CPT-4 CODES/PROCEDURES (Code or Description)</th>
<th>TESTS</th>
<th>RESULTS</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
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</table>

<table>
<thead>
<tr>
<th>MEDICATIONS/Rx</th>
<th>NAME</th>
<th>DOSAGE</th>
<th>TYPE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name/Dosage/Type</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(Tablet, capsule, shot, etc)</td>
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</tbody>
</table>

I-2 Ohio Medicaid Group VIII Assessment Methodology The Ohio Department of Medicaid
Appendix J:
Group VIII Medical Records Authorization Packet
Thank you for speaking with me earlier. Per our conversation, this fax packet includes the study information and the signed patient authorization forms. These forms were signed by your patients who are actively participating in this research study. These signed forms allow us to contact you to obtain data from the *complete* medical records (including Date(s) of Service, Services Provided (CPT-4, DRG, or descriptions), Diagnoses or Conditions (ICD codes), Tests and Results, and Prescriptions), for 2013, 2015, and/or 2016, for the patients listed on the enclosed confidential patient checklist.

Enclosures:
- Letter from the Ohio Department of Medicaid
- Confidential Patient Check List
- Fax Coversheet and Mail Return Form
- Frequently Asked Questions (FAQ)
- «TOTAL_AFS» – Signed Authorization Forms

*This fax includes confidential information, and may be used only by the person or entity to which it is addressed. If the receiver of this fax is not the intended recipient or his or her authorized agent, the receiver is hereby notified that dissemination, distribution or copying of this fax is prohibited. If you have received this fax in error, please notify the sender by calling «TOLL_PHONE_NUMBER» and destroy the contents of this fax immediately. Thank you.*
Dear «POC_NAME»:

Thank you for agreeing to participate in the Medical Records component of the Ohio Medicaid Group VIII Study. We understand that one of our data collection specialists recently spoke to you about the study, which is being conducted by the Ohio Department of Medicaid and the Ohio State University (OSU). We thank you in advance for your contributions and would like to take this opportunity to tell you more about the study.

The objective of the study is to collect data from Ohio Medicaid enrollees across the state, with the goal of assessing the health status and health care utilization of the “newly-eligible” Medicaid population – those who gained Medicaid through State expansion under the Affordable Care Act – as compared with the “previously-eligible” population who met the pre-ACA eligibility criteria. The study is required by specific legislation passed by the State of Ohio legislature late last year, which requires this data for the program evaluation of the effectiveness and impact of Medicaid expansion under the ACA.

With the written permission from the enrollees, we are now contacting the appropriate medical providers to request medical records on selected visits, one in 2015 after Medicaid expansion, and one in 2013 before Medicaid expansion, to determine presence of specific diagnostic and health care information, such as chronic conditions, prescriptions, and other care-related information. You are receiving this letter because one or more of your patients have given us written authorization to request this information from your medical records.

The study materials enclosed with this letter include a list of your patients who have agreed to participate in the survey with an authorization form for each patient.

A data collection specialist from our research partner, RTI International, will call shortly after you have received these materials to address any additional questions and confirm receipt of the Authorization Forms. If you have questions about the forms or procedures, call RTI International toll-free at «TOLL_PHONE_NUMBER».

Again, thank you for your participation.

Sincerely,

[Signature]

Dr. Mary Applegate, MD
Medical Director
Confidential Patient Checklist – PLEASE

Step 1: Please check the appropriate box next to the patient name on the list below to indicate which of the following applies to each patient: you were able to locate the patient’s records for 2013, 2015 and/or 2016 or you were able to locate the patient but there were no 2013, 2015 and/or 2016 records.

Step 2: Please Provide the Complete Records for Each Patient (year specified in parentheses) that you were able to locate for 2013, 2015 and/or 2016. For each patient listed below, we are requesting information for all services each patient received for the year specified in parentheses.

FOR EACH PATIENT EVENT WE NEED THE FOLLOWING:
- Date(s) of Service
- Services Provided (CPT-4, DRG, revenue code, HCPCS, or descriptions)
- Diagnoses or Conditions (ICD-9 Codes or descriptions)
- Tests and Results
- Prescriptions (all)

Step 3: Please Return Copies of the Records by Fax or Mail: When returning copies, please use the Fax Cover Sheet or Mail Return Form included in this fax. Please include this completed Confidential Patient Check List, which includes the patients name and specific year of records we are looking to obtain.

The patient(s) listed below have given us written authorization to contact you and request information from your records. Copies of the signed authorization forms are included in this fax.

<table>
<thead>
<tr>
<th>Provider Name</th>
<th>(Year of Records), Patient Name</th>
<th>Date of Birth</th>
<th>Gender</th>
<th>Patient Records Located</th>
<th>No Patient Records Located</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tr>
</tbody>
</table>
Fax Cover Sheet and Mail Return Form

When returning the Confidential Patient Checklist and copies of the records, please use this page as either a Fax Cover Sheet or Mail Return Form.

<table>
<thead>
<tr>
<th>To</th>
<th>Ohio Group VIII Study – Medical Records</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fax</td>
<td>«TOLL_FAX_NUMBER»</td>
</tr>
<tr>
<td>Phone</td>
<td>«TOLL_PHONE_NUMBER»</td>
</tr>
<tr>
<td>From</td>
<td></td>
</tr>
<tr>
<td>Reference Number</td>
<td>«GID»</td>
</tr>
<tr>
<td>Date</td>
<td></td>
</tr>
<tr>
<td>Total Pages (including cover sheet)</td>
<td></td>
</tr>
</tbody>
</table>

Please send mail to:

Ohio Group VIII Study – Medical Records
«MEPS_MAIL_ADDRESS»

REFERENCE#: «GID»

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Frequently Asked Questions

What information is needed?
For each of the patients on the enclosed list, we need information about their hospital events. For each date of service in 2013, 2015, and/or 2016, we need:

- Date(s) of Service
- Services Provided (CPT-4, DRG, revenue code, HCPCS, or descriptions)
- Diagnoses or Conditions (ICD-9 Codes or descriptions)
- Tests and Results (all)
- Prescriptions (all)

Who is sponsoring/conducting this study?
This study is sponsored by the State of Ohio. This study is sponsored by the State of Ohio Department of Medicaid.

What is this survey about? / What is the purpose of this survey?
The purpose of the study is to help the State of Ohio gather information on Medicaid coverage, the use of medical services, and problems getting health care. These data will inform healthcare policy decisions and ultimately, have the potential to make a significant impact on the lives of people living in Ohio.

How do I know the information will be kept confidential?
The confidentiality of data collected for the Ohio Group VIII Study is protected by Federal law under Sections 944(c) and 308(d) of the Public Health Service Act [42 U.S.C. 299c-3(c) and 242m(d)]. No information that could identify an individual or establishment will be disclosed unless that individual or establishment has consented to such a disclosure.

Personal identifying information such as names or addresses are removed before information from the study is made available to researchers. Findings are published in statistical summaries and tables and micro-data is released on “public use” data files.

How are Provider’s or Offices chosen?
Provider’s names and/or facilities associated with a medical provider were named by respondents in the household data collection as sources of care during 2013, 2015, and/or 2016. The patients we are asking about signed HIPAA-compliant forms authorizing and requesting you to release the information sought by the study.
Appendix K:
Group VIII Stakeholder Interview Questions
Stakeholder Interview Questions

We are very interested in knowing what you think about this important issue. Questions will be about your experiences with Medicaid recipients. The interview will be audio taped with a tape recorder and transcripts of the discussion will be created and the data will then be analyzed. Identifiable information will not be included in the report.

1. How has Medicaid expansion affected your organization?
2. How has Medicaid expansion affected your job?
3. Has Medicaid expansion impacted the demand on providers within your organization?
4. What impact did it have on the supply of providers from your perspective?
5. Have there been any surprises that are directly related to Medicaid expansion?
6. What are you hearing about Medicaid expansion from providers in your organization or from others outside the organization?
7. From your perspective, what are the benefits of Medicaid expansion on your clients? What are the challenges the clients have faced with Medicaid expansion?
Appendix L:
Group VIII Focus Group Script
I would like to introduce myself. My name is Amy and I welcome you to the focus group discussion today and thank you for taking the time to participate. This focus group is being held today to talk about your experiences with the Ohio Medicaid program since you became covered by Medicaid.

We are very interested in knowing what you think about this important issue. Questions will be about your experiences enrolling in Medicaid, getting care from doctors and other health care providers, and how the health care you receive now differs from what you received before you had Medicaid.

We use focus groups to gather information about opinions and beliefs. We invite all of you to participate and to assist us by doing the following:

- Please speak up when you have an opinion or comment on any of the topics we discuss.
- If you do not hear clearly or understand a specific question, please let me know.

This part of the session today will last between 60 and 90 minutes. Remember that the session today will be audio taped with a tape recorder and transcripts of the discussion will be created and the data will then be analyzed.

Again, we ask that you speak up and directly to the recorder so that everyone’s responses will be heard. We want everyone to participate and speak out.

- I do ask that only one person speak at a time.
- Please feel free to share your ideas, even if they are different from others.
- There is no right or wrong answer.
- Also, remember that everything that is said during the discussion is confidential and specifics of what individuals say should not be repeated outside of the discussion today. None of your names or personal information will be shared with anyone outside of the study team.
- Your information will only be presented in summary form.
- If at any time you wish not to participate any longer, you may be excused.

ICEBREAKER QUESTION: First I would like to go around the room and have each of you introduce yourself and tell us when you enrolled in Medicaid and which managed care company handles your Medicaid coverage.

NOTE: Throughout this discussion, I will refer to “Medicaid” but when you answer the questions you should consider both Ohio Medicaid and the managed care company that handles your Medicaid coverage.

Throughout the discussion, when I ask about doctors and healthcare I want you to consider both your physical health and mental health.
Questions:
1. The first topic is about your use of health care services, like doctors, hospitals, clinics, and emergency rooms. Since you enrolled in Medicaid have you had to change your usual source of care, whether it be a doctor, clinic or the emergency room?
   a. Have you or anyone in your household had a change in use of the emergency room? Why did the change occur?
   b. Have you or anyone in your household had a problem getting in to see a doctor? Elaborate on the reason.
   c. For those of you who are newly enrolled in Medicaid, what has not worked so well with Medicaid, either accessing care, coverage of services, or anything else?
2. The next topic relates to the effect that Medicaid has had on your finances. We have heard in the survey that most people say that Medicaid has made it easier for them to look for work? Has Medicaid had an impact on your ability, or the ability of anyone in your household, to look for a job?
   a. How else has Medicaid impacted your family finances?
   b. If you have been able to save more money because of Medicaid, how have you used the money?
   c. Let’s now talk a bit about your health-related costs now compared to before you had Medicaid. Thinking of all the costs, including time off work, transportation, and other costs related to going to appointments, do you think the costs are now greater or less compared to before you had Medicaid?
3. The third topic relates to how Medicaid may have impacted your health. A number of participants in the survey told us that their health has improved. Can you talk about why health may be better when someone is on Medicaid?
4. The final topic relates to some specific questions from the surveys you completed a while back. If you recall, we asked about your “usual source of care”. Did you know what we meant when we used that phrase? If no, how would we ask who you see when you are sick/ill?
5. We also asked about who you saw for health care in 2013. How easy was it for you to recall who you usually saw in 2013?
6. When thinking about the medical provider you saw in 2013, what would help you to recall who you saw?
Appendix M:
Group VIII Telephone Survey Verbatim Question Coding
<table>
<thead>
<tr>
<th>Code</th>
<th>Definition</th>
<th>% Quotes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Generally negative</td>
<td>General negative response about Medicaid or the government’s decision to fund Medicaid.</td>
<td>0.6</td>
</tr>
<tr>
<td>Generally positive</td>
<td>Only used if nothing else applies and the comment is positive about Medicaid or having insurance. For example, a general positive response about Medicaid or the government’s decision to fund Medicaid.</td>
<td>30.1</td>
</tr>
<tr>
<td>Don’t know</td>
<td>Person does not know what to say.</td>
<td>0.3</td>
</tr>
<tr>
<td>Relief/less stress or worry</td>
<td>Response mentions feeling relieved, secured, peace of mind, having less worry, less stress; feeling assured because of medical access.</td>
<td>27.9</td>
</tr>
<tr>
<td>Costs – Positive</td>
<td>Response mentions cost savings or that Medicaid will cover medical bills.</td>
<td>22.7</td>
</tr>
<tr>
<td>Access to care</td>
<td>Response explicitly mentions the ability to access medical care or see a doctor. Coded yes if person talks about being able to go to the doctor, get medical care, go to the hospital, get prescriptions, and or get dental or vision care.</td>
<td>31.3</td>
</tr>
<tr>
<td>Health</td>
<td>Mentions the health benefits of having Medicaid, both physical and mental health. Talks about health improvements.</td>
<td>10.1</td>
</tr>
<tr>
<td>Knowledge</td>
<td>Response indicates that person knows more about health now that Medicaid is available. Or, the person says that he/she has a better understanding of health or health problems.</td>
<td>1.0</td>
</tr>
<tr>
<td>Cost/access – Negative</td>
<td>Any negative mention of costs or limited access, costs still incurred; costs person had to pay for before Medicaid.</td>
<td>1.9</td>
</tr>
<tr>
<td>Medical debt</td>
<td>Any specific mention of medical debt.</td>
<td>1.3</td>
</tr>
<tr>
<td>No fine</td>
<td>Any mention of getting Medicaid to avoid receiving a fine.</td>
<td>1.2</td>
</tr>
</tbody>
</table>
Appendix N:
Supplemental Analyses of Group VIII Medicaid Administrative, Telephone Survey, 
& Biometric Screening Data
HEDIS-based Measures from the Medicaid Administrative Data
Ohio Medicaid administrative data were used to create measures of the provision of evidence based preventive care and clinically effective-based care for chronic health conditions. Methods of analysis were derived from the National Center for Quality Assurance (NCQA) Healthcare Effectiveness Data and Information Set (HEDIS). The HEDIS measures are a standard used to measure the effectiveness of all health plans in the U.S., including Medicare, commercial, and Medicaid. Measures included:

Adult BMI Assessment

Description
The percentage of members 18–64 years of age as of December 31, 2015 who had an outpatient visit and whose body mass index (BMI) was documented during 2015. Eligible participants must not have more than one gap in enrollment of up to one month during 2015.

Measure Specification

<table>
<thead>
<tr>
<th>Denominator</th>
<th>The eligible population.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Numerator</td>
<td>For members 21 years of age or older on the date of service, BMI (BMI Value Set) during 2015.</td>
</tr>
<tr>
<td></td>
<td>For members younger than 21 years of age on the date of service, BMI percentile (BMI Percentile Value Set) during 2015.</td>
</tr>
</tbody>
</table>

Exhibit N-1. Percentage of Adults with a BMI Screening in 2015

![BMI Screening Chart]

Table N-1. Adult BMI Screening by Enrollee Type

<table>
<thead>
<tr>
<th></th>
<th>Group-VIII</th>
<th>Pre-Expansion</th>
</tr>
</thead>
<tbody>
<tr>
<td>BMI Screening (n)</td>
<td>7,327</td>
<td>20,048</td>
</tr>
<tr>
<td>BMI Screening (%)</td>
<td>4.9</td>
<td>5.3</td>
</tr>
</tbody>
</table>
Breast Cancer Screening

Description

The percentage of women 50–64 years of age as of December 31, 2015 who had a mammogram to screen for breast cancer during 2015. Eligible participants must not have more than one gap in enrollment of up to one month during 2015.

Measure Specification

Denominator

The eligible population.

Numerator

One or more mammograms (Mammography Value Set) any time during 2015.

Exhibit N-2. Percentage of Women Ages 50-64 with Breast Cancer Screening in 2015

Table N-2. Breast Cancer Screening by Enrollee Type

<table>
<thead>
<tr>
<th></th>
<th>Group-VIII</th>
<th>Pre-Expansion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Breast Cancer Screening (n)</td>
<td>14,174</td>
<td>11,933</td>
</tr>
<tr>
<td>Breast Cancer Screening (%)</td>
<td>35.3</td>
<td>33.0</td>
</tr>
</tbody>
</table>
Cervical Cancer Screening

Description

The percentage of women 21–64 years of age as of December 31, 2015 who were screened for cervical cancer using either of the following criteria:

- Women age 21–64 who had cervical cytology performed every 3 years.
- Women age 30–64 who had cervical cytology/human papillomavirus (HPV) co-testing performed every 5 years.

Eligible participants must not have more than one gap in enrollment of up to one month during 2015.

Measure Specification

<table>
<thead>
<tr>
<th>Denominator</th>
<th>The eligible population.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Numerator</td>
<td>Identify women 24–64 years of age as of December 31, 2015 who had cervical cytology (Cervical Cytology Value Set) during 2015.</td>
</tr>
</tbody>
</table>

**Exclusion:** Hysterectomy with no residual cervix, cervical agenesis or acquired absence of cervix (Absence of Cervix Value Set) through December 31, 2015.

Exhibit N-3. Percentage of Women Ages 21-64 Cervical Cancer Screening in 2015

Table N-3. Cervical Cancer Screening by Enrollee Type

<table>
<thead>
<tr>
<th></th>
<th>Group-VIII</th>
<th>Pre-Expansion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cervical Cancer Screening (n)</td>
<td>11,507</td>
<td>31,624</td>
</tr>
<tr>
<td>Cervical Cancer Screening (%)</td>
<td>12.9</td>
<td>12.7</td>
</tr>
</tbody>
</table>
Chlamydia Screening in Women

Description

The percentage of women 16–24 years of age as of December 31, 2015 who were identified as sexually active and who had at least one test for chlamydia during 2015. Eligible participants must not have more than one gap in enrollment of up to one month during 2015.

Eligible Population

<table>
<thead>
<tr>
<th>Event/diagnosis</th>
<th>Sexually active. Two methods identify sexually active women: pharmacy data and claim/encounter data. A member only needs to be identified in one method to be eligible for the measure.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Claim/encounter data</td>
<td>Members who had a claim or encounter indicating sexual activity during 2015. A code from any of the following meets criteria:</td>
</tr>
<tr>
<td></td>
<td>- Pregnancy Value Set.</td>
</tr>
<tr>
<td></td>
<td>- Sexual Activity Value Set.</td>
</tr>
<tr>
<td></td>
<td>- Pregnancy Tests Value Set.</td>
</tr>
<tr>
<td>Pharmacy data</td>
<td>Members who were dispensed prescription contraceptives during 2015 (Table CHL-A).</td>
</tr>
</tbody>
</table>

Table N-4: Prescriptions to Identify Contraceptives

<table>
<thead>
<tr>
<th>Description</th>
<th>Prescription</th>
</tr>
</thead>
</table>
| Contraceptives  | • Desogestrel-ethinyl estradiol  
                  | • Dienogest-estradiol multiphasic                                          
                  | • Drospirenone-ethinyl estradiol                                            
                  | • Drospirenone-ethinyl estradiol-levomefolate biphasic                      
                  | • Ethinyl estradiol-ethynodiol                                              
                  | • Ethinyl estradiol-etonogestrel                                            
                  | • Ethinyl estradiol-levonorgestrel                                          
                  | • Ethinyl estradiol-norelgestromin                                         |
| Diaphragm       | • Diaphragm                                                                  |
| Spermicide      | • Nonxynol 9                                                                  |
| Ethinyl estradiol-norethindrone |                                                                             |
| Ethinyl estradiol-norgestrel |                                                                             |
| Ethinyl estradiol-norgestrel |                                                                             |
| Etonogestrel    |                                                                             |
| Levonorgestrel  |                                                                             |
| Medroxyprogesterone |                                                                         |
| Mestranol-norethindrone |                                                                   |
| Norethindrone   |                                                                             |

Measure Specification

<table>
<thead>
<tr>
<th>Denominator</th>
<th>The eligible population.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Numerator</td>
<td>At least one chlamydia test (Chlamydia Tests Value Set) during the measurement year.</td>
</tr>
</tbody>
</table>

Exclusion: Exclude members who qualified for the denominator based on a pregnancy test (Pregnancy Tests Value Set) alone and who meet either of the following:
A pregnancy test (Pregnancy Test Exclusion Value Set) during 2015 and a prescription for isotretinoin (Table CHL-E) on the date of the pregnancy test or the 6 days after the pregnancy test.

A pregnancy test (Pregnancy Test Exclusion Value Set) during 2015 and an x-ray (Diagnostic Radiology Value Set) on the date of the pregnancy test or the 6 days after the pregnancy.

### Exhibit N-4. Percentage of Chlamydia Screening among Women

![Percentage of Chlamydia Screening among Women](chart)

### Table N-5. Chlamydia Screening by Enrollee Type

<table>
<thead>
<tr>
<th></th>
<th>Group-VIII</th>
<th>Pre-Expansion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chlamydia Screening (n)</td>
<td>2,256</td>
<td>21,705</td>
</tr>
<tr>
<td>Chlamydia Screening (%)</td>
<td>55.4</td>
<td>65.1</td>
</tr>
</tbody>
</table>
Colorectal Cancer Screening

Description

The percentage of members 50–64 years of age as of December 31, 2015 who had appropriate screening for colorectal cancer. Eligible participants must not have more than one gap in enrollment of up to one month during 2015.

Measure Specification

Denominator: The eligible population.

Numerator: One or more screenings for colorectal cancer. Any of the following meet criteria:

- Fecal occult blood test (FOBT Value Set) during 2015. For administrative data, assume the required number of samples were returned, regardless of FOBT type.
- Flexible sigmoidoscopy (Flexible Sigmoidoscopy Value Set) during 2015.
- Colonoscopy (Colonoscopy Value Set) during 2015.

Exclusion: Either of the following any time during the member’s history through December 31, 2015:

- Colorectal cancer (Colorectal Cancer Value Set).
- Total colectomy (Total Colectomy Value Set).

Exhibit N-5. Percentage of Colorectal Cancer Screenings

<table>
<thead>
<tr>
<th>Group</th>
<th>Number (n)</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Group VIII</td>
<td>11,814</td>
<td>10.0%</td>
</tr>
<tr>
<td>Pre-Expansion</td>
<td>6,828</td>
<td>20.0%</td>
</tr>
</tbody>
</table>
Table N-6. Colorectal Cancer Screening by Enrollee Type

<table>
<thead>
<tr>
<th></th>
<th>Group-VIII</th>
<th>Pre-Expansion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Colorectal Cancer Screening (n)</td>
<td>11,814</td>
<td>6,828</td>
</tr>
<tr>
<td>Colorectal Cancer Screening (%)</td>
<td>13.5</td>
<td>11.0</td>
</tr>
</tbody>
</table>

Comprehensive Diabetes Care (CDC)

**Description**

The percentage of members 18–64 years of age as of December 31, 2015 with diabetes (type 1 and type 2) who had each of the following:

- Hemoglobin A1c (HbA1c) testing.
- HbA1c poor control (>9.0%).
- HbA1c control (<8.0%).
- Smoking status and date of cessation counseling, or treatment during 2015 if the patient is a tobacco smoker.
- Eye exam (retinal) performed.
- Medical attention for nephropathy.
- BP control (<140/90 mm Hg).
- LDL-C Screen.

**Eligible Population**

**Event/diagnosis** There are two ways to identify members with diabetes: by claim/encounter data and by pharmacy data. A member only needs to be identified by one method to be included in the measure. Members may be identified as having diabetes during 2015.

**Claim/encounter data.** Members who met any of the following criteria during 2015 (count services that occur over one year):

- At least two outpatient visits (Outpatient Value Set), observation visits (Observation Value Set), ED visits (ED Value Set) or nonacute inpatient encounters (Nonacute Inpatient Value Set) on different dates of service, with a diagnosis of diabetes (Diabetes Value Set). Visit type need not be the same for the two visits.
- At least one acute inpatient encounter (Acute Inpatient Value Set) with a diagnosis of diabetes (Diabetes Value Set).

**Pharmacy data.** Members who were dispensed insulin or hypoglycemics/antihyperglycemics on an ambulatory basis during 2015 (Table CDC-A).
### Table N-7: Prescriptions to Identify Members With Diabetes

<table>
<thead>
<tr>
<th>Description</th>
<th>Prescription</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Alpha-glucosidase inhibitors</strong></td>
<td>• Acarbose  • Miglitol</td>
</tr>
<tr>
<td><strong>Amylin analogs</strong></td>
<td>• Pramlintide</td>
</tr>
<tr>
<td><strong>Antidiabetic combinations</strong></td>
<td>• Alogliptin-metformin  • Alogliptin-pioglitazone  • Canagliflozin-metformin</td>
</tr>
<tr>
<td></td>
<td>• Glimepiride-pioglitazone  • Glimepiride-rosiglitazone  • Glyburide-metformin</td>
</tr>
<tr>
<td></td>
<td>• Metformin-metformin  • Metformin-pioglitazone  • Metformin-rosiglitazone</td>
</tr>
<tr>
<td></td>
<td>• Metformin-saxagliptin  • Metformin-sitagliptin  • Sitagliptin-simvastatin</td>
</tr>
<tr>
<td><strong>Insulin</strong></td>
<td>• Insulin aspart  • Insulin aspart-insulin aspart protamine  • Insulin detemir</td>
</tr>
<tr>
<td></td>
<td>• Insulin glargine  • Insulin glulisine</td>
</tr>
<tr>
<td></td>
<td>• Insulin isophane human  • Insulin isophane-insulin regular  • Insulin lispro</td>
</tr>
<tr>
<td></td>
<td>• Insulin lpro-insulin lpro protamine  • Insulin regular human</td>
</tr>
<tr>
<td><strong>Meglitinides</strong></td>
<td>• Nateglinide  • Repaglinide</td>
</tr>
<tr>
<td><strong>Glucagon-like peptide-1 (GLP1) agonists</strong></td>
<td>• Exenatide  • Liraglutide  • Albiglutide</td>
</tr>
<tr>
<td><strong>Sodium glucose cotransporter 2 (SGLT2) inhibitor</strong></td>
<td>• Canagliflozin  • Dapagliflozin  • Empagliflozin</td>
</tr>
<tr>
<td><strong>Sulfonylureas</strong></td>
<td>• Chlorpropamide  • Glimepiride  • Glyburide  • Tolazamide  • Tolbutamide</td>
</tr>
<tr>
<td><strong>Thiazolidinediones</strong></td>
<td>• Pioglitazone  • Rosiglitazone</td>
</tr>
<tr>
<td><strong>Dipeptidyl peptidase-4 (DDP-4) inhibitors</strong></td>
<td>• Alogliptin  • Linagliptin  • Saxagliptin  • Sitagliptin</td>
</tr>
</tbody>
</table>

### Measure Specification

**Denominator Numerators**

The eligible population.

**HbA1c Testing**

An HbA1c test ([HbA1c Tests Value Set](#)) performed during 2015, as identified by claim/encounter or automated laboratory data.

**HbA1c Poor Control >9%**

Use codes in the HbA1c Tests Value Set to identify the most recent HbA1c test during 2015. The member is numerator compliant if the most recent HbA1c level is >9.0% or is missing a result, or if an HbA1c test was not done during 2015. The member is not numerator compliant if the result for the most recent HbA1c test during the measurement year is ≤9.0%.

<table>
<thead>
<tr>
<th>Value Set</th>
<th>Numerator Compliance</th>
</tr>
</thead>
<tbody>
<tr>
<td>HbA1c Level Less Than 7.0 Value Set</td>
<td>Not compliant</td>
</tr>
</tbody>
</table>
### HbA1c Control <8%

Use codes in the `HbA1c Tests Value Set` to identify the *most recent* HbA1c test during 2015. The member is numerator compliant if the most recent HbA1c level is <8.0%. The member is not numerator compliant if the result for the most recent HbA1c test is ≥8.0% or is missing a result, or if an HbA1c test was not done during 2015.

<table>
<thead>
<tr>
<th>Value Set</th>
<th>Numerator Compliance</th>
</tr>
</thead>
<tbody>
<tr>
<td>HbA1c Level Less Than 7.0 Value Set</td>
<td>Compliant</td>
</tr>
<tr>
<td>HbA1c Level 7.0–9.0 Value Set</td>
<td>Not compliant</td>
</tr>
<tr>
<td>HbA1c Level Greater Than 9.0 Value Set</td>
<td>Not compliant</td>
</tr>
</tbody>
</table>

### Eye Exam

An eye screening for diabetic retinal disease as identified by administrative data. This includes diabetics who had one of the following:

- A retinal or dilated eye exam by an eye care professional (optometrist or ophthalmologist) in 2015.
- A *negative* retinal or dilated eye exam (negative for retinopathy) by an eye care professional in 2015.

Any of the following meet criteria:

- Any code in the `Diabetic Retinal Screening Value Set` billed by an eye care professional (optometrist or ophthalmologist) during 2015.
- Any code in the `Diabetic Retinal Screening Value Set` billed by an eye care professional (optometrist or ophthalmologist) during 2015, with a negative result (negative for retinopathy).
- Any code in the `Diabetic Retinal Screening With Eye Care Professional Value Set` billed by any provider type during 2015.
- Any code in the `Diabetic Retinal Screening With Eye Care Professional Value Set` billed by any provider type during 2015, with a negative result (negative for retinopathy).
- Any code in the `Diabetic Retinal Screening Negative Value Set` billed by any provider type during 2015.

### Medical Attention for Nephropathy

A nephropathy screening or monitoring test or evidence of nephropathy, as documented through administrative data. This includes diabetics who had one of the following during 2015:

- A nephropathy screening or monitoring test (`Urine Protein Tests Value Set`).
- Evidence of treatment for nephropathy or ACE/ARB therapy (`Nephropathy Treatment Value Set`).
- Evidence of stage 4 chronic kidney disease (`CKD Stage 4 Value Set`).
- Evidence of ESRD (`ESRD Value Set`).
• Evidence of kidney transplant (Kidney Transplant Value Set).
• A visit with a nephrologist, as identified by the organization’s specialty provider codes (no restriction on the diagnosis or procedure code submitted).
• At least one ACE inhibitor or ARB dispensing event (Table CDC-L).

Table N-8: ACE Inhibitors/ARBs

<table>
<thead>
<tr>
<th>Description</th>
<th>Description</th>
<th>Prescription</th>
</tr>
</thead>
<tbody>
<tr>
<td>Angiotensin converting enzyme inhibitors</td>
<td>• Benazepril</td>
<td>• Enalapril</td>
</tr>
<tr>
<td></td>
<td>• Captopril</td>
<td>• Lisinopril</td>
</tr>
<tr>
<td></td>
<td>• Fosinopril</td>
<td>• Moexipril</td>
</tr>
<tr>
<td></td>
<td>• Perindopril</td>
<td>• Quinapril</td>
</tr>
<tr>
<td></td>
<td>• Ramipril</td>
<td>• Telmisartan</td>
</tr>
<tr>
<td>Angiotensin II inhibitors</td>
<td>• Azilsartan</td>
<td>• Eprosartan</td>
</tr>
<tr>
<td></td>
<td>• Candesartan</td>
<td>• Iresartan</td>
</tr>
<tr>
<td></td>
<td>• Losartan</td>
<td>• Olmesartan</td>
</tr>
<tr>
<td></td>
<td>• Telmisartan</td>
<td>• Valsartan</td>
</tr>
<tr>
<td>Antihypertensive combinations</td>
<td>• Aliskiren-valsartan</td>
<td>• Azilsartan-chlorthalidone</td>
</tr>
<tr>
<td></td>
<td>• Amlodipine-benazepril</td>
<td>• Benazepril-hydrochlorothiazide</td>
</tr>
<tr>
<td></td>
<td>• Amlodipine-hydrochlorothiazide-valsartan</td>
<td>• Candesartan-hydrochlorothiazide</td>
</tr>
<tr>
<td></td>
<td>• Amlodipine-hydrochlorothiazide-olmesartan</td>
<td>• Captopril-hydrochlorothiazide</td>
</tr>
<tr>
<td></td>
<td>• Amlodipine-olmesartan</td>
<td>• Enalapril-hydrochlorothiazide</td>
</tr>
<tr>
<td></td>
<td>• Amlodipine-telmisartan</td>
<td>• Eprosartan-hydrochlorothiazide</td>
</tr>
<tr>
<td></td>
<td>• Amlodipine-valsartan</td>
<td>• Fosinopril-hydrochlorothiazide</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Hydrochlorothiazide-irbesartan</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Hydrochlorothiazide-lisinopril</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Hydrochlorothiazide-losartan</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Hydrochlorothiazide-moexipril</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Hydrochlorothiazide-olmesartan</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Hydrochlorothiazide-quinapril</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Hydrochlorothiazide-telmisartan</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Hydrochlorothiazide-valsartan</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Trandolapril-verapamil</td>
</tr>
</tbody>
</table>

**BP Control <140/90 mm Hg**

Use automated data to identify the most recent BP reading taken during a visit in 2015. The member is numerator compliant if the BP is <140/90 mm Hg. The member is not compliant if the BP is ≥140/90 mm Hg, if there is no BP reading during the measurement year or if the reading is incomplete (e.g., the systolic or diastolic level is missing). If there are multiple BPs on the same date of service, use the lowest systolic and lowest diastolic BP on that date as the representative BP.
The proportion of Group VIII Diabetics who had an HbA1c test performed was 83.5%. The proportion of Pre-Expansion Diabetics who had an HbA1c test was 79.6%.
The proportion of Group VIII Diabetics who had their HbA1c values under control was 0.6%, the proportion of Pre-Expansion Diabetics who had their HbA1c values under control was 0.7%.

The proportion of Group VIII Diabetics who had their Blood Pressure tested was 1.1%, the proportion of Pre-Expansion Diabetics who had their Blood Pressure tested was 2.2%.
The proportion of Group VIII Diabetics who had their Blood Pressure under control was 0.8%. The proportion of Pre-Expansion Diabetics who had their Blood Pressure under control was 1.6%.

The proportion of Group VIII Diabetics who had their LDL-C screened was 70.1%. The proportion of Pre-Expansion Diabetics who had their LDL-C screened was 66.3%.
The proportion of Group VIII Diabetics who had their LDL-C under control was 0.2%. The proportion of Pre-Expansion Diabetics who had their LDL-C under control was 0.3%.

The proportion of Group VIII Diabetics who had a Retinal Eye Exam performed was 97.2%. The proportion of Pre-Expansion Diabetics who had a Retinal Eye Exam performed was 97.6%.
The proportion of Group VIII Diabetics who received medical attention for Nephropathy was 73.8%. The proportion of Pre-Expansion Diabetics who received medical attention for Nephropathy was 75.9%.

**Table N-9. Comprehensive Diabetes Care**

<table>
<thead>
<tr>
<th>Metric</th>
<th>Group-VIII</th>
<th>Pre-Expansion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diabetics with HbA1c test performed (n)</td>
<td>20,500</td>
<td>39,719</td>
</tr>
<tr>
<td>Diabetics with HbA1c test performed (%)</td>
<td>83.5</td>
<td>79.6</td>
</tr>
<tr>
<td>Diabetics with HbA1c levels under control (n)</td>
<td>157</td>
<td>359</td>
</tr>
<tr>
<td>Diabetics with HbA1c levels under control (%)</td>
<td>0.6</td>
<td>0.7</td>
</tr>
<tr>
<td>Diabetics with blood pressure tested (n)</td>
<td>268</td>
<td>1107</td>
</tr>
<tr>
<td>Diabetics with blood pressure tested (%)</td>
<td>1.1</td>
<td>2.2</td>
</tr>
<tr>
<td>Diabetics with blood pressure under control (n)</td>
<td>187</td>
<td>868</td>
</tr>
<tr>
<td>Diabetics with blood pressure under control (%)</td>
<td>0.8</td>
<td>1.6</td>
</tr>
<tr>
<td>Diabetics with LDL-cholesterol screen (n)</td>
<td>17,215</td>
<td>33,090</td>
</tr>
<tr>
<td>Diabetics with LDL-cholesterol screen (%)</td>
<td>70.1</td>
<td>66.3</td>
</tr>
<tr>
<td>Diabetics with LDL-cholesterol under control (n)</td>
<td>40</td>
<td>144</td>
</tr>
<tr>
<td>Diabetics with LDL-cholesterol under control (%)</td>
<td>0.2</td>
<td>0.3</td>
</tr>
<tr>
<td>Diabetics with retinal eye exam performed (n)</td>
<td>23,864</td>
<td>48,715</td>
</tr>
<tr>
<td>Diabetics with retinal eye exam performed (%)</td>
<td>97.2</td>
<td>97.6</td>
</tr>
<tr>
<td>Diabetics receiving medical attention for nephropathy (n)</td>
<td>18,122</td>
<td>37,851</td>
</tr>
<tr>
<td>Diabetics receiving medical attention for nephropathy (%)</td>
<td>73.8</td>
<td>75.9</td>
</tr>
</tbody>
</table>
Controlling High Blood Pressure

Description

The percentage of members 18–64 years of age as of December 31, 2015 who had a diagnosis of hypertension (HTN) and whose BP was adequately controlled during 2015 based on the following criteria:

- Members 18–64 years of age whose BP was <140/90 mm Hg.
- Members 18-64 years of age with a diagnosis of diabetes whose BP was <140/90 mm Hg.

Eligible participants must not have more than one gap in enrollment of up to one month during 2015.

Eligible Population

Event/diagnosis

Members are identified as hypertensive if there is at least one outpatient visit (Outpatient Without UBREV Value Set) with a diagnosis of hypertension (Essential Hypertension Value Set) during the first six months of 2015.

Diabetes Flag for Numerator Assessment

After the Eligible Population is identified, assign each member either a diabetic or not diabetic flag using only administrative data and the steps below. The flag is used to determine the appropriate BP threshold to use during numerator assessment.

**Step 1** Assign a flag of diabetic to members identified as diabetic using claim/encounter data or pharmacy data. The organization must use both methods to assign the diabetes flag, but a member only needs to be identified by one method. Members may be identified as having diabetes during 2015.

- **Claim/encounter data.** Members who met any of the following criteria during 2015:
  - At least two outpatient visits (Outpatient Value Set), observation visits (Observation Value Set), ED visits (ED Value Set) or nonacute inpatient encounters (Nonacute Inpatient Value Set) on different dates of service, with a diagnosis of diabetes (Diabetes Value Set). Visit type need not be the same for the two visits.
  - At least one acute inpatient encounter (Acute Inpatient Value Set) with a diagnosis of diabetes (Diabetes Value Set).

- **Pharmacy data.** Members who were dispensed insulin or hypoglycemics/antihyperglycemics on an ambulatory basis during 2015 (Table CDC-A).

**Step 2** From the members identified in Step 1, assign a flag of not diabetic to members who do not have a diagnosis of diabetes (Diabetes Value Set), in any setting, during 2014 or 2015 and who had a diagnosis of gestational diabetes or steroid-induced diabetes (Diabetes Exclusions Value Set), in any setting, during 2015.

**Step 3** For members who were not assigned a flag in step 1 or step 2, assign a flag of not diabetic.
Table N-10. Controlled Blood Pressure by Diabetic Status

<table>
<thead>
<tr>
<th></th>
<th>Group-VIII</th>
<th>Pre-Expansion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diabetes (n)</td>
<td>78</td>
<td>437</td>
</tr>
<tr>
<td>Diabetes (%)</td>
<td>79.6</td>
<td>80.5</td>
</tr>
<tr>
<td>No Diabetes (n)</td>
<td>589</td>
<td>145</td>
</tr>
<tr>
<td>No Diabetes (%)</td>
<td>68.1</td>
<td>70.6</td>
</tr>
</tbody>
</table>
Statin Therapy for Patients With Cardiovascular Disease

4. Description

The percentage of males 21–64 years of age and females 40–64 years of age during 2015, who were identified as having clinical atherosclerotic cardiovascular disease (ASCVD) and met the following criteria. Eligible participants must not have more than one gap in enrollment of up to one month during 2015. The following rates are reported:

1. Received Statin Therapy. Members who were dispensed at least one high or moderate-intensity statin medication during 2015.

2. Statin Adherence 80%. Members who remained on a high or moderate-intensity statin medication for at least 80% of the treatment period.

5. Eligible Population: Rate 1—Received Statin Therapy

Step 1: Members are identified for the eligible population in two ways: by event or by diagnosis. A member only needs to be identified by one method to be included in the measure.

Event. Any of the following during 2015 meet criteria:

- ANY MI DIAGNOSIS (MI Value Set).
- ANY CABG DIAGNOSIS (CABG Value Set).
- ANY PCI DIAGNOSIS (PCI Value Set) in any setting.
- Other revascularization. Members who had any other revascularization procedures (Other Revascularization Value Set) in any setting.

Diagnosis. Identify members as having ischemic vascular disease (IVD) who met at least one of the following criteria during 2015.

- ANY IVD diagnosis (IVD Value Set).

Step 2: Exclude members who meet any of the following criteria:

Required exclusions

- Pregnancy (Pregnancy Value Set) during 2015.
- In vitro fertilization (IVF Value Set) in 2015.
- Dispensed at least one prescription for clomiphene (Table SPC-A) during 2015.
- ESRD (ESRD Value Set) during 2015.
- Cirrhosis (Cirrhosis Value Set) during 2015.
- Myalgia, myositis, myopathy, or rhabdomyolysis (Muscular Pain and Disease Value Set) during 2015.
6. Measure Specification: Rate 1—Received Statin Therapy

**Denominator**
The Rate 1 eligible population.

**Numerator**
The number of members who had at least one dispensing event for a high or moderate-intensity statin medication (Table SPC-B) during 2015.

**Table N-11: High and Moderate-Intensity Statin Medications**

<table>
<thead>
<tr>
<th>Description</th>
<th>Prescription</th>
</tr>
</thead>
<tbody>
<tr>
<td>High-intensity statin therapy</td>
<td>• Atorvastatin 40–80 mg</td>
</tr>
<tr>
<td></td>
<td>• Amlodipine-atorvastatin 40-80 mg</td>
</tr>
<tr>
<td></td>
<td>• Ezetimibe-atorvastatin 40-80 mg</td>
</tr>
<tr>
<td></td>
<td>• Rosuvastatin 20–40 mg</td>
</tr>
<tr>
<td></td>
<td>• Simvastatin 80 mg</td>
</tr>
<tr>
<td></td>
<td>• Ezetimibe-simvastatin 80 mg</td>
</tr>
<tr>
<td>Moderate-intensity statin therapy</td>
<td>• Atorvastatin 10–20 mg</td>
</tr>
<tr>
<td></td>
<td>• Amlodipine-atorvastatin 10-20 mg</td>
</tr>
<tr>
<td></td>
<td>• Ezetimibe-atorvastatin 10-20 mg</td>
</tr>
<tr>
<td></td>
<td>• Rosuvastatin 5–10 mg</td>
</tr>
<tr>
<td></td>
<td>• Simvastatin 20–40 mg</td>
</tr>
<tr>
<td></td>
<td>• Ezetimibe-simvastatin 20-40 mg</td>
</tr>
<tr>
<td></td>
<td>• Niacin-simvastatin 20-40 mg</td>
</tr>
<tr>
<td></td>
<td>• Sitagliptin-simvastatin 20-40 mg</td>
</tr>
<tr>
<td></td>
<td>• Pravastatin 40–80 mg</td>
</tr>
<tr>
<td></td>
<td>• Aspirin-pravastatin 40-80 mg</td>
</tr>
<tr>
<td></td>
<td>• Lovastatin 40 mg</td>
</tr>
<tr>
<td></td>
<td>• Niacin-lovastatin 40 mg</td>
</tr>
<tr>
<td></td>
<td>• Fluvastatin XL 80 mg</td>
</tr>
<tr>
<td></td>
<td>• Fluvastatin 40 mg bid</td>
</tr>
<tr>
<td></td>
<td>• Fluvastatin 40 mg bid</td>
</tr>
<tr>
<td></td>
<td>• Pitavastatin 2–4 mg</td>
</tr>
</tbody>
</table>

**Exhibit N-15. Percent of Individuals with Cardiovascular Disease Receiving Statin Therapy**

![Bar chart showing the percentage of individuals receiving statin therapy by group and pre-expansion period]

**Table N-12. Statin Therapy by Enrollee Type**

<table>
<thead>
<tr>
<th></th>
<th>Group-VIII</th>
<th>Pre-Expansion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Statin Therapy (n)</td>
<td>5,097</td>
<td>7,668</td>
</tr>
<tr>
<td>Statin Therapy (%)</td>
<td>74.4</td>
<td>76.7</td>
</tr>
<tr>
<td>No Statin Therapy (n)</td>
<td>1,553</td>
<td>2,327</td>
</tr>
<tr>
<td>No Statin Therapy (%)</td>
<td>25.6</td>
<td>23.3</td>
</tr>
</tbody>
</table>
7. Measure Specification: Rate 2—Statin Adherence 80%

**Denominator**
The Rate 2 eligible population.

**Numerator**
The number of members who achieved a PDC of at least 80% during the treatment period.

Follow the steps below to identify numerator compliance.

**Step 1** Identify the IPSD. The IPSD is the earliest dispensing event for any high or moderate-intensity statin medication (Table SPC-B) during 2015.

**Step 2** To determine the treatment period, calculate the number of days from the IPSD (inclusive) to the end of 2015.

**Step 3** Count the days covered by at least one prescription for statin medication (Table SPC-B) during the treatment period. To ensure that days supply that extends beyond 2015 is not counted, subtract any days supply that extends beyond December 31, 2015.

**Step 4** Calculate the member’s PDC using the following equation.

\[
\frac{\text{Total Days Covered by a Statin Medication in the Treatment Period (step 3)}}{\text{Total Days in Treatment Period (step 2)}}
\]

**Step 5** Sum the number of members whose PDC is \( \geq 80\% \) for the treatment period.

---

**Exhibit N-16. Percent of Individuals with Cardiovascular Disease with 80%+ Adherence to Statin Therapy**

![Bar chart showing adherence to statin therapy](chart)

**Table N-13. Adherence to Statin Therapy by Enrollee Type**

<table>
<thead>
<tr>
<th></th>
<th>Group-VIII</th>
<th>Pre-Expansion</th>
</tr>
</thead>
<tbody>
<tr>
<td>80%+ Adherence (n)</td>
<td>4,236</td>
<td>3,099</td>
</tr>
<tr>
<td>80%+ Adherence (%)</td>
<td>61.8</td>
<td>69.0</td>
</tr>
<tr>
<td>Less than 80% Adherence (n)</td>
<td>2,614</td>
<td>6,896</td>
</tr>
<tr>
<td>Less than 80% Adherence (%)</td>
<td>38.2</td>
<td>31.0</td>
</tr>
</tbody>
</table>
Statin Therapy for Patients With Diabetes

8. **Description**

The percentage of members 40–64 years of age during 2015 with diabetes who do not have clinical atherosclerotic cardiovascular disease (ASCVD) who met the following criteria. Two rates are reported:

1. **Received Statin Therapy.** Members who were dispensed at least one statin medication of any intensity during 2015.
2. **Statin Adherence 80%.** Members who remained on a statin medication of any intensity for at least 80% of the treatment period.

Eligible participants must not have more than one gap in enrollment of up to one month during 2015.

9. **Eligible Population: Rate 1—Received Statin Therapy**

**Step 1**

There are two ways to identify members with diabetes: by claim/encounter data and by pharmacy data. A member only needs to be identified by one method to be included in the measure. Members may be identified as having diabetes during 2015.

*Claim/encounter data.* Members who met any of the following criteria during 2015):

- At least two outpatient visits (Outpatient Value Set), observation visits (Observation Value Set), ED visits (ED Value Set) or non-acute inpatient encounters (Nonacute Inpatient Value Set) on different dates of service, with a diagnosis of diabetes (Diabetes Value Set). Visit type need not be the same for the two visits.
- At least one acute inpatient encounter (Acute Inpatient Value Set) with a diagnosis of diabetes (Diabetes Value Set).

*Pharmacy data.* Members who were dispensed insulin or hypoglycemics/ anti-hyperglycemics on an ambulatory basis during 2015 (Table CDC-A).

**Step 2: Required exclusions**

Exclude members who meet any of the following criteria:

- Members with cardiovascular disease are identified in two ways: by event or by diagnosis. A member only needs to be identified by one method to be excluded from the measure.
  
  - **Event.** Any of the following during 2015 meet criteria:
    
    - MI. Discharged from an inpatient setting with an MI (MI Value Set). To identify discharges:
      
      1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).
    - CABG. Discharged from an inpatient setting with a CABG (CABG Value Set). To identify discharges:
      
      1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set)
    - PCI. Members who had PCI (PCI Value Set) in any setting.
    - Other revascularization. Members who had any other revascularization procedure (Other Revascularization Value Set) in any setting.
  
  - **Diagnosis.** Identify members as having ischemic vascular disease (IVD) who met at least one of the following criteria during 2015.
• At least one outpatient visit (Outpatient Value Set) with an IVD diagnosis (IVD Value Set), or
• At least one acute inpatient encounter (Acute Inpatient Value Set) with an IVD diagnosis (IVD Value Set).

• Pregnancy (Pregnancy Value Set) during 2015.
• In vitro fertilization (IVF Value Set) in 2015.
• Dispensed at least one prescription for clomiphene (Table SPC-A) during 2015.
• ESRD (ESRD Value Set) during 2015.
• Cirrhosis (Cirrhosis Value Set) during 2015.
• Myalgia, myositis, myopathy, or rhabdomyolysis (Muscular Pain and Disease Value Set) during 2015.

10. **Measure Specification: Rate 1—Received Statin Therapy**

**Denominator**
The Rate 1 eligible population.

**Numerator**
The number of members who had at least one dispensing event for a statin medication of any intensity (Table SPD-A) during 2015.

**Table N-14. High, Moderate and Low-Intensity Statin Prescriptions**

<table>
<thead>
<tr>
<th>Description</th>
<th>Prescription</th>
</tr>
</thead>
<tbody>
<tr>
<td>High-intensity statin therapy</td>
<td>• Atorvastatin 40–80 mg</td>
</tr>
<tr>
<td></td>
<td>• Amlodipine-atorvastatin 40–80 mg</td>
</tr>
<tr>
<td></td>
<td>• Ezetimibe-atorvastatin 40–80 mg</td>
</tr>
<tr>
<td>Moderate-intensity statin therapy</td>
<td>• Atorvastatin 10–20 mg</td>
</tr>
<tr>
<td></td>
<td>• Amlodipine-atorvastatin 10–20 mg</td>
</tr>
<tr>
<td></td>
<td>• Ezetimibe-atorvastatin 10–20 mg</td>
</tr>
<tr>
<td></td>
<td>• Rosuvastatin 5–10 mg</td>
</tr>
<tr>
<td></td>
<td>• Simvastatin 20–40 mg</td>
</tr>
<tr>
<td></td>
<td>• Ezetimibe-simvastatin 20–40 mg</td>
</tr>
<tr>
<td></td>
<td>• Pravastatin 40–80 mg</td>
</tr>
<tr>
<td></td>
<td>• Aspirin-pravastatin 40–80 mg</td>
</tr>
<tr>
<td>Low-intensity statin therapy</td>
<td>• Simvastatin 10 mg</td>
</tr>
<tr>
<td></td>
<td>• Ezetimibe-simvastatin 10 mg</td>
</tr>
<tr>
<td></td>
<td>• Sitagliptin-simvastatin 10 mg</td>
</tr>
<tr>
<td></td>
<td>• Lovastatin 20 mg</td>
</tr>
<tr>
<td></td>
<td>• Niacin-lovastatin 20 mg</td>
</tr>
<tr>
<td></td>
<td>• Fluvastatin 40 mg bid</td>
</tr>
</tbody>
</table>

11. **Eligible Population: Rate 2—Statin Adherence 80%**

**Event/diagnosis**
All members who meet the numerator criteria for Rate 1.

12. **Measure Specification: Rate 2—Statin Adherence 80%**

**Denominator**
The Rate 2 eligible population.
The number of members who achieved a PDC of at least 80% during the treatment period. Follow the steps below to identify numerator compliance.

**Step 1** Identify the IPSD. The IPSD is the earliest dispensing event for any intensity statin medication (Table SPD-A) during the measurement year.

**Step 2** To determine the treatment period, calculate the number of days from the IPSD (inclusive) to the end of 2015.

**Step 3** Count the days covered by at least one prescription for statin medication during the treatment period. To ensure the measure does not give credit for supply that extends beyond 2015, subtract any days supply that extends beyond December 31, 2015.

**Step 4** Calculate the member’s PDC using the following equation.

\[
\text{PDC} = \frac{\text{Total Days Covered by a Statin Medication in the Treatment Period (step 3)}}{\text{Total Days in Treatment Period (step 2)}}
\]

**Step 5** Sum the number of members whose PDC is \(\geq 80\%\) for the treatment period.

Exhibit N-17. Percentage of Diabetics without atherosclerotic cardiovascular disease dispensed a Statin drug during 2015

The compliance rate for statin treatment of diabetic Group VIII patients was 38.4%. The compliance rate for statin treatment of pre-expansion diabetic patients was 42.5%.
Table N-15. Compliance rates for statin treatment by diabetic group

<table>
<thead>
<tr>
<th></th>
<th>Group-VIII</th>
<th>Pre-Expansion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diabetics dispensed Statin (n)</td>
<td>8,026</td>
<td>14,849</td>
</tr>
<tr>
<td>Diabetics dispensed a Statin (%)</td>
<td>27.9</td>
<td>33.0</td>
</tr>
<tr>
<td>Diabetics not dispensed a Statin (n)</td>
<td>12,901</td>
<td>20,108</td>
</tr>
<tr>
<td>Diabetics not dispensed a Statin (%)</td>
<td>61.6</td>
<td>57.5</td>
</tr>
</tbody>
</table>

The compliance rate for remaining on statin treatment by diabetic Group VIII patients was 27.9%. The compliance rate for remaining on statin treatment by pre-expansion diabetic patients was 33.0%.
Antidepressant Medication Management (AMM)

Description

The percentage of members 18 years of age and older who were treated with antidepressant medication, had a diagnosis of major depression and who remained on an antidepressant medication treatment during 2014 and 2015. Two rates are reported:

1. **Effective Acute Phase Treatment.** The percentage of members who remained on an antidepressant medication for at least 84 days (12 weeks).

2. **Effective Continuation Phase Treatment.** The percentage of members who remained on an antidepressant medication for at least 180 days (6 months).

Eligible participants must not have more than one gap in enrollment of up to one month during 2015.

Definitions

**Intake Period**
The 12-month window starting on May 1, 2014 and ending on April 30, 2015.

**IPSD**
Index Prescription Start Date. The earliest prescription dispensing date for an antidepressant medication during the Intake Period.

**Negative Medication History**
A period of 105 days prior to the IPSD when the member had no pharmacy claims for either new or refill prescriptions for an antidepressant medication.

**Treatment days**
The actual number of calendar days covered with prescriptions within the specified 180-day (6-month) measurement interval. For Effective Continuation Phase Treatment, a prescription of 90 days (3 months) supply dispensed on the 151st day will have 80 days counted in the 231-day interval.

Eligible Population

**Event/diagnosis**
Follow the steps below to identify the eligible population, which is used for both rates.

**Step 1**
Determine the IPSD. Identify the date of the earliest dispensing event for an antidepressant medication (Table AMM-C) during the Intake Period.

**Step 2: Required exclusion**
Exclude members who did not have a diagnosis of major depression in an inpatient, outpatient, ED, intensive outpatient or partial hospitalization setting during the 121-day period from 60 days prior to the IPSD, through the IPSD and the 60 days after the IPSD. Members who meet any of the following criteria remain in the eligible population:

- An outpatient visit, intensive outpatient encounter or partial hospitalization with any diagnosis of major depression. Either of the following code combinations meets criteria:
  - AMM Stand Alone Visits Value Set with Major Depression Value Set.
- AMM Visits Value Set with AMM POS Value Set and Major Depression Value Set.
  - An ED visit (ED Value Set) with any diagnosis of major depression (Major Depression Value Set).
  - An acute or nonacute inpatient stay (Inpatient Stay Value Set) with any diagnosis of major depression (Major Depression Value Set).

**Step 3**
Test for Negative Medication History. Exclude members who filled a prescription for an antidepressant medication 105 days prior to the IPSD.

**Step 4**
Calculate continuous enrollment. Members must be continuously enrolled for 105 days prior to the IPSD to 231 days after the IPSD.

---

**Administrative Specification**

**Denominator**
The eligible population.

**Numerator**

### Effective Acute Phase Treatment

At least 84 days (12 weeks) of continuous treatment with antidepressant medication (Table AMM-C) beginning on the IPSD through 114 days after the IPSD (115 total days). Continuous treatment allows gaps in medication treatment up to a total of 30 days during the 115-day period. Gaps can include either washout period gaps to change medication or treatment gaps to refill the same medication.

Regardless of the number of gaps, there may be no more than 30 gap days. Count any combination of gaps (e.g., two washout gaps of 15 days each, or two washout gaps of 10 days each and one treatment gap of 10 days).

**Table N-16. Antidepressant Medications**

<table>
<thead>
<tr>
<th>Description</th>
<th>Prescription</th>
</tr>
</thead>
<tbody>
<tr>
<td>Miscellaneous antidepressants</td>
<td>• Bupropion</td>
</tr>
<tr>
<td></td>
<td>• Vilazodone</td>
</tr>
<tr>
<td></td>
<td>• Vortioxetine</td>
</tr>
<tr>
<td>Monoamine oxidase inhibitors</td>
<td>• Isocarboxazid</td>
</tr>
<tr>
<td></td>
<td>• Phelazine</td>
</tr>
<tr>
<td>Phenylpiperazine antidepressants</td>
<td>• Nefazodone</td>
</tr>
<tr>
<td>Psychotherapeutic combinations</td>
<td>• Amitriptyline-chlordiazepoxide</td>
</tr>
<tr>
<td></td>
<td>• Amitriptyline-perphenazine</td>
</tr>
<tr>
<td>SNRI antidepressants</td>
<td>• Desvenlafaxine</td>
</tr>
<tr>
<td></td>
<td>• Duloxetine</td>
</tr>
<tr>
<td>SSRI antidepressants</td>
<td>• Citalopram</td>
</tr>
<tr>
<td></td>
<td>• Escitalopram</td>
</tr>
<tr>
<td>Tetracyclic antidepressants</td>
<td>• Maprotiline</td>
</tr>
<tr>
<td></td>
<td>• Mirtazapine</td>
</tr>
</tbody>
</table>
Tricyclic antidepressants
- Amitriptyline
- Amoxapine
- Clomipramine
- Desipramine
- Doxepin (>6 mg)
- Imipramine
- Nortriptyline
- Protriptyline
- Trimipramine

**Effective Continuation Phase Treatment**

At least 180 days (6 months) of continuous treatment with antidepressant medication (Table AMM-C) beginning on the IPSD through 231 days after the IPSD (232 total days).

Continuous treatment allows gaps in medication treatment up to a total of 51 days during the 232-day period. Gaps can include either washout period gaps to change medication or treatment gaps to refill the same medication.

Regardless of the number of gaps, there may be no more than 51 gap days. Count any combination of gaps (e.g., two washout gaps of 25 days each, or two washout gaps of 10 days each and one treatment gap of 10 days).

Table N-17. Antidepressant Medication Management by Enrollee Type

<table>
<thead>
<tr>
<th></th>
<th>Group-VIII</th>
<th>Pre-Expansion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Effective Acute Phase Treatment (n)</td>
<td>10,515</td>
<td>13,527</td>
</tr>
<tr>
<td>Effective Acute Phase Treatment (%)</td>
<td>61.7</td>
<td>51.0</td>
</tr>
<tr>
<td>Effective Continuation Phase Treatment (n)</td>
<td>8,671</td>
<td>9,744</td>
</tr>
<tr>
<td>Effective Continuation Phase Treatment (%)</td>
<td>50.9</td>
<td>36.7</td>
</tr>
</tbody>
</table>
**Telephone & Biometric Screening Analyses**

To assess whether observed differences in the biometric screening between Group VIII enrollees and pre-expansion enrollees were due to demographic differences, the research team estimated a series of logistic regression models which predicted the likelihood of biometric risk indicators with controls for age, gender, race, marital status, and whether there were children in the household. The models employed sample weights and were adjusted for the fact that the sample selection process was over-weighted towards Group VIII enrollees. These results are depicted in Exhibit N-21.

The research team found that the differences in the estimated probability of Group VIII enrollees and pre-expansion enrollees having high blood pressure, A1C levels consistent with diabetes, and high cholesterol were not significantly different after accounting for demographic differences in these subpopulations. The key differences were that Group VIII enrollees were older and more likely to be male; these characteristics are associated with higher blood pressure, diabetes, and high cholesterol.

**Exhibit N-21. Predicted probabilities of biometric risk indicators with demographic adjustments, Group VIII and pre-expansion enrollees**

*Derived from logistic regression models with controls for race, age, gender, education, marital status, and parental status.*

Source: Group VIII Biometric Screening (n=886).
Cardiovascular risk is defined as a combination of risk factors (age, sex, blood pressure, and cholesterol) that produce an estimate for an individual's risk over the next 10 years. High cardiovascular risk is defined as greater than a 7.5% risk over the next 10 years. The larger proportion of individuals at high cardiovascular risk in the Group VIII population, shown in Exhibit N-22, is expected given the demographic differences in the population (larger proportion of older males).