IOWA

Interim Report
Iowa Wellness Plan Evaluation
Supplemental Materials

November 2023

The University of Iowa

Contents

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COVID-19 flexibilities for all Medicaid programs

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Department of HUMAN SERVICES

Medicaid Flexibilities Requests in Response to COVID-19 Emergency

July 9, 2021

The Department has made the following requests to the Centers for Medicare and Medicaid Services (CMS) to continue serving Medicaid members during the COVID-19 emergency. ***The Department is doing a gradual return to regular processes. The federal flexibilities will remain in place and can be used should a member have a documented need. CMS will provide the Department with a 60-day notice prior to the official end of the public health emergency, and at that time, further clarification on the ending of flexibilities will be communicated.***

Request	Start Date	Expected End Date*
Provision of Services in Alternative Settings • Allow for the provision of services in alternative settings when a licensed facility is unavailable due to the COVID-19 emergency	March 1, 2020	End of Federal Public Health Emergency (PHE) *(July 14, 2021)*
CHIP/Hawki Age-out • Continued eligibility for Children's Health Insurance Program (CHIP) enrollees who turn 19 years old during the national emergency and who are otherwise ineligible for Medicaid due to income above 133% of the federal poverty level (FPL).	March 1, 2020	End of Federal PHE + 60 Days *(September 12, 2021)*
CHIP/Hawki Eligibility • Extend eligibility to CHIP members beyond their certification period. • Provide CHIP members additional time to submit renewal or verification materials.	March 1, 2020	End of Federal PHE *(July 14,2021)*
Continuous Eligibility • Establish up to 12-months of continuous eligibility for all Medicaid enrollees age 19 and over (already in place for those under age 19).	March 1, 2020	End of the Month in which Federal PHE Ends *(July 31, 2021)*
Cost Sharing Suspended Suspend cost-sharing for all members and suspend premiums for: • Medicaid for Employed People with Disabilities (MEPD) • Iowa Health and Wellness Plan (IHAWP) • Dental Wellness Plan (DWP) • Healthy and Well Kids in Iowa (Hawki) • Client participation is not suspended.	March 1, 2020	Premiums could resume: End of Federal PHE *(July 14, 2021)* Disenrollment for non-payment could resume: End of the quarter in which Federal PHE Ends: *(October 1, 2021)*
Coverage for Uninsured • Cover COVID-19 testing and related visits for uninsured individuals during the emergency, as allowed under the Families First Coronavirus Response Act.	June 1, 2020	End of Federal PHE *(July 14, 2021)*

1305 E. Walnut Street, Des Moines, IA 50319-0114

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Request	Start Date	Expected End Date*
Fair Hearing Flexibilities • Suspend adverse actions for individuals for whom the state has completed a determination but either: (1) has not yet sent the notice; or (2) who the state believes likely did not receive the notice. • Delay scheduling fair hearings and issuing fair hearing decisions under 42 C.F.R. 431.244(f)(4)(i)(B). • Hold fair hearings via video conferencing or telephone, provided the state adheres to other fair hearing requirements (42 C.F.R. part 431, subpart E), including ensuring that the hearing system is accessible to persons who are limited English proficient and persons who have disabilities (see 42 C.F.R. § 431.205(e) and 435.905(b)). • Reinstate services or eligibility if discontinued because the beneficiary's whereabouts were unknown due to displacement, after the beneficiary's whereabouts become known (if still eligible), consistent with 42 C.F.R. 431.231(d).	March 13, 2020	End of Federal PHE *(July 14, 2021)*
Home Delivered Meals • Provide home delivered meals, subject to prior authorization, for Medicaid enrollees **who are not enrolled in a 1915(c) waiver**, and are homebound due to the national emergency.	March 13, 2020	End of Federal PHE *(July 14, 2021)*
Home Delivered Meals • Provide home delivered meals for members receiving habilitation services.	March 13, 2020	End of Federal PHE *(July 14, 2021)*
Home Delivered Meals • Provide home delivered meals for all 1915(c) enrollees who are homebound due to the national public health emergency. **(Members receiving Home- and Community-Based HCBS waiver services.)**	January 27, 2020	End of Federal PHE + 6 Months* *(January 20, 2022)*

Additional Services
• **For Non-HCBS Population/Non-Habilitation**
  ○ Companion services
  ○ Homemaker services
	March 13, 2020	End of Federal PHE
		(July 14, 2021)

Additional Services
• **For HCBS Population**
  ○ Companion services
  ▪ Includes the alternative for companion services to replace supported community living, and consumer directed attendant care services that are unavailable if there is a shortage of providers or providers are not able to deliver goal directed service due to the COVID-19 emergency.
	January 27, 2020	End of Federal PHE + 6 Months*
		(January 20, 2022)

Request	Start Date	Expected End Date*
○ Homemaker services ○ Allow self-direction of the added services		
Additional Services • **Habilitation Population** ○ Companion services ▪ Includes the alternative for companion services to replace habilitation services that are unavailable if there is a shortage of providers or providers are not able to deliver goal directed service due to the COVID-19 emergency. ○ Homemaker services ○ Allow self-direction of the added services	March 13, 2020	End of Federal PHE *(July 14, 2021)*
Hospital 24-Hour Nursing Flexibility • Waive the 24-hour nursing requirement, which will permit a nurse to cover more than one ward in the event of staffing shortages caused by the COVID-19 emergency.	March 1, 2020	End of Federal PHE *(July 14, 2021)*
Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) Flexibilities • Waive the requirement for direct care residential living unit staff, which will allow changes to direct care staff numbers, if necessary, due to the COVID-19 emergency. • Waive the continuous active treatment program requirement, which will allow the health and safety needs of residents to be met if sufficient staff are unavailable to implement continuous active treatment due to the COVID-19 emergency.	March 1, 2020	End of Federal PHE *(July 14, 2021)*
Nursing Facility COVID-19 Relief Rate (CRR) • CRR payments are available to Medicaid certified skilled nursing facilities (SNF) and nursing facilities (NF) during the period of the federal public health emergency who meet the requirements in IL 2146-MC-FFS-CVD.	March 13, 2020	End of Federal PHE *(July 14, 2021)*
Preadmission Screening and Resident Review (PASRR) • Waive the PASRR, which will allow a nursing home to continue admission of an individual who has not had an assessment completed if there is a workforce disruption or hospitals reduce or limit outside contact in their facilities.	March 1, 2020	End of Federal PHE *(July 14, 2021)*

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Request	Start Date	Expected End Date*
Provider Enrollment • Waive payment of application fee to temporarily enroll a provider • Waive site visits to temporarily enroll a provider • Waive requirements that physicians and other health care professionals be licensed in the state in which they are providing services, so long as they have equivalent licensing in another state	March 1, 2020	End of Federal PHE + 6 Months *(January 20, 2022)*
Provider Enrollment • Permit providers located out-of-state/territory to provide care to an emergency State's Medicaid enrollee and be reimbursed for that service • Postpone deadlines for revalidation of providers who are located in the state or otherwise directly impacted by the emergency • Waive conditions of participation or conditions for coverage for existing providers for facilities for providing services in alternative settings, including using an unlicensed facility, if the provider's licensed facility has been evacuated • Temporarily delay or suspend onsite re-certification and revisit surveys, and enforcement actions, and allow additional time for facilities to submit plans of correction.	March 1, 2020	End of Federal PHE *(July 14, 2021)*
Long Term Service and Supports (LTSS) • Extend minimum data set (MDS) authorizations for nursing facility and skilled nursing facility residents • Modify deadlines for OASIS (HHA) assessments and transmission	March 1, 2020	End of Federal PHE *(July 14, 2021)*
Reporting and Oversight • Suspend 2-week aide supervision requirement by a registered nurse for home health agencies • Suspend supervision of hospice aides by a registered nurse every 14 days' requirement for hospice agencies	March 1, 2020	End of Federal PHE *(July 14, 2021)*
Residency • Consider beneficiaries evacuated from the state temporarily absent and maintain enrollment in their home state (for home state where disaster occurred or public health emergency exists)	March 13, 2020	End of Federal PHE *(July 14, 2021)*
Telehealth • Allow telehealth for any Medicaid service for which it is appropriate, regardless of member location.	March 13, 2020	End of Federal PHE *(July 14, 2021)*

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Request	Start Date	Expected End Date*
Allow case management companies to provide direct services in order to address potential personnel crisis for: • HCBS Population • Habilitation Population	January 27, 2020 March 1, 2020	HCBS: End of Federal PHE + 6 Months* *(January 20, 2022)* Habilitation: End of Federal PHE *(July 14, 2021)*
Exceed Respite Service Limitations • Remove the annual cost limit for respite services on the Intellectual Disabilities (ID) Waiver. • Remove the limitation on respite being provided for children while parents, or primary caregivers, are working from home in order to relieve pressure created by work, school and daycare closures during the emergency. **(HCBS Population)**	January 27, 2020	End of Federal PHE + 6 Months* *(January 20, 2022)*
HCBS Regulations • Not comply with the HCBS settings requirement at 42 CFR 441.301(c)(4)(vi)(D) that individuals are able to have visitors of their choosing at any time, for settings added after March 17, 2014, to minimize the spread of infection during the COVID-19 pandemic. ○ **HCBS Population** ○ **Habilitation Population**	January 27, 2020 March 1, 2020	HCBS: End of Federal PHE + 6 Months* *(January 20, 2022)* Habilitation: End of Federal PHE *(July 14, 2021)*
Out-of-State Background Checks • Temporarily waive out-of-state background checks for Consumer Directed Attendant Care (CDAC) providers. The State will continue to conduct Iowa background checks during the emergency.	March 1, 2020	End of Federal PHE *(July 14, 2021)*
Parents and Family Members • Allow parents and family members to provide direct services. ○ Services allowed include: home based habilitation services, supported community living, CDAC, and meals ▪ **HCBS Population** ▪ **Habilitation Population**	January 27, 2020 March 1, 2020	HCBS: End of Federal PHE + 6 Months* *(January 20, 2022)* Habilitation: End of Federal PHE *(July 14, 2021)*
Use of Legally Responsible Individuals to Render Personal Care Services (Early Periodic Screening, Diagnosis and Treatment, EPSDT) • For 1905(a) personal care services to be rendered by legally responsible individuals, including legally responsible family caregivers	March 1, 2020	End of Federal PHE *(July 14, 2021)*
Processes • Allow an extension for reassessments and reevaluations for up to one year past the due date. • Allow the option to conduct evaluations, assessments, and person-centered service planning meetings virtually/remotely in lieu of face-to-face meetings. • Adjust prior approval/authorization elements approved in waiver. • Adjust assessment requirements.		

Request	Start Date	Expected End Date*
• Add an electronic method of signing off on required documents such as the person-centered service plan. ○ **HCBS Population** ○ **Habilitation Population**	January 27, 2020 March 1, 2020	HCBS: End of Federal PHE + 6 Months* *(January 20, 2022)* Habilitation: End of Federal PHE *(July 14, 2021)*
Retainer Payments Option for the State to make retainer payments to providers when a member is unable to receive normally authorized and scheduled services due to hospitalization, short term facility stay, isolation, or closure of a service line for any of the services listed below of no more than 30 days related to the COVID-19 emergency: • **HCBS Population** ○ Adult Day Care **(AIDS, ID, and BI)** ○ Consumer Directed Attendant Care **(AIDS, PD, ID, BI)** ○ Day Habilitation **(ID)** ○ Prevocational Services **(ID, BI)** ○ Supported Employment **(ID, BI)** • **Habilitation Population** ○ Day Habilitation ○ Prevocational Services ○ Supported Employment	January 27, 2020 March 13, 2020	HCBS: End of Federal PHE + 6 Months* *(January 20, 2022)* End of Federal PHE *(July 14, 2021)*
Settings for HCBS expanded, if necessary and appropriate • Allow services to be provided in ICF/ID or other facility settings • Allow direct care provider's homes to be authorized settings – subject to IME approval through an exception to policy request after all other options have been exhausted • Allow direct care providers to move into member's homes – subject to IME approval through an exception to policy request after all other options have been exhausted • Lift the existing limitation on five person homes to no longer designate an upper limit; providers allowed to consolidate members into homes, with this allowance limited by the home's capacity. ○ **HCBS Population** ○ **Habilitation Population**	January 27, 2020 March 1, 2020	HCBS: End of Federal PHE + 6 Months* *(January 20, 2022)* Habilitation: End of Federal PHE *(July 14, 2021)*

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Request	Start Date	Expected End Date*
Typically Face-to-Face Processes • Level of care and need based assessment evaluations and reevaluations • Service plan reviews • Interim service plan changes based on member's change in needs • Quarterly face to face case manager contacts ○ **HCBS Population** ○ **Habilitation Population**	January 27, 2020 March 1, 2020	HCBS: End of Federal PHE + 6 Months* *(January 20, 2022)* Habilitation: End of Federal PHE *(July 14, 2021)*
Dental Relief Payment ▪ Allowed a temporary enhanced payment to dental providers to help address facility and safety upgrades in accordance with IL 2148-FFS-D-CVD.	May 1, 2020	August 31, 2020
Provider Relief ▪ Allowed the distribution of $50 million in grants to specific providers in accordance with IL 2173-MC-FFS-CVD. This money was provided to the State under the federal Coronavirus Aid, Relief, and Economic Security (CARES) Act.	March 1, 2020	June 30, 2021
Grants to Nursing Facilities ○ Allow civil money penalty (CMP) funds to be distributed as grants to nursing facilities to purchase communicative technology during COVID-19 in accordance with IL 2133-MC-FFS-CVD. ○ Allow CMP funds to be distributed as grants to nursing facilities for In-Person Visitation Aids.	March 1, 2020 October 26, 2020	Technology: End of Federal PHE *(July 14, 2021)* In-Person Visitation Aids: End of Federal PHE *(July 14, 2021)*
E-Learning • Allow e-learning for Supported Community Living (SCL) members living outside the family home. **(HCBS Population)** • Allow e-learning for home based Habilitation members living outside the family home. **(Habilitation Population)**	January 27, 2020 March 1, 2020	HCBS: End of Federal PHE + 6 Months* *(January 20, 2022)* Habilitation: End of Federal PHE *(July 14, 2021)*
Provider Relief • Allowed the distribution of $24 million in grants to specific providers in accordance with IL 2194-MC-FFS-CVD. This money was provided to the State under the federal Coronavirus Aid, Relief, and Economic Security (CARES) Act.	March 1, 2020	June 30, 2021

** Pending CMS approval.*

Blanket waivers announced by CMS, applicable to all states without need to specifically waive:
https://www.cms.gov/files/document/covid19-emergency-declaration-health-care-providers-fact-sheet.pdf

COVID-19 Waivers for Health Facilities announced by the Department of Internal Inspections:
https://dia.iowa.gov/document/covid-19-waivers-health-facilities

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Telehealth Billing

Department of HUMAN SERVICES

INFORMATIONAL LETTER NO. 2126-MC-FFS-D-CVD

DATE:	April 2, 2020
TO:	All Iowa Medicaid Providers
APPLIES TO:	Managed Care (MC), Fee-for-Service (FFS), Dental (D) Coronavirus Disease (CVD)
FROM:	Iowa Department of Human Services (DHS), Iowa Medicaid Enterprise (IME)
RE:	Update to Billing Services for Telehealth related to Coronavirus and COVID-19
EFFECTIVE:	Immediately

The purpose of this Informational Letter is to provide additional guidance related to telehealth billing for covered services during the public health COVID-19 emergency. The billing requirements will return to normal when the public health emergency is lifted.

During this interim period, the expanded list of telehealth services is billable by multiple provider types including, but not limited to, physicians, physician assistants, dentists, physical therapists, occupational therapists, speech therapists, home health, hospice, behavioral health and home and community-based services (HCBS) providers. Generally speaking, the IME will allow services that by definition are direct contact services and are typically rendered in person to be rendered via telehealth when clinically appropriate. It is permissible for both the member and the provider to be located in their homes during the provision of telehealth services through video or telephonic conferencing.

In addition to the information provided in Informational Letter No. 2115-MC-FFS[1], and Informational Letter No. 2119-MC-FFS-CVD[2], the IME will provide ongoing support through a Provider Frequently Asked Questions[3] page on our website. Please refer to this for the most up-to-date information.

[1] https://dhs.iowa.gov/sites/default/files/2115-MC-FFS_Billing_related_to_COVID-19.pdf
[2] https://dhs.iowa.gov/sites/default/files/2119-MC-FFS-CVD_Telehealth_and_Pharmacy_Billing_COVID19_2.pdf
[3] https://dhs.iowa.gov/ime/providers/faqs/covid19

Although IME has expanded the telehealth benefits, providers should be aware that services provided to Medicaid members via telehealth must be clinically appropriate and within the providers scope of practice. Providers are required to obtain the member's consent prior to the delivery of services. In addition, providers are required to ensure appropriate documentation to substantiate the provision of services is maintained and available for post-payment review. The documentation must indicate the services were rendered via telehealth and clearly identify the location of both the provider and the member.

Please submit telehealth billing questions to IMECOVID19@dhs.state.ia.us.

Medicaid Informational Letters: Waiver of Retroactive Eligibility

Iowa Department of Human Services

Kim Reynolds, Governor | Adam Gregg, Lt. Governor | Jerry R. Foxhoven, Director

INFORMATIONAL LETTER NO. 1808-MC-FFS-D

DATE: June 30, 2017

TO: All Iowa Medicaid Providers

APPLIES TO: Managed Care (MC), Fee-for-Service (FFS), Dental (D)

FROM: Iowa Department of Human Services (DHS), Iowa Medicaid Enterprise (IME)

RE: Retroactive Medicaid Coverage

EFFECTIVE: October 1, 2017

The state fiscal year (SFY) 2018/19 Human Services appropriations bill (House File 653), included a number of legislatively mandated cost-containment initiatives. One such initiative was to eliminate retroactive benefits for all Iowa Medicaid eligibility groups currently eligible to receive up to three months of retroactive coverage.

Medicaid applications that are received by DHS on or before September 30, 2017, will still be eligible for retroactive Medicaid benefits, if all other eligibility factors are met. The effective date of coverage for Medicaid remains unchanged and begins on the first of the month in which the application is received.

The elimination of retroactive coverage does NOT impact presumptive eligibility, annual renewals/reviews, or the 90-day reconsideration period.

If you have questions, please contact the Iowa Medicaid Provider Services Unit at 1-800-338-7909, Monday- Friday, from 7:30 a.m. to 4:30 p.m., or by email at imeproviderservices@dhs.state.ia.us.

All Informational Letters are sent to the Managed Care Organizations
Iowa Medicaid Enterprise – 100 Army Post Road - Des Moines, IA 50315

Iowa Department of Human Services

Kim Reynolds, Governor | Adam Gregg, Lt. Governor | Jerry R. Foxhoven, Director

INFORMATIONAL LETTER NO.1841-MC-FFS-D

DATE: October 26, 2017

TO: All Iowa Medicaid Providers

APPLIES TO: Managed Care (MC), Fee-for-Service (FFS) and Dental (D)

FROM: Iowa Department of Human Services (DHS), Iowa Medicaid Enterprise (IME)

RE: Retroactive Medicaid Coverage

EFFECTIVE: Upon Receipt

The state fiscal year (SFY) 2018/19 Human Services appropriations bill (House File 653), included a number of legislatively mandated cost-containment initiatives. One such initiative was to eliminate retroactive benefits for all Iowa Medicaid eligibility groups currently eligible to receive up to three months of retroactive coverage. This was announced in Informational Letter 1808-MC-FFS-D[1].

This change requires approval from the Centers for Medicare and Medicaid Services (CMS). The department has not yet received approval from CMS on the elimination of retroactive benefits, and these changes will not be implemented until an approval has been received. Further information and details will be shared once final decisions are made and DHS is ready to implement. **Until that time, retroactive benefits continue as they have in the past.**

If you have questions, please contact the IME Provider Services Unit at 1-800-338- 7909, Monday- Friday, from 7:30 a.m. to 4:30 p.m., or by email at imeproviderservices@dhs.state.ia.us.

[1] https://dhs.iowa.gov/sites/default/files/1808-MC-FFS-D_RetroactiveMedicaidCoverage.pdf

Iowa Department of Human Services

Kim Reynolds, Governor | Adam Gregg, Lt. Governor | Jerry R. Foxhoven, Director

INFORMATIONAL LETTER NO.1847-MC-FFS-D

DATE: October 30, 2017

TO: All Iowa Medicaid Providers

APPLIES TO: Managed Care (MC), Fee-for-Service (FFS), Dental (D)

FROM: Iowa Department of Human Services (DHS), Iowa Medicaid Enterprise (IME)

RE: Retroactive Medicaid Coverage

EFFECTIVE: November 1, 2017

On August 2, 2017, Iowa, as directed by the legislature, submitted a request to the Centers for Medicare and Medicaid Services (CMS) to eliminate retroactive eligibility for all Medicaid applicants.

CMS has approved Iowa's request to eliminate the three month retroactive eligibility period, except for pregnant women (and during the 60-day period beginning on the last day of the pregnancy) and infants under one year of age, for applications filed on or after November 1, 2017. This includes initial applications and applications to add new household members.

Medicaid applications that are received by DHS on or before October 31, 2017, will still be eligible for retroactive Medicaid benefits, if all other eligibility factors are met. The effective date of coverage for Medicaid remains unchanged and begins on the first of the month in which the application is received.

The elimination of retroactive coverage does **not** impact presumptive eligibility, annual renewals/reviews, or the 90-day reconsideration period.

If you have questions, please contact the IME Provider Services Unit at 1-800-338- 7909, Monday- Friday, from 7:30 a.m. to 4:30 p.m., or by email at imeproviderservices@dhs.state.ia.us.

Iowa Department of Human Services

INFORMATIONAL LETTER NO. 1955-MC-FFS-D

DATE: September 28, 2018

TO: All Iowa Medicaid Providers

APPLIES TO: Managed Care (MC), Fee-for-Service (FFS), Dental (D)

FROM: Iowa Department of Human Services (DHS), Iowa Medicaid Enterprise (IME)

RE: Retroactive Medicaid Coverage

EFFECTIVE: July 1, 2018

Reinstatement of Retroactive Coverage for Individuals Residing in a Nursing Facility at Application

In 2017, consistent with the state fiscal year (SFY) 2018/19 Human Services appropriations bill (House File 653), DHS requested to eliminate retroactive benefits for all Iowa Medicaid eligibility groups that were previously eligible to receive up to three months of retroactive coverage. The Centers for Medicare and Medicaid Services (CMS) approved this request, with an exception for pregnant women and during the 60-day period beginning on the last day of the pregnancy and infants under one year of age, who continue to receive the 3-month retroactive eligibility period.

Today, in accordance with Senate File 2418 passed by the Iowa Legislature during the 2018 session, DHS is revising its policy and will reinstate a 3-month retroactive Medicaid coverage benefit for applicants who are residents of a nursing facility at the time of application and are otherwise Medicaid-eligible.

This revised policy is effective for new Medicaid applications filed on or after July 1, 2018. System changes in alignment with this policy revision will be made effective October 1, 2018. Providers who are assisting applicants impacted by this policy change with applications filed between July 1, 2018, and the effective date of the system changes should have the applicant, the applicant's Power of Attorney (POA), or the applicant's authorized representative contact the Centralized Facility Eligibility Unit (CFEU) to request that retroactive eligibility be determined for the application previously submitted during the effected time frame. The request can be made by phone, email, or mail to CFEU:

Phone: 1-877-344-9628
Email: facilities@dhs.state.ia.us
Mail: CFEU
Imaging Center #1
417 E. Kanesville Blvd.
Council Bluffs, IA 51503

If you have questions, please contact the Iowa Medicaid Provider Services Unit at 1-800-338-7909, Monday - Friday, from 7:30 a.m. to 4:30 p.m., or by email at imeproviderservices@dhs.state.ia.us.

Department of HUMAN SERVICES

INFORMATIONAL LETTER NO. 2085-MC-FFS-D

DATE:	January 3, 2020
TO:	All Iowa Medicaid Providers
APPLIES TO:	Managed Care (MC), Fee-for-Service (FFS), Dental (D)
FROM:	Iowa Department of Human Services (DHS), Iowa Medicaid Enterprise (IME)
RE:	Retroactive Medicaid Coverage
EFFECTIVE:	January 1, 2020

Reinstatement of Retroactive Coverage for Children at Application

Upon review and approval of the state's request to extend the Iowa Wellness Plan waiver demonstration, the Centers of Medicare and Medicaid Services (CMS) has updated the waiver of retroactive coverage to exempt children under 19 years of age.

A 3-month retroactive Medicaid coverage period will be available to children under age 19 at the time of application and who are otherwise Medicaid eligible. The earliest that a retroactive eligibility can begin is January 1, 2020, for applications filed on or after January 1, 2020.

A 3-month retroactive Medicaid coverage period will continue for pregnant women (and during the 60-day period beginning on the last day of the pregnancy), infants under one year of age and applicants who are residents of a nursing facility at the time of application.

The effective date of coverage for Medicaid remains unchanged and begins on the first of the month in which the application is received.

If you have questions, please contact the Iowa Medicaid Provider Services Unit at 1-800-338-7909, Monday – Friday, from 7: 30 a.m. to 4:30 p.m., or by email at imeproviderservices@dhs.state.ia.us.

New Enrollee Surveys

New Enrollee Survey (Adults)

QUESTIONNAIRE INTRODUCTION/CONSENT

Hello! My name is [Interviewer Name] and I am with the University of Iowa. May I please speak with [First Name, Last Name]?

We are calling to ask you to be a part of a survey of new [PLAN NAME] members that is being done by researchers at the University of Iowa. Hopefully you received a gold and blue postcard letting you know that we would be calling you?

We got your name from the Iowa Department of Human and Human Services (DHHS) as a person who recently joined [PLAN NAME]. We would like to ask you a few questions about your experiences with the plan and about joining the plan. To thank you for your time, we will mail you $20 after you complete the survey.

The questions should take around 20 minutes to answer. You can skip any questions that you don't want to answer. The survey is voluntary. You do not have to take part if you do not want to. If you choose not to, it will not affect the benefits you qualify for, including [PLAN NAME].

Your answers will be combined with answers from other people in the program and included in a report that will be given to both the Iowa and US Departments of Health and Human Services (DHHS). They will use the information to better understand how the program works in Iowa and help other states learn from Iowa's program. Your individual responses will not be shared.

Do you have any questions about the survey?

[ENTER PLAN THEY ARE ON BELOW]

1. Iowa Health and Wellness Plan
2. Iowa Wellness Plan
3. Marketplace Choice
4. TFMP
5. TANF
6. FIP
7. OTHER (FILL IN)

C1. Are you willing to complete this phone survey?

1. YES [CONTINUE TO SCREENING]
2. NO [IF NO: END SURVEY]

<u>CALLBACK</u>

What day and time would be best for us to call back?

SURVEY QUESTIONS

Great! The survey will ask about your personal coverage only. First, I will ask you a few questions about joining [PLAN NAME]. There are also questions about insurance coverage, your health, your opinions, and a few questions that help describe you. If there is a question you don't want to answer, let me know and, we can skip it. Throughout the survey, please tell me if you have questions or if anything is not clear.

Enrollment Experience

Q1. First, I'm going to read a list of reasons why people may apply to receive health care coverage through [PLAN NAME]. Please tell me if any of these were a reason why YOU applied for [PLAN NAME]. You can answer yes or no.

1. You [OR YOUR SPOUSE] lost employer-based insurance.
2. Your doctor's office or hospital told you to apply.
3. Your caseworker told you to apply.
4. Your health got worse.
5. Your family situation changed (such as a divorce).
6. You are required to have health insurance.
7. You recently moved to Iowa.
8. You were no longer covered by your parents' insurance. [TURNED 26]
9. Is there a different reason you applied? Please describe___

77. NOT APPLICABLE
88. DON'T KNOW
99. REFUSED

Q2. Did you have any help signing up for [PLAN NAME]?

1. YES
2. NO [SKIP TO Q4]

77. NOT APPLICABLE [SKIP TO Q4]
88. DON'T KNOW [SKIP TO Q4]
99. REFUSED [SKIP TO Q4]

[IF Q2=1]

Q3. Who helped you sign up? (Field code the answers)

1. FAMILY MEMBER
2. FRIEND
3. A HEALTH CARE PROVIDER/STAFF
4. A CASE WORKER
5. SOMEONE ON THE PHONE – MEDICAID HELP LINE, 1-800 number
6. OTHER_____

77. NOT APPLICABLE
88. DON'T KNOW

99. REFUSED

Q4. How easy or difficult was it to apply for [PLAN NAME]? Would you say it was:

1. Very easy [SKIP TO Q6]
2. Somewhat Easy [SKIP TO Q6]
3. Somewhat Difficult
4. Very difficult
77. NOT APPLICABLE
88. DON'T KNOW [SKIP TO Q6]
99. REFUSED [SKIP TO Q6]

[IF Q4=3 or 4]

Q5. What difficulties did you have when applying?

1. YOU COULDN'T UNDERSTAND THE FORMS.
2. THE PROCESS WAS TOO COMPLICATED.
3. YOU HAD NO TRANSPORTATION TO APPOINTMENT.
4. YOU DID NOT KNOW WHERE TO GO TO GET HELP.
5. YOU DID NOT HAVE ALL THE NEEDED DOCUMENTS.
6. YOU HAD NO ONE TO HELP YOU FILL OUT THE FORMS.
7. YOU COULD NOT ACCESS THE ONLINE FORMS.
8. OTHER _____
77. NOT APPLICABLE
88. DON'T KNOW
99. REFUSED

Coverage/enrollment Gap

Q6. In the year prior to joining [PLAN NAME], so since [CURRENT MONTH] [CURRENT YEAR-1], were you covered by any kind of health insurance?

1. YES
2. NO [SKIP TO Q9]
77. NOT APPLICABLE [SKIP TO Q9]
88. DON'T KNOW [SKIP TO Q9]
99. REFUSED [SKIP TO Q9]

[IF Q6=1]

Q7. Was the most recent insurance private insurance? (Private means you or your family got it through an employer or individually purchased it?)

1. YES [SKIP TO Q8]
2. NO
77. NOT APPLICABLE [SKIP TO Q8]
88. DON'T KNOW [SKIP TO Q8]
99. REFUSED [SKIP TO Q8]

Q7.1 [IF NO] What [public] insurance did you use prior to applying for [PLAN NAME]

1. Medicare
2. Medicaid

3. Children's Health Insurance Program (CHIP)/Hawki
4. Military related health care: TRICARE (CHAMPUS) / VA health care / CHAMP-VA
5. Indian Health Service
6. State-sponsored health plan
7. OR WAS IT ANOTHER government program? ___ [INCLUDE TEXT] _____
77. NOT APPLICABLE
88. DON'T KNOW
99. REFUSED

[IF Q6=1]

Q8. In which year did that earlier coverage end?

1. 2022
2. 2023
3. 2024

77. NOT APPLICABLE [SKIP TO Q9]
88. DON'T KNOW [SKIP TO Q9]
99. REFUSED [SKIP TO Q9]

Q8.1. In which month in [display year answer from previous question] did that earlier coverage end?

1. January
2. February
3. March
4. April
5. May
6. June
7. July
8. August
9. September
10. October
11. November
12. December

77. NOT APPLICABLE
88. DON'T KNOW
99. REFUSED

Q9. Thinking about your recent application to [PLAN NAME], how long ago did you start thinking about applying.

_____# MONTHS or
_____# WEEKS
77. NOT APPLICABLE
88. DON'T KNOW
99. REFUSED

Q10. For some people, [PLAN NAME] may pay the costs of medical care they received before joining the plan. When you applied for [PLAN NAME], did you think that the plan would pay for any of the medical care you received BEFORE joining?

1. YES
2. NO [SKP to Q12]

77. NOT APPLICABLE [SKP TO Q12]
88. DON'T KNOW [SKP to Q12]
99. REFUSED [SKP to Q12]

[IF Q10=1]

Q11. How far back did you think the program would pay for the medical care you received before joining [PLAN NAME]?

Did you think the program would pay for care back

1. TO THE FIRST OF THE APPLICATION MONTH--ONLY SELECT IF R EXPLICITLY STATES THIS
2. 1-DAY TO ONE MONTH (1-30 DAYS)
3. >1 MONTH TO 2 MONTHS (31-60 DAYS)
4. >2 MONTHS TO 3 MONTHS (61-90 DAYS)
5. MORE THAN 3 MONTHS (>93 DAYS)
6. OR SOMETHING DIFFERENT: [OPEN TEXT]
77. NOT APPLICABLE
88. DON'T KNOW
99. REFUSED

Q12. Everyone has their own opinion about health insurance: What about you? Would you say that, for you, having health insurance coverage is...?

1. Very important
2. Somewhat important
3. Not very important or
4. Not at all important
77. NOT APPLICABLE
88. DON'T KNOW
99. REFUSED

Medical Debt

Q17. In the last 3 months [or in the past x months – calculated from the coverage gap time if fewer than 3 months], did you have any health care bills? Include bills such as from doctors, dentists, hospitals, therapists, and pharmacies etc.

1. YES
2. NO [SKIP TO Q20]
77. NOT APPLICABLE
88. DON'T KNOW [SKIP TO Q20]
99. REFUSED [SKIP TO Q20]

Q18. Did you have any difficulty paying these bills?

1. YES
2. NO
77. NOT APPLICABLE
88. DON'T KNOW
99. REFUSED

Q19. Were these bills for any of the following types of services?

1. Medical care? Y/N

2. Dental care? Y/N
3. Prescription medication? Y/N
77. NOT APPLICABLE
88. DON'T KNOW
99. REFUSED

Q20. The next questions focus on the affordability of health care for you [IF DOV_FAMSIZE>1] and your family. We're interested in your immediate family, which would include you, a spouse or partner (if applicable), and any of your children or stepchildren under 19 who live with you].
For this question, think about your [IF DOV_FAMSIZE>1: and your family's] health care experiences over the past 12 months, that is, since [CURRENT MONTH] [CURRENT YEAR-1]. Did you [IF DOV_FAMSIZE>1: or anyone in your family] have problems paying any medical bills? Include bills for doctors, dentists, hospitals, therapists, medication, equipment, nursing home, or home care.

1. YES
2. NO
77. NOT APPLICABLE
88. DON'T KNOW
99. REFUSED

Q20_A. Do you [IF DOV_FAMSIZE>1: or anyone in your family] currently have any medical bills that are being paid off over time? This could include medical bills being paid off with a credit card, through personal loans, or bill paying arrangements with hospitals, doctors, or other health care providers. The bills can be from earlier years as well as this year.

1. YES
2. NO
77. NOT APPLICABLE
88. DON'T KNOW
99. REFUSED

Q21. Do you [IF DOV_FAMSIZE>1: or anyone in your family] currently have any unpaid medical bills that are past due? Include bills for doctors, dentists, hospitals, therapists, medication, equipment, nursing home, or home care. This could include medical bills owed directly to health care providers or paid with a credit card or personal loan. The bills can be from earlier years as well as this year.

1. YES
2. NO [SKIP TO Q23]
77. NOT APPLICABLE
88. DON'T KNOW [SKIP TO Q23]
99. REFUSED [SKIP TO Q23]

[IF Q21=1]
Q22. About how much do you [IF DOV_FAMSIZE>1: or your family] currently owe for medical bills that are past due? Exclude bills that will likely be paid by an insurance company. Your best estimate is fine.

1. LESS THAN $500
2. $500 TO LESS THAN $1,000
3. $1,000 TO LESS THAN $2,500
4. $2,500 TO LESS THAN $5,000
5. $5,000 TO LESS THAN $10,000
6. $10,000 OR MORE

77. NOT APPLICABLE
88. DON'T KNOW
99. REFUSED

Place for Health Care

23. A personal doctor is the person you would see if you need a check-up, want advice about a health problem, or get sick or hurt. Do you have a personal doctor?
1. YES
2. NO
77. NOT APPLICABLE
88. DON'T KNOW
99. REFUSED

24. A regular dentist is one you would go to for check-ups and cleanings or when you have a cavity or tooth pain. Do you currently have a regular dentist?
1. YES
2. NO
77. NOT APPLICABLE
88. DON'T KNOW
99. REFUSED

25. Next I'm going to ask you about the use of emergency rooms. How easy or hard is it for you to decide whether to use the emergency room?
1. Very easy
2. Easy
3. Hard or
4. Very hard
77. NOT APPLICABLE
88. DON'T KNOW
99. REFUSED

26. Next, I will ask what you would do if you experience the following symptoms during a normal business day.

26.1 Shortness of breath lasting more than 15 minutes. Would you:	Stay home	Go to a doctor's office	To Urgent Care	To an Emergency Room	N/A	DK	RF
26.2 Low grade fever (under 102) lasting for more than a day	1	2	3	4	7	8	9
26.3 Severe stomach pain lasting more than 15 minutes	1	2	3	4	7	8	9
26.4 A sore throat lasting more than 2 days	1	2	3	4	7	8	9
26.5 A possible broken bone	1	2	3	4	7	8	9
26.6 A severe headache lasting more than 3 hours	1	2	3	4	7	8	9

Health and Well-being

Q27. In general, how would you rate your physical health now? Would you say it is…

1. Excellent
2. Very good
3. Good
4. Fair or
5. Poor
77. NOT APPLICABLE
88. DON'T KNOW
99. REFUSED

Q28. In general, how would you rate your overall mental and behavioral health now?

1. Excellent
2. Very good
3. Good
4. Fair or
5. Poor
77. NOT APPLICABLE
88. DON'T KNOW
99. REFUSED

Q29. In general, how would you rate your overall dental health now?

1. Excellent
2. Very good
3. Good
4. Fair or
5. Poor
77. NOT APPLICABLE
88. DON'T KNOW

99. REFUSED

The next set of questions ask about issues related to your financial situation.

Q30. Which of the following best describes your financial situation? Do you see yourself as...

1. Very financially secure
2. Somewhat financially secure
3. Not very financially secure or
4. Not at all financially secure

77. NOT APPLICABLE
88. DON'T KNOW/NOT SURE
99. REFUSED

Q31. How difficult is it for you to live on your household income right now? Is it…

1. Not at all difficult
2. Somewhat difficult
3. Very difficult or
4. Extremely difficult

77. NOT APPLICABLE
88. DON'T KNOW/NOT SURE
99. REFUSED

Q32. How confident are you that you could come up with $2,000 if an unexpected expense arose within the next month? Would you say…

1. Very confident
2. Somewhat confident
3. Not too confident or
4. Not at all confident

77. NOT APPLICABLE
88. DON'T KNOW/NOT SURE
99. REFUSED

Next, I'm going to read you two statements that people have made about their food situation.

Q33. Within the past 30 days, we worried whether our food would run out before we got money to buy more. Would you say that was often true, sometimes true, or never true?

1. OFTEN TRUE
2. SOMETIMES TRUE
3. NEVER TRUE

77. NOT APPLICABLE
88. DON'T KNOW/NOT SURE
99. REFUSED

Q34. Within the past 30 days, the food we bought just didn't last and we didn't have enough money to get more. Would you say that was often true, sometimes true, or never true?

1. OFTEN TRUE
2. SOMETIMES TRUE
3. NEVER TRUE

77. NOT APPLICABLE
88. DON'T KNOW/NOT SURE

99. REFUSED

The next questions ask you about your utilities.

Q35. In the last 30 days, did you ever not pay the **full** amount of a utility bill, including water, gas, oil, or electricity at the time it was due?

1. YES
2. NO
77. NOT APPLICABLE
88. DON'T KNOW/NOT SURE
99. REFUSED

Q36. In the last 30 days, was your cellphone or telephone service ever disconnected, or did you ever run out of minutes because there wasn't enough money?

1. YES
2. NO
77. NOT APPLICABLE
88. DON'T KNOW/NOT SURE
99. REFUSED

Demographics

Q37. Are you Hispanic or Latino/a?

1. HISPANIC OR LATINO
2. NOT HISPANIC OR LATINO
77. NOT APPLICABLE
88. DON'T KNOW
99. REFUSED

Q38. How would you describe your race? [SELECT ALL THAT APPLY]

1. American Indian/Alaskan native
2. Asian
3. Black/African American
4. Middle eastern/North African
5. Native Hawaiian or other Pacific islander
6. White
7. Other race or ethnicity [open text]:
77. NOT APPLICABLE
88. DON'T KNOW
99. REFUSED

Q39. What is the highest grade level of school that you have completed?
[MAY BE FIELD CODED IF RESPONDENT DOES NOT NEED PROMPTING]

1. 8th grade or less
2. Some high school, did not graduate.

3. High school graduate or GED
4. Some college or 2-year degree
5. 4-year college degree
6. More than 4-year college degree
77. NOT APPLICABLE
88. DON'T KNOW
99. REFUSED

QComments.
And finally, do you have any comments about [PLAN NAME] program that you would like to share? [OPEN TEXT].

DEBRIEFING/CLOSING

Those are all the questions we have for you. Thank you so much for taking the time to talk with me today. We'd like to thank you for participating by sending you twenty dollars. I will just need to confirm your mailing address so we can send that to you. **[CONFIRM MAILING ADDRESS; IF DIFFERENT, UPDATE ADDRESS]**

[ONCE CONFIRMED] We will be sending that out **in the order interviews are completed,** so you should expect it in the mail within the next four to six weeks. If you have any questions or concerns or if you have not received your gift card within a reasonable amount of time, feel free to call us at **855-204-4692** Thank you again for your help. Have a great day/night. Goodbye.

END SURVEY

Thank you for your time.

New Enrollee Survey (Children)

QUESTIONNAIRE INTRODUCTION/CONSENT

Hello! My name is [Interviewer Name] and I am with the University of Iowa. May I please speak with [First Name, Last Name]?

We are calling to ask you to be a part of a survey of new [PLAN NAME] members being done by researchers at the University of Iowa. [CHILDNAME] is on our list of new enrollees in that plan. Hopefully you received a gold and blue postcard letting you know that we would be calling you?

We got this child's name from the Iowa Department of Health and Human Services (DHHS) as a part of a list of new plan members. We would like to ask you a few questions about your experiences with the plan and about joining the plan. To thank you for your time, we will mail you $20 after you complete the survey.

The questions should take around 20 minutes to answer. You can skip any questions that you don't want to answer. The survey is voluntary. You do not have to take part if you do not want to. If you choose not to, it will not affect the benefits you qualify for, including [PLAN NAME].

Your answers will be combined with answers from other people in the program and included in a report that will be given to both the Iowa and US Departments of Health and Human Services (DHHS). They will use the information to better understand how the program works in Iowa and help other states learn from Iowa's program. Your individual responses will not be shared.

Do you have any questions about the survey?

[ENTER PLAN THEY ARE ON BELOW]

8. Iowa Health and Wellness Plan
9. Iowa Wellness Plan
10. Marketplace Choice
11. TFMP
12. TANF
13. FIP
14. OTHER (FILL IN)

C1. Are you willing to complete this phone survey?

3. YES [CONTINUE TO SCREENING]
4. NO [IF NO: END SURVEY]

CALLBACK

What day and time would be best for us to call back?

SURVEY QUESTIONS

Great! Throughout the interview, is there another name you prefer us to use to talk about [display child's first name]?
Sounds great! First, I will ask you a few questions about [display child preferred name] joining [PLAN NAME]. There are also questions about insurance coverage, [display child preferred name]'s health, your opinions, and a few questions that help describe [display child preferred name]. If there is a question you don't want to answer, let me know and, we can skip it. Throughout the survey, please tell me if you have questions or if anything is not clear.

Enrollment Experience

Q1. First, I am going to ask about why you applied for [PLAN NAME] for [display child preferred name]. I'm going to read a list of reasons why people may apply to [PLAN NAME]. Please tell me if any of these were a reason why YOU applied. You can answer yes or no.

10. You [or your spouse] lost employer-based insurance, and [display child preferred name] lost the coverage.
11. Your doctor's office or hospital told you to apply.
12. Your caseworker told you to apply.
13. [display child preferred name]'s health got worse.
14. Your family situation changed (such as a divorce).
15. [display child preferred name] is required to have health insurance.
16. You recently moved to Iowa.
17. You were no longer covered by your parents' insurance. [TURNED 26]
18. Is there a different reason you applied? Please describe___
78. NOT APPLICABLE
88. DON'T KNOW
99. REFUSED

Q2. Did you have any help signing up [display child preferred name] for [PLAN NAME]?

3. YES
4. NO [SKIP TO Q4]
78. NOT APPLICABLE [SKIP TO Q4]
88. DON'T KNOW [SKIP TO Q4]
99. REFUSED [SKIP TO Q4]

[IF Q2=1]
Q3. Who helped you sign up? (Field code the answers)

7. FAMILY MEMBER
8. FRIEND
9. A HEALTH CARE PROVIDER/STAFF

10. A CASE WORKER
11. SOMEONE ON THE PHONE – MEDICAID HELP LINE, 1-800 number
12. OTHER_____
77. NOT APPLICABLE
88. DON'T KNOW
99. REFUSED

Q4. How easy or difficult was it to apply for [PLAN NAME]? Would you say it was:

5. Very easy [SKIP TO Q6]
6. Somewhat Easy [SKIP TO Q6]
7. Somewhat Difficult
8. Very difficult
78. NOT APPLICABLE
88. DON'T KNOW [SKIP TO Q6]
100. REFUSED [SKIP TO Q6]

[IF Q4=3 or 4]

Q5. What difficulties did you have when applying?

9. YOU COULDN'T UNDERSTAND THE FORMS.
10. THE PROCESS WAS TOO COMPLICATED.
11. YOU HAD NO TRANSPORTATION TO APPOINTMENT.
12. YOU DID NOT KNOW WHERE TO GO TO GET HELP.
13. YOU DID NOT HAVE ALL THE NEEDED DOCUMENTS.
14. YOU HAD NO ONE TO HELP YOU FILL OUT THE FORMS.
15. YOU COULD NOT ACCESS THE ONLINE FORMS.
16. OTHER _____
77. NOT APPLICABLE
88. DON'T KNOW
99. REFUSED

Coverage/enrollment Gap

Q6. In the year prior to joining [PLAN NAME], so since [CURRENT MONTH] [CURRENT YEAR-1], was [display child preferred name] covered by any kind of health insurance?

3. YES
4. NO [SKIP TO Q9]
77. NOT APPLICABLE [SKIP TO Q9]
88. DON'T KNOW [SKIP TO Q9]
99. REFUSED [SKIP TO Q9]

[IF Q6=1]

Q7. Was the most recent insurance private insurance? (Private means you or your family got it through an employer or individually purchased it?)

1. YES [SKIP TO Q8]
2. NO

77. NOT APPLICABLE [SKIP TO Q8]
88. DON'T KNOW [SKIP TO Q8]
99. REFUSED [SKIP TO Q8]

Q7.1 [IF NO] What [public] insurance did you use prior to applying for [PLAN NAME]

1. Medicare
2. Medicaid
3. Children's Health Insurance Program (CHIP)/Hawki
4. Military related health care: TRICARE (CHAMPUS) / VA health care / CHAMP-VA
5. Indian Health Service
6. State-sponsored health plan
7. OR WAS IT ANOTHER government program? ___ [INCLUDE TEXT] _____
77. NOT APPLICABLE
88. DON'T KNOW
99. REFUSED

[IF Q6=1]

Q8. In which year did that earlier coverage end?

4. 2022
5. 2023
6. 2024
77. NOT APPLICABLE [SKIP TO Q9]
88. DON'T KNOW [SKIP TO Q9]
99. REFUSED [SKIP TO Q9]

Q8.1. In which month in [display year answer from previous question] did that earlier coverage end?

13. January
14. February
15. March
16. April
17. May
18. June
19. July
20. August
21. September
22. October
23. November
24. December
77. NOT APPLICABLE
88. DON'T KNOW
99. REFUSED

Q9. Thinking about [display child preferred name]'s recent application to [PLAN NAME], how long ago did you start thinking about applying?

_____# MONTHS or
_____# WEEKS
77. NOT APPLICABLE
88. DON'T KNOW

99. REFUSED

Q10. For some people, [PLAN NAME] may pay the costs of medical care they received before joining the plan. When you applied for [PLAN NAME]. Did you think that the program would pay for any of the medical care received BEFORE [display child preferred name] joined?

3. YES
4. NO [SKP to Q12]
77. NOT APPLICABLE [SKP TO Q12]
88. DON'T KNOW [SKP to Q12]
99. REFUSED [SKP to Q12]

[IF Q10=1]

Q11. How far back did you think the program would pay for medical care [display child preferred name] received before joining [PLAN NAME]?

Did you think the program would pay for care back

7. TO THE FIRST OF THE APPLICATION MONTH--ONLY SELECT IF R EXPLICITLY STATES THIS
8. 1-DAY TO ONE MONTH (1-30 DAYS)
9. >1 MONTH TO 2 MONTHS (31-60 DAYS)
10. >2 MONTHS TO 3 MONTHS (61-90 DAYS)
11. MORE THAN 3 MONTHS (>93 DAYS)
12. OR SOMETHING DIFFERENT: [OPEN TEXT]
78. NOT APPLICABLE
88. DON'T KNOW
100. REFUSED

Q12. Everyone has their own opinion about health insurance: some think that having health insurance is important and some think that having health insurance is not important. What about you? Would you say that, having health insurance coverage for [display child preferred name] is...?

5. Very important
6. Somewhat important
7. Not very important or
8. Not at all important
78. NOT APPLICABLE
88. DON'T KNOW
100. REFUSED

Next, I'm going to ask you about YOUR OWN health care coverage.

Q13. Are you currently on Medicaid?

1. YES
2. NO [SKIP TO Q16]
77. NOT APPLICABLE [SKIP TO Q16]
88. DON'T KNOW [SKIP TO Q16]
99. REFUSED [SKIP TO Q16]

[IF Q13=1]

Q14. For some people, [PLAN NAME] may pay the costs of medical care they received before joining the plan. When you applied for Medicaid, did you think that the program would pay for any of the medical care received BEFORE joining?

1. YES
2. NO [SKIP TO Q16]
77. NOT APPLICABLE [SKIP TO Q16]
88. DON'T KNOW [SKIP TO Q16]
99. REFUSED [SKIP TO Q16]

[IF Q14=1]

Q15. How far back did you think the program would pay for medical care you received before joining Medicaid?

Did you think the program would pay for care back …

1. TO THE FIRST OF THE APPLICATION MONTH--ONLY SELECT IF R EXPLICITLY STATES THIS
2. 1-DAY TO ONE MONTH (1-30 DAYS)
3. >1 MONTH TO 2 MONTHS (31-60 DAYS)
4. >2 MONTHS TO 3 MONTHS (61-90 DAYS)
5. MORE THAN 3 MONTHS (>93 DAYS)
6. OR SOMETHING DIFFERENT: [OPEN TEXT]
77. NOT APPLICABLE
88. DON'T KNOW
99. REFUSED

Q16. Everyone has their own opinion about health insurance: some think that having health insurance is important and some think that having health insurance is not important. What about you? Would you say that, for you, having health insurance coverage is...?

1. Very important
2. Somewhat important
3. Not very important
4. Not at all important
77. NOT APPLICABLE
88. DON'T KNOW
99. REFUSED

Medical Debt

Q17. In the last 3 months [or during the past x months – calculated from the coverage gap time if fewer than 3 months], did [display child preferred name] have any health care bills? Include bills such as from doctors, dentists, hospitals, therapists, and pharmacies.

3. YES
4. NO [SKIP TO Q20]
78. NOT APPLICABLE
88. DON'T KNOW [SKIP TO Q20]
100. REFUSED [SKIP TO Q20]

Q18. Did you have any difficulty paying these bills?

3. YES
4. NO
78. NOT APPLICABLE
88. DON'T KNOW
100. REFUSED

Q19. Were these bills for any of the following types of services?

4. Medical care? Y/N
5. Dental care? Y/N
6. Prescription medication? Y/N
78. NOT APPLICABLE
88. DON'T KNOW
100. REFUSED

Q20. The next questions focus on the affordability of health care for you [IF DOV_FAMSIZE>1] and your family. We're interested in your immediate family, which would include you, a spouse or partner (if applicable), and any of your children or stepchildren under 19 who live with you].
For this question, think about your [IF DOV_FAMSIZE>1: and your family's] health care experiences over the past 12 months, that is, since [CURRENT MONTH] [CURRENT YEAR-1]. Did you [IF DOV_FAMSIZE>1: or anyone in your family] have problems paying any medical bills? Include bills for doctors, dentists, hospitals, therapists, medication, equipment, nursing home, or home care.

1. YES
2. NO
78. NOT APPLICABLE
88. DON'T KNOW
100. REFUSED

Q20_A. Do you [IF DOV_FAMSIZE>1: or anyone in your family] currently have any medical bills that are being paid off over time? This could include medical bills being paid off with a credit card, through personal loans, or bill paying arrangements with hospitals, doctors, or other health care providers. The bills can be from earlier years as well as this year.

3. YES
4. NO
77. NOT APPLICABLE
88. DON'T KNOW
99. REFUSED

Q21. Do you [IF DOV_FAMSIZE>1: or anyone in your family] currently have any unpaid medical bills that are past due? Include bills for doctors, dentists, hospitals, therapists, medication, equipment, nursing home, or home care. This could include medical bills owed directly to health care providers or paid with a credit card or personal loan. The bills can be from earlier years as well as this year.

3. YES
4. NO [SKIP TO Q23]
78. NOT APPLICABLE
88. DON'T KNOW [SKIP TO Q23]
100. REFUSED [SKIP TO Q23]

[IF Q21=1]

Q22. About how much do you [IF DOV_FAMSIZE>1: or your family] currently owe for medical bills that are past due? Exclude bills that will likely be paid by an insurance company. Your best estimate is fine.

1. LESS THAN $500
2. $500 TO LESS THAN $1,000
3. $1,000 TO LESS THAN $2,500
4. $2,500 TO LESS THAN $5,000

5. $5,000 TO LESS THAN $10,000
6. $10,000 OR MORE
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88. DON'T KNOW
99. REFUSED

Place for Health Care

23. A personal doctor is the person [display child preferred name] would see if they need a check-up, want advice about a health problem, or get sick or hurt. Does [display child preferred name] have a personal doctor?
3. YES
4. NO
77. NOT APPLICABLE
88. DON'T KNOW
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24. A regular dentist is one [display child preferred name] would go to for check-ups and cleanings or when they have a cavity or tooth pain. Does [display child preferred name] currently have a regular dentist?
3. YES
4. NO
77. NOT APPLICABLE
88. DON'T KNOW
99. REFUSED

25. Next I'm going to ask you about the use of emergency rooms. How easy or hard has it been for you to decide whether to use the emergency room when [display child preferred name] has been sick or injured?
5. Very easy
6. Easy
7. Hard or
8. Very hard
77. NOT APPLICABLE
88. DON'T KNOW
99. REFUSED

26. Next, I will ask what you would do if [CHILD NAME] experiences the following symptoms during a normal business day.

26.1 Shortness of breath lasting more than 15 minutes. Would you:	Stay home	Go to a doctor's office	To Urgent Care	To an Emergency Room	N/A	DK	RF
26.2 Low grade fever (under 102) lasting for more than a day	1	2	3	4	7	8	9
26.3 Severe stomach pain lasting more than 15 minutes	1	2	3	4	7	8	9
26.4 A sore throat lasting more than 2 days	1	2	3	4	7	8	9
26.5 A possible broken bone	1	2	3	4	7	8	9
26.6 A severe headache lasting more than 3 hours	1	2	3	4	7	8	9

Health and Well-being

Q27. In general, how would you rate [display child preferred name]'s physical health now? Would you say it is…

6. Excellent
7. Very good
8. Good
9. Fair or
10. Poor
78. NOT APPLICABLE
88. DON'T KNOW
99. REFUSED

Q28. In general, how would you rate [display child preferred name]'s overall mental and behavioral health now?

6. Excellent
7. Very good
8. Good
9. Fair or
10. Poor
78. NOT APPLICABLE
88. DON'T KNOW
100. REFUSED

Q29. In general, how would you rate [display child preferred name]'s overall dental health now?

6. Excellent
7. Very good
8. Good
9. Fair or

10. Poor
78. NOT APPLICABLE
88. DON'T KNOW
100. REFUSED

The next set of questions ask about issues related to your financial situation.

Q30. Which of the following best describes your financial situation? Do you see yourself as...

5. Very financially secure
6. Somewhat financially secure
7. Not very financially secure or
8. Not at all financially secure
77. NOT APPLICABLE
88. DON'T KNOW/NOT SURE
99. REFUSED

Q31. How difficult is it for you to live on your household income right now? Is it…

1. Not at all difficult
2. Somewhat difficult
3. Very difficult or
4. Extremely difficult
77. NOT APPLICABLE
88. DON'T KNOW/NOT SURE
99. REFUSED

Q32. How confident are you that you could come up with $2,000 if an unexpected expense arose within the next month? Would you say…

5. Very confident
6. Somewhat confident
7. Not too confident or
8. Not at all confident
77. NOT APPLICABLE
88. DON'T KNOW/NOT SURE
99. REFUSED

Next, I'm going to read you two statements that people have made about their food situation.

Q33. Within the past 30 days, we worried whether our food would run out before we got money to buy more. Would you say that was often true, sometimes true, or never true?

4. OFTEN TRUE
5. SOMETIMES TRUE
6. NEVER TRUE
77. NOT APPLICABLE
88. DON'T KNOW/NOT SURE
99. REFUSED

Q34. Within the past 30 days, the food we bought just didn't last and we didn't have enough money to get more. Would you say that was often true, sometimes true, or never true?

4. OFTEN TRUE
5. SOMETIMES TRUE

6. NEVER TRUE
77. NOT APPLICABLE
88. DON'T KNOW/NOT SURE
99. REFUSED

The next questions ask you about your utilities.

Q35. In the last 30 days, did you ever not pay the **full** amount of a utility bill, including water, gas, oil, or electricity at the time it was due?

3. YES
4. NO
77. NOT APPLICABLE
88. DON'T KNOW/NOT SURE
99. REFUSED

Q36. In the last 30 days, was your cellphone or telephone service ever disconnected, or did you ever run out of minutes because there wasn't enough money?

3. YES
4. NO
77. NOT APPLICABLE
88. DON'T KNOW/NOT SURE
99. REFUSED

Demographics

Q37. Is [display child preferred name] Hispanic or Latino/a?

1. Hispanic or Latino
2. Not Hispanic or Latino
77. NOT APPLICABLE
88. DON'T KNOW
99. REFUSED

Q38. How would you describe [display child preferred name]'s race? [SELECT ALL THAT APPLY]

8. American Indian/Alaskan native
9. Asian
10. Black/African American
11. Middle eastern/North African
12. Native Hawaiian or other Pacific islander
13. White
14. Other race or ethnicity [open text]:
78. NOT APPLICABLE
88. DON'T KNOW
100. REFUSED

Q39. What is the highest grade level of school that you have completed?

7. 8th grade or less
8. Some high school, did not graduate.
9. High school graduate or GED
10. Some college or 2-year degree
11. 4-year college degree
12. More than 4-year college degree
78. NOT APPLICABLE
88. DON'T KNOW
100. REFUSED

QComments.
And finally, do you have any comments about [PLAN NAME] program that you would like to share? [OPEN TEXT].

DEBRIEFING/CLOSING

Those are all the questions we have for you. Thank you so much for taking the time to talk with me today. We'd like to thank you for participating by sending you twenty dollars. I will just need to confirm your mailing address so we can send that to you. **[CONFIRM MAILING ADDRESS; IF DIFFERENT, UPDATE ADDRESS]**

[ONCE CONFIRMED] We will be sending that out **in the order interviews are completed,** so you should expect it in the mail within the next four to six weeks. If you have any questions or concerns or if you have not received your gift card within a reasonable amount of time, feel free to call us at **855-204-4692** Thank you again for your help. Have a great day/night. Goodbye.

END SURVEY

Thank you for your time.

Encuesta para miembros nuevos (adultos)

PRESENTACIÓN DEL CUESTIONARIO Y CONSENTIMIENTO

¡Hola! Mi nombre es [Interviewer Name] y me comunico con usted de parte de University of Iowa. ¿Podría hablar con [First Name, Last Name]?

Le estamos llamando para ofrecerle la posibilidad de participar en una encuesta dirigida a miembros nuevos del plan [PLAN NAME]. La encuesta está a cargo de investigadores de University of Iowa.
Con suerte, habrá recibido una tarjeta azul y dorada en la que le avisábamos de esta llamada.

Obtuvimos su nombre del Departamento de Salud y Servicios Humanos de Iowa, dado que acaba de inscribirse en el plan [PLAN NAME]. Nos gustaría hacerle algunas preguntas sobre su experiencia con el plan y con el proceso de inscripción. En agradecimiento por su tiempo, le enviaremos $20 por correo postal después de que complete la encuesta.

Responder las preguntas no debería tomarle más de 20 minutos. Puede saltear cualquier pregunta que no quiera responder. La encuesta es voluntaria. No tiene la obligación de participar si noquiere hacerlo. Si decide no participar, no se verán afectados los beneficios que le corresponden, incluido el plan [PLAN NAME].

Sus respuestas se combinarán con las de otras personas del programa y se incluirán en un informe que se entregará a los Departamentos de Salud y Servicios Humanos de Iowa y de Estados Unidos. La información se usará para comprender mejor cómo funciona el programa en Iowa y para que otros estados aprendan de esta experiencia. No se compartirán las respuestas personales, a menos que lo exija la ley.

¿Tiene alguna duda sobre la encuesta?

ACLARE LAS DUDAS O DIRÍJALAS AL SUPERVISOR/GERENTE DE PROYECTO O A LA JUNTA DE REVISIÓN INSTITUCIONAL, O BIEN, PROGRAME UNA NUEVA LLAMADA.

C1. ¿Está de acuerdo en completar esta encuesta telefónica?

1. SÍ [CONTINUE TO SCREENING]
2. NO [IF NO: END

SURVEY] NUEVA LLAMADA

¿Qué día y a qué hora le convendría recibir una nueva llamada?

IOWA

PREGUNTAS DE LA ENCUESTA

¡Excelente! La encuesta solo incluye preguntas sobre su cobertura personal. Primero, le haré algunas preguntas sobre el proceso de inscripción en el plan [PLAN NAME]. También habrá preguntas sobre la cobertura del seguro, su salud, sus opiniones y algunas otras preguntas que nos permitan describirle. Si hubiera alguna pregunta que preferiría no responder, dígamelo y la saltearemos. Por favor, si tiene dudas o hay algo que no le queda claro en cualquier momento de la encuesta, dígamelo.

Experiencia de inscripción

P1. Para empezar, le voy a leer una lista de motivos por los que las personas solicitan la cobertura de atención de salud a través del plan [PLAN NAME]. Por favor, indique si USTED solicitó inscribirse en el plan [PLAN NAME] por alguno de estos motivos. Puede responder "sí" o "no".

1. Usted [O SU CÓNYUGE] perdió el seguro que tenía con su empleador.
2. Usted siguió la recomendación del consultorio u hospital donde trabaja su médico.
3. Usted siguió la recomendación de su asistente social.
4. Empeoró su salud.
5. Cambió la situación familiar (por ejemplo, un divorcio).
6. Usted tiene la obligación de contar con un seguro de salud.
7. Se mudó a Iowa recientemente.
8. Usted ya no tenía cobertura del seguro de sus padres [CUMPLIÓ 26 AÑOS].
9. ¿Su solicitud de cobertura se debió a algún otro motivo? Por favor, explique. ____

77. DON'T KNOW
99. REFUSED

P2. ¿Le ayudó alguien a inscribirse en el plan [PLAN NAME]?

1. SÍ
2. NO [SKIP TO P4]

77. DON'T KNOW [SKIP TO Q4]
99. REFUSED [SKIP TO Q4]

[IF Q2=1]

P3. ¿Quién le ayudó? (Field code the answers)

1. FAMILIAR
2. AMIGO(A)
3. PROVEEDOR/PERSONAL DE ATENCIÓN DE SALUD
4. ASISTENTE SOCIAL
5. ALGUIEN CON QUIEN HABLÓ POR TELÉFONO [la línea de ayuda de Medicaid, un número "1-800"]
6. OTRO_____

77. DON'T KNOW
99. REFUSED

P4. ¿Qué tan fácil o difícil le resultó solicitar la inscripción en el plan [PLAN NAME]? Diría que fue:

1. Muy fácil [SKIP TO P6]
2. Bastante fácil [SKIP TO P6]

3. Bastante difícil
4. Muy difícil
77. DON'T KNOW [SKIP TO Q6]
99. REFUSED [SKIP TO Q6]

[IF Q4=3 or 4]
P5. ¿Qué dificultades tuvo al solicitar la inscripción?
[PROBE UNTIL NO NEW RESPONSES] ¿Tuvo alguna otra dificultad?
[**DO NOT READ - SELECT ALL THAT APPLY]**

1. Tuvo problemas para entender los formularios.
2. El proceso fue demasiado complicado.
3. No tenía quién le llevara a la cita.
4. No sabía a quién acudir para pedir ayuda.
5. No tenía todos los documentos necesarios.
6. No tenía a nadie que le ayudara a completar los formularios.
7. No podía acceder a los formularios en internet.
8. Otro _____
77. DON'T KNOW
99. REFUSED

Intervalo entre otra cobertura y la inscripción

P6. En el año anterior a su inscripción en el plan [PLAN NAME], es decir, desde [CURRENT MONTH] de [CURRENT YEAR-1], ¿tuvo usted alguna clase de seguro de salud?

1. SÍ
2. NO [SKIP TO P9]
77. DON'T KNOW [SKIP TO Q9]
99. REFUSED [SKIP TO Q9]

[IF Q6=1]
P7. ¿Era un seguro privado? ("Privado" significa que usted o su familia tenían la cobertura a través de un empleador o por compra personal).

1. SÍ [SKIP TO P8]
2. NO
77. DON'T KNOW [SKIP TO Q8]
99. REFUSED [SKIP TO Q8]

P7.1. [IF NO] ¿Qué seguro [público] tenía antes de solicitar la inscripción en el plan [PLAN NAME]?

1. Medicare
2. Medicaid
3. Programa de Seguro Médico para Niños (CHIP)/Programa Hawki
4. Atención de salud asociada a las Fuerzas Armadas: TRICARE (CHAMPUS)/Atención de salud para veteranos/CHAMP-VA
5. Servicio de Salud para Pueblos Indígenas
6. Plan de salud patrocinado por el estado

IOWA

7. O BIEN, ¿CONTABA CON OTRO programa del gobierno?____[INCLUDE TEXT] _____
77. DON'T KNOW
99. REFUSED

IOWA

[IF Q6=1]
P8. ¿En qué año finalizó la cobertura que tenía?
1. 2022
2. 2023
77. DON'T KNOW [SKIP TO Q9]
99. REFUSED [SKIP TO Q9]

P8.1. ¿En qué mes del año [display year answer from previous question] finalizó esa cobertura que tenía?
1. Enero
2. Febrero
3. Marzo
4. Abril
5. Mayo
6. Junio
7. Julio
8. Agosto
9. Septiembre
10. Octubre
11. Noviembre
12. Diciembre
77. DON'T KNOW
99. REFUSED

P9. Teniendo en cuenta su reciente solicitud de inscripción en el plan [PLAN NAME], ¿cuánto hace que comenzó a evaluar esta posibilidad?

_____MESES
77. DON'T KNOW
99. REFUSED

P10. Para algunas personas, el plan [PLAN NAME] podría cubrir los gastos de la atención médica recibida antes de inscribirse. Cuando solicitó inscribirse en el plan [PLAN NAME], ¿pensó que le cubriría los gastos de la atención médica recibida ANTES de inscribirse?
1. SÍ
2. NO [SKIP to P12]
77. DON'T KNOW [SKP to Q12]
99. REFUSED [SKP to Q12]

[IF Q10=1]
P11. ¿Con cuánta retroactividad pensó que el programa le pagaría la atención médica recibida antes de inscribirse en el plan [PLAN NAME]?
Usted pensó que el programa pagaría la atención recibida con esta retroactividad:
1. HASTA EL PRIMER DÍA DEL MES DE SOLICITUD (SELECCIONE UNA OPCIÓN SOLO SI LA PERSONA ENCUESTADA LO AFIRMA EXPLÍCITAMENTE)
2. DE 1 DÍA A UN MES (DE 1 A 30 DÍAS)
3. DE MÁS DE 1 MES A 2 MESES (DE 31 A 60 DÍAS)
4. DE MÁS DE 2 MESES A 3 MESES (DE 61 A 90 DÍAS)

IOWA

5. MÁS DE 3 MESES (MÁS DE 93 DÍAS)
6. UN PERIODO DIFERENTE: [OPEN TEXT]
77. DON'T KNOW
99. REFUSED

P12. Cada persona tiene su propia opinión sobre el seguro de salud: algunas consideran que es importante tenerlo, mientras que otras no lo ven de la misma manera. Y usted, ¿qué opina?
Para usted, ¿cuál de las siguientes opciones describe mejor su opinión acerca de tener la cobertura de un seguro de salud?

1. Es muy importante
2. Es bastante importante
3. No es muy importante
4. No es para nada importante
77. DON'T KNOW
99. REFUSED

Deudas médicas

P13. En los últimos 3 meses [Or: En los últimos x meses (calculated from the coverage gap time if fewer than 3 months)], ¿tuvo que pagar alguna factura de atención de salud? Incluya facturas de médicos, dentistas, hospitales, terapeutas, farmacias, etc.

1. SÍ
2. NO [SKIP TO P16]
77. DON'T KNOW [SKIP TO Q16]
99. REFUSED [SKIP TO Q16]

P14. ¿Tuvo complicaciones para pagar estas facturas?

1. SÍ
2. NO
77. DON'T KNOW
99. REFUSED

P15. ¿Qué clases de servicios pagó en estas facturas?

1. Atención médica Sí/No
2. Atención odontológica Sí/No
3. Medicamentos recetados Sí/No
77. DON'T KNOW
99. REFUSED

P16. Las siguientes preguntas se centran en su capacidad económica para pagar la atención de salud para usted [IF DOV_FAMSIZE>1] y su familia. Nos interesa su familia inmediata, es decir, usted, un cónyuge o pareja (si corresponde) y cualquiera de sus hijos(as) o hijastros(as) menores de 19 años que vivan con usted.
Cuando responda esta pregunta, piense en las experiencias de atención de salud que tuvo [IF DOV_FAMSIZE>1: y que tuvo su familia] en los últimos 12 meses, es decir, desde [CURRENT MONTH] de [CURRENT YEAR-1]. ¿Tuvo usted [IF DOV_FAMSIZE>1: o cualquier integrante de su familia] complicaciones para pagar, o no pudo pagar, alguna factura médica? Incluya las facturas de médicos, dentistas, hospitales, terapeutas, medicamentos, equipos, centros de adultos mayores y personas con discapacidad, o cuidados en el hogar.

1. SÍ
2. NO

P16A. ¿Continúa usted [IF DOV_FAMSIZE>1: o algún integrante de su familia] pagando alguna factura médica? Esto podría incluir facturas médicas que se están pagando con una tarjeta de crédito, con un préstamo personal o mediante un acuerdo de pago con hospitales, médicos u otros proveedores de atención de salud. Las facturas pueden ser de años anteriores o de este año.

1. SÍ
2. NO
77. DON'T KNOW
99. REFUSED

P17. ¿Tiene usted [IF DOV_FAMSIZE>1: o algún integrante de su familia] alguna factura médica actualmente impaga, que haya vencido? Incluya las facturas de médicos, dentistas, hospitales, terapeutas, medicamentos, equipos, centros de adultos mayores y personas con discapacidad, o cuidados en el hogar. Esto podría incluir facturas médicas adeudadas directamente a proveedores de atención de salud o pagadas con una tarjeta de crédito o préstamo personal. Las facturas pueden ser de años anteriores o de este año.

1. SÍ
2. NO [SKIP TO P19]
77. DON'T KNOW [SKIP TO Q19]
99. REFUSED [SKIP TO Q19]

[IF Q17=1]

P18. Y, en la actualidad, ¿cuánto dinero debe usted [IF DOV_FAMSIZE>1: o su familia] en concepto de facturas médicas vencidas? No incluya facturas que probablemente pague una compañía de seguros. Un cálculo estimativo estará bien.

1. MENOS DE $500
2. DE $500 A MENOS DE $1,000
3. DE $1,000 A MENOS DE $2,500
4. DE $2,500 A MENOS DE $5,000
5. DE $5,000 A MENOS DE $10,000
6. $10,000 O MÁS
77. DON'T KNOW
99. REFUSED

Dónde obtiene atención de salud

19. Un médico de cabecera es la persona a la que usted acudiría si necesitara hacerse un control, quisiera consejos sobre un problema de salud, se enfermara o lesionara. ¿Tiene médico de cabecera?

1. SÍ
2. NO
77. DON'T KNOW
99. REFUSED

IOWA

20. Un dentista de cabecera es el profesional al que usted acudiría para controles y limpiezas, osi tuviese una caries o dolor en los dientes o las muelas. ¿Tiene actualmente dentista decabecera?
    1. SÍ
    2. NO
    77. DON'T KNOW
    99. REFUSED

21. A continuación, le haré preguntas sobre el uso de las salas de emergencias. ¿Qué tan fácil o difícil le resulta tomar la decisión de ir a una sala de emergencias?
    1. Muy fácil
    2. Fácil
    3. Difícil
    4. Muy difícil
    77. DON'T KNOW
    99. REFUSED

22. Ahora, le voy a preguntar qué haría si tuviera estos síntomas en un día hábil normal./Ahora, le voy a preguntar qué haría si [CHILD NAME] tuviera estos síntomas en un día hábil normal.

22.1 Problemas para respirar durante más de 15 minutos. ¿Qué haría?:	Quedarse en casa	Ir al consultorio del médico	Ir a un centro de atención de urgencias	Ir a una sala de emergencias
22.2 Fiebre baja (menos de 102 °F) durante más de un día	1	2	3	4
22.3 Dolor intenso de estómago durante más de 15 minutos	1	2	3	4
22.4 Dolor de garganta durante más de 2 días	1	2	3	4
22.5 Una posible fractura	1	2	3	4
22.6 Dolor de cabeza intenso durante más de 3 horas	1	2	3	4

Salud y bienestar

P23. En general, ¿cómo clasificaría su salud física en estos momentos? Diría que es...
    1. Excelente
    2. Muy buena
    3. Buena

4. Regular
5. Mala

77. DON'T KNOW

99. REFUSED

P24. En general, ¿cómo clasificaría su salud mental y conductual global en estos momentos?

1. Excelente
2. Muy buena
3. Buena
4. Regular
5. Mala

77. DON'T KNOW

99. REFUSED

P25. En general, ¿cómo clasificaría su salud dental global en estos momentos?

1. Excelente
2. Muy buena
3. Buena
4. Regular
5. Mala

77. DON'T KNOW
99. REFUSED

Las siguientes preguntas se refieren a problemas relacionados con su situación económica.

P26. ¿Cuál de las siguientes afirmaciones describe mejor su situación económica? Usted se ve...

[READ 1-4 -SELECT ONLY ONE]

1. Con mucha seguridad económica
2. Con bastante seguridad económica
3. Sin mucha seguridad económica
4. Sin nada de seguridad económica

77. DON'T KNOW/NOT SURE
99. REFUSED

P27. ¿Qué tan difícil es vivir con los ingresos de su familia en estos momentos? Diría que...

[READ 1-4 - SELECT ONLY ONE]

1. Para nada difícil
2. Bastante difícil
3. Muy difícil
4. Extremadamente difícil

77. DON'T KNOW/NOT SURE
99. REFUSED

P28. Si el mes próximo surgiera un gasto inesperado, ¿cuánta confianza se tiene para conseguir $2,000? Diría que...

[READ 1-4 - SELECT ONLY ONE]

1. Tiene mucha confianza
2. Tiene bastante confianza
3. No tiene demasiada confianza
4. No tiene nada de confianza

77. DON'T KNOW/NOT SURE
99. REFUSED

A continuación, voy a leerle dos afirmaciones expresadas por personas sobre la situación alimentaria. Para cada afirmación, por favor dígame si fue a menudo verdadera, a veces verdadera o nunca verdadera para su familia en los últimos 30 días.

P29. En los últimos 30 días, nos preocupó quedarnos sin comida antes de tener dinero para comprar más. ¿Diría que esta situación fue a menudo verdadera, a veces verdadera o nunca verdadera?
[DO NOT READ - SELECT ONLY ONE]
1. A MENUDO VERDADERA
2. A VECES VERDADERA
3. NUNCA VERDADERA
77. DON'T KNOW/NOT SURE
99. REFUSED

P30. En los últimos 30 días, la comida que compramos simplemente no alcanzaba y no teníamos dinero para comprar más. ¿Diría que esta situación fue a menudo verdadera, a veces verdadera o nunca verdadera?
[DO NOT READ - SELECT ONLY ONE]
1. A MENUDO VERDADERA
2. A VECES VERDADERA
3. NUNCA VERDADERA
77. DON'T KNOW/NOT SURE
99. REFUSED

Las siguientes preguntas se refieren a los servicios públicos.

P31. En los últimos 30 días, ¿alguna vez no pudo pagar el monto **total** de la factura de un servicio público, por ejemplo, agua, gas, combustible o electricidad, en el momento de su vencimiento?
[DO NOT READ - SELECT ONLY ONE]
1. SÍ
2. NO
77. DON'T KNOW/NOT SURE
99. REFUSED

P32. En los últimos 30 días, ¿le desconectaron alguna vez el teléfono fijo o celular, o se le agotaron los minutos porque no había suficiente dinero?
1. SÍ
2. NO
77. DON'T KNOW/NOT SURE
99. REFUSED

Datos demográficos

¡Gracias por sus respuestas! Estamos a punto de terminar la encuesta. Solo me quedan algunas preguntas sobre usted y finalizaremos. Recuerde que sus respuestas se combinarán con las de otras personas y no se compartirá la información identificatoria.

P33. ¿Es usted de raza hispana o latina?
1. HISPANA O LATINA
2. NI HISPANA NI LATINA
77. DON'T KNOW

IOWA

99. REFUSED

P34. ¿Cómo describiría su raza? [SELECT ALL THAT APPLY]

1. Indoamericana o nativo(a) de Alaska
2. Asiática
3. Negra o afroamericana
4. Del Medio Oriente o Norte de África
5. Nativo(a) de Hawái o de otra isla del Pacífico
6. Blanca
7. Otra raza u origen étnico [open text]:

77. DON'T KNOW
99. REFUSED

P35. ¿Cuál es el nivel de educación más alto que ha completado?
[MAY BE FIELD CODED IF RESPONDENT DOES NOT NEED PROMPTING]

1. 8.º grado o menos
2. Algo de preparatoria, sin título
3. Título de preparatoria o GED
4. Algo de estudios universitarios o título de 2 años
5. Título de carrera universitaria de 4 años
6. Título de carrera universitaria de más de 4 años

77. DON'T KNOW
99. REFUSED

Comentarios
Por último, ¿tiene algún comentario sobre el programa [PLAN NAME] que quisiera compartir con nosotros? [OPEN TEXT].

RECAPITULACIÓN Y CIERRE

Esas son todas las preguntas que tengo para hacerle. Muchas gracias por dedicar tiempo a conversar conmigo hoy. Quisiéramos enviarle veinte dólares en agradecimiento por su participación. Solo necesito confirmar su dirección postal para que podamos hacer ese envío.
[CONFIRM MAILING ADDRESS; IF DIFFERENT, UPDATE ADDRESS]
[ONCE CONFIRMED] Enviaremos el dinero **por orden de realización de las encuestas,** por lo que debería recibirlo en la correspondencia dentro de las próximas cuatro a seis semanas. Si tiene preguntas o inquietudes, o si no recibe la tarjeta de obsequio dentro de un plazo razonable, no dude en llamarnos al **855-204-4692**.

Gracias nuevamente por su ayuda. Que tenga buen día/buenas noches. Adiós.
FIN DE LA ENCUESTA

¡Gracias por su tiempo!

Encuesta para miembros nuevos (niños)

PRESENTACIÓN DEL CUESTIONARIO Y CONSENTIMIENTO

¡Hola! Mi nombre es [Interviewer Name] y me comunico con usted de parte de University of Iowa. ¿Podría hablar con [First Name, Last Name]?

Le estamos llamando para ofrecerle la posibilidad de participar en una encuesta dirigida a miembros nuevos del plan [PLAN NAME] en el que se ha inscrito [First Name, Last Name]. Este estudio está a cargo de University of Iowa. Con suerte, habrá recibido una tarjeta azul y dorada en la que le avisábamos de esta llamada.

Le pedimos su ayuda porque [First Name, Last Name] fue inscrito recientemente en el plan [PLAN NAME]. Obtuvimos su nombre de una lista de nuevos miembros del plan [PLAN NAME]
extendida por el Departamento de Salud y Servicios Humanos de Iowa. Nos gustaría hacerle algunas preguntas sobre la experiencia de [First Name, Last Name] con el plan y con el proceso de inscripción.
En agradecimiento por su tiempo, le enviaremos $20 por correo postal después de que complete la encuesta.

Responder las preguntas no debería tomarle más de 20 minutos. Puede saltear cualquier pregunta que no quiera responder. La encuesta es voluntaria. No tiene la obligación de participar si no quiere hacerlo. Si decide no participar, no se verán afectados los beneficios que le corresponden a [First Name, Last Name], incluido el plan [PLAN NAME].

Sus respuestas se combinarán con las de otras personas del programa y se incluirán en un informe que se entregará a los Departamentos de Salud y Servicios Humanos de Iowa y de Estados Unidos. La información se usará para comprender mejor cómo funciona el programa en Iowa y para que otros estados aprendan de esta experiencia. No se compartirán las respuestas personales, a menos que lo exija la ley.

¿Tiene alguna duda sobre la encuesta?

ACLARE LAS DUDAS O DIRÍJALAS AL SUPERVISOR/GERENTE DE PROYECTO O A LA JUNTA DE REVISIÓN INSTITUCIONAL, O BIEN, PROGRAME UNA NUEVA LLAMADA.

C1. ¿Está de acuerdo en completar esta encuesta telefónica?

1. SÍ [CONTINUE TO SCREENING]
2. NO [IF NO: END

SURVEY] NUEVA LLAMADA

¿Qué día y a qué hora le convendría recibir una nueva llamada?

PREGUNTAS DE LA ENCUESTA

¡Excelente! ¿Hay algún otro nombre que prefiere que usemos para referirnos a [display child's first name] durante la encuesta?
¡Perfecto! Primero, le haré algunas preguntas sobre el proceso de inscripción de [display child preferred name] en el plan [PLAN NAME]. También habrá preguntas sobre la cobertura del seguro, la salud de [display child preferred name], sus opiniones y algunas otras preguntas que nos permitan describir a [display child preferred name]. Si hubiera alguna pregunta que preferiría no responder, dígamelo y la saltearemos. Por favor, si tiene dudas o hay algo que no le queda claro en cualquier momento de la encuesta, dígamelo.

Experiencia de inscripción

P1. Para empezar, le voy a preguntar por qué solicitó la inscripción de [display child preferred name] en el plan [PLAN NAME]. Voy a leerle una lista de motivos por los que las personas solicitan la inscripción en el plan [PLAN NAME]. Por favor, indique si USTED solicitó la inscripción por alguno de estos motivos. Puede responder "sí" o "no".

1. Usted [o su cónyuge] perdió el seguro que tenía con su empleador y [display child preferred name] se quedó sin cobertura.Usted siguió la recomendación del consultorio u hospital donde trabaja el médico.
2. Usted siguió la recomendación del asistente social.
3. Empeoró la salud de [display child preferred name].
4. Cambió la situación familiar (por ejemplo, un divorcio).
5. [display child preferred name] tiene la obligación de contar con un seguro de salud.
6. Se mudó a Iowa recientemente.
7. ¿Su solicitud de cobertura se debió a algún otro motivo? Por favor, explique. ____

77. DON'T KNOW
99. REFUSED

P2. ¿Le ayudó alguien a inscribir a [display child preferred name] en el plan [PLAN NAME]?

1. SÍ
2. NO [SKIP TO P4]

77. DON'T KNOW [SKIP TO Q4]
99. REFUSED [SKIP TO Q4]

[IF Q2=1]
P3. ¿Quién le ayudó?

1. FAMILIAR
2. AMIGO(A)
3. PROVEEDOR/PERSONAL DE ATENCIÓN DE SALUD
4. ASISTENTE SOCIAL
5. ALGUIEN CON QUIEN HABLÓ POR TELÉFONO [la línea de ayuda de Medicaid, un número "1-800"]
6. OTRO _____

77. DON'T KNOW
99. REFUSED

P4. ¿Qué tan fácil o difícil le resultó solicitar la inscripción en el plan [PLAN NAME]? Diría que fue:
1. Muy fácil [SKIP TO P6]
2. Bastante fácil [SKIP TO P6]
3. Bastante difícil
4. Muy difícil
77. DON'T KNOW [SKIP TO Q6]
99. REFUSED [SKIP TO Q6]

[IF Q4=3 or 4]
P5. ¿Qué dificultades tuvo al solicitar la inscripción?
1. Tuvo problemas para entender los formularios.
2. El proceso fue demasiado complicado.
3. No tenía quién le llevara a la cita.
4. No sabía a quién acudir para pedir ayuda.
5. No tenía todos los documentos necesarios.
6. No tenía a nadie que le ayudara a completar los formularios.
7. Otro _____
77. DON'T KNOW
99. REFUSED

Intervalo entre otra cobertura y la inscripción

P6. En el año anterior a la inscripción en el plan [PLAN NAME], es decir, desde [CURRENT MONTH] de [CURRENT YEAR-1], ¿tuvo [display child preferred name] alguna clase de seguro de salud?
1. SÍ
2. NO [SKIP TO P9]
77. DON'T KNOW [SKIP TO Q9]
99. REFUSED [SKIP TO Q9]

[IF Q6=1]
P7. ¿Era un seguro privado? ("Privado" significa que usted o su familia tenían la cobertura a través de un empleador o por compra personal).
1. SÍ [SKIP TO P8]
2. NO
77. DON'T KNOW [SKIP TO Q8]
99. REFUSED [SKIP TO Q8]

[IF Q7=2]
P7.1. ¿Qué seguro [público] tenía antes de solicitar la inscripción en el plan [PLAN]?
1. Medicare
2. Medicaid
3. Programa de Seguro Médico para Niños (CHIP)/Programa Hawki
4. Atención de salud asociada a las Fuerzas Armadas: TRICARE (CHAMPUS)/Atención de salud para veteranos/CHAMP-VA
5. Servicio de Salud para Pueblos Indígenas

6. Plan de salud patrocinado por el estado
7. O BIEN, ¿CONTABA CON OTRO programa del gobierno?____[INCLUDE TEXT] _____

[IF Q6=1]
P8. ¿En qué año finalizó la cobertura que tenía?
1. 2022
2. 2023
77. DON'T KNOW [SKIP TO Q9]
99. REFUSED [SKIP TO Q9]

P8.1. ¿En qué mes del año [display year answer from previous question] finalizó esa cobertura que tenía?
1. Enero
2. Febrero
3. Marzo
4. Abril
5. Mayo
6. Junio
7. Julio
8. Agosto
9. Septiembre
10. Octubre
11. Noviembre
12. Diciembre
77. DON'T KNOW
99. REFUSED

P9. Teniendo en cuenta la reciente solicitud de inscripción de [display child preferred name] en el plan [PLAN NAME], ¿cuánto hace que comenzó usted a evaluar esta posibilidad?
_____MESES
77. DON'T KNOW
99. REFUSED

P10. Para algunas personas, el plan [PLAN NAME] podría cubrir los gastos de la atención médica recibida antes de inscribirse. Cuando solicitó la inscripción en el plan [PLAN NAME], ¿pensó que el programa pagaría la atención médica recibida por [display child preferred name] ANTES de inscribirse?
1. SÍ
2. NO [SKIP to P12]
77. DON'T KNOW [SKP to Q12]
99. REFUSED [SKP to Q12]

[IF Q10=1]
P11. ¿Con cuánta retroactividad pensó que el programa pagaría la atención médica recibida por [display child preferred name] antes de inscribirse en el plan [PLAN NAME]?
Usted pensó que el programa pagaría la atención recibida con esta retroactividad:
1. HASTA EL PRIMER DÍA DEL MES DE SOLICITUD (SELECCIONE UNA OPCIÓN SOLO SI LA PERSONA ENCUESTADA LO AFIRMA EXPLÍCITAMENTE)
2. DE 1 DÍA A UN MES (DE 1 A 30 DÍAS)

3. DE MÁS DE 1 MES A 2 MESES (DE 31 A 60 DÍAS)
4. DE MÁS DE 2 MESES A 3 MESES (DE 61 A 90 DÍAS)
5. MÁS DE 3 MESES (MÁS DE 93 DÍAS)
6. UN PERIODO DIFERENTE: [OPEN TEXT]

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P12. Cada persona tiene su propia opinión sobre el seguro de salud: algunas consideran que es importante tenerlo, mientras que otras no lo ven de la misma manera. Y usted, ¿qué opina? Para usted, ¿cuál de las siguientes opciones describe mejor su opinión acerca de que [display child preferred name] tenga la cobertura de un seguro de salud?

1. Es muy importante
2. Es bastante importante
3. No es muy importante
4. No es para nada importante

77. DON'T KNOW
99. REFUSED

A continuación, voy a hacerle preguntas sobre SU PROPIA cobertura de atención de salud.

P13. ¿Tiene Medicaid actualmente?

1. SÍ
2. NO [SKIP TO P16]

77. DON'T KNOW [SKIP TO Q16]
99. REFUSED [SKIP TO Q16]

[IF Q13=1]

P14. Para algunas personas, el plan [PLAN NAME] podría cubrir los gastos de la atención médica recibida antes de inscribirse. Cuando solicitó inscribirse en Medicaid, ¿pensó que el programa le cubriría los gastos de cualquier parte de la atención médica recibida ANTES de inscribirse?

1. SÍ
2. NO [SKIP P16]

77. DON'T KNOW [SKIP Q16]
99. REFUSED [SKIP Q16]

[IF Q14=1]

P15. ¿Con cuánta retroactividad pensó que el programa le pagaría la atención médica recibida antes de inscribirse en Medicaid?

Usted pensó que el programa pagaría la atención recibida con esta retroactividad:

1. HASTA EL PRIMER DÍA DEL MES DE SOLICITUD (SELECCIONE UNA OPCIÓN SOLO SI LA PERSONA ENCUESTADA LO AFIRMA EXPLÍCITAMENTE)
2. DE 1 DÍA A UN MES (DE 1 A 30 DÍAS)
3. DE MÁS DE 1 MES A 2 MESES (DE 31 A 60 DÍAS)
4. DE MÁS DE 2 MESES A 3 MESES (DE 61 A 90 DÍAS)
5. MÁS DE 3 MESES (MÁS DE 93 DÍAS)
6. UN PERIODO DIFERENTE: [OPEN TEXT]

77. DON'T KNOW
99. REFUSED

IOWA

P16. Cada persona tiene su propia opinión sobre el seguro de salud: algunas consideran que es importante tenerlo, mientras que otras no lo ven de la misma manera. Y usted, ¿qué opina? Para usted, ¿cuál de las siguientes opciones describe mejor su opinión acerca de tener la cobertura de un seguro de salud?

1. Es muy importante
2. Es bastante importante
3. No es muy importante
4. No es para nada importante

77. DON'T KNOW
99. REFUSED

Deudas médicas

P17. En los últimos 3 meses [Or: En los últimos x meses (calculated from the coverage gap time if fewer than 3 months)], ¿tuvo que pagar alguna factura de atención de salud de [display child preferred name]? Incluya facturas de médicos, dentistas, hospitales, terapeutas y farmacias.

1. SÍ
2. NO [SKIP TO P20]

77. DON'T KNOW [SKIP TO Q20]
99. REFUSED [SKIP TO Q20]

P18. ¿Tuvo complicaciones para pagar estas facturas?

1. SÍ
2. NO

77. DON'T KNOW
99. REFUSED

P19. ¿Qué clases de servicios pagó en estas facturas? [Select all that apply]

1. Atención médica Sí/No
2. Atención odontológica Sí/No
3. Medicamentos recetados Sí/No

77. NO SABE
99. SE NIEGA A CONTESTAR

P20. Las siguientes preguntas se centran en su capacidad económica para pagar la atención de salud para usted [IF DOV_FAMSIZE>1] y su familia. Nos interesa su familia inmediata, es decir, usted, un cónyuge o pareja (si corresponde) y cualquiera de sus hijos(as) o hijastros(as) menores de 19 años que vivan con usted Cuando responda esta pregunta, piense en las experiencias de atención de salud que tuvo [IF DOV_FAMSIZE>1: y que tuvo su familia] en los últimos 12 meses, es decir, desde [CURRENT MONTH] de [CURRENT YEAR-1]. ¿Tuvo usted [IF DOV_FAMSIZE>1: o cualquier integrante de su familia] <u>complicaciones para pagar, o no pudo pagar,</u> alguna factura médica? Incluya las facturas de médicos, dentistas, hospitales, terapeutas, medicamentos, equipos, centros de adultos mayores y personas con discapacidad, o cuidados en el hogar.

1. SÍ
2. NO

[IF DOV_FAMSIZE>1 AND Q20=1]
P20B. ¿Estuvo alguna de esas facturas médicas relacionada con la atención de salud que recibió [display child preferred name]?
1. SÍ
2. NO
P20A. ¿Continúa usted [IF DOV_FAMSIZE>1: o algún integrante de su familia] pagando alguna factura médica? Esto podría incluir facturas médicas que se están pagando con una tarjeta de crédito, con un préstamo personal o mediante un acuerdo de pago con hospitales, médicos u otros proveedores de atención de salud. Las facturas pueden ser de años anteriores o de este año.
1. SÍ
2. NO
77. DON'T KNOW
99. REFUSED
P21. ¿Tiene usted [IF DOV_FAMSIZE>1: o algún integrante de su familia] alguna factura médica actualmente impaga, que haya vencido? Incluya las facturas de médicos, dentistas, hospitales, terapeutas, medicamentos, equipos, centros de adultos mayores y personas con discapacidad, o cuidados en el hogar. Esto podría incluir facturas médicas adeudadas directamente a proveedores de atención de salud o pagadas con una tarjeta de crédito o préstamo personal. Las facturas pueden ser de años anteriores o de este año.
1. SÍ
2. NO [SKIP TO P23]
77. DON'T KNOW [SKIP TO Q23]
99. REFUSED [SKIP TO Q23]
[IF Q21=1]
P22. Y, en la actualidad, ¿cuánto dinero debe usted [IF DOV_FAMSIZE>1: o su familia] en concepto de facturas médicas vencidas? No incluya facturas que probablemente pague una compañía de seguros. Un cálculo estimativo estará bien.
1. MENOS DE $500
2. DE $500 A MENOS DE $1,000
3. DE $1,000 A MENOS DE $2,500
4. DE $2,500 A MENOS DE $5,000
5. DE $5,000 A MENOS DE $10,000
6. $10,000 O MÁS
77. DON'T KNOW
99. REFUSED

Dónde obtiene atención de salud

23. Un médico de cabecera es la persona a la que [display child preferred name] acudiría si necesitara hacerse un control, quisiera consejos sobre un problema de salud, se enfermara o lesionara. ¿Tiene [display child preferred name] médico de cabecera?

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1. SÍ
2. NO

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24. Un dentista de cabecera es el profesional al que [display child preferred name] acudiría para controles y limpiezas, o si tuviese una caries o dolor en los dientes o las muelas. ¿Tiene [display child preferred name] actualmente dentista de cabecera?
    1. SÍ
    2. NO
    77. DON'T KNOW
    99. REFUSED
25. A continuación, le haré preguntas sobre el uso de las salas de emergencias. ¿Qué tan fácil o difícil le resulta tomar la decisión de ir a una sala de emergencias cuando [display child preferred name] se enferma o lesiona?
    1. Muy fácil
    2. Fácil
    3. Difícil
    4. Muy difícil
    77. DON'T KNOW
    99. REFUSED
26. Ahora, le voy a preguntar qué haría si tuviera estos síntomas en un día hábil normal./Ahora, le voy a preguntar qué haría si [CHILD NAME] tuviera estos síntomas en un día hábil normal.

26.1 Problemas para respirar durante más de 15 minutos. ¿Qué haría?:	Quedarse en casa	Ir al consultorio del médico	Ir a un centro de atención de urgencias	Ir a una sala de emergencias
26.2 Fiebre baja (menos de 102 °F) durante más de un día	1	2	3	4
26.3 Dolor intenso de estómago durante más de 15 minutos	1	2	3	4
26.4 Dolor de garganta durante más de 2 días	1	2	3	4
26.5 Una posible fractura	1	2	3	4
26.6 Dolor de cabeza intenso durante más de 3 horas	1	2	3	4

Salud y bienestar

IOWA

P27. En general, ¿cómo clasificaría la salud física de [display child preferred name] en estos momentos? Diría que es...

1. Excelente
2. Muy buena
3. Buena
4. Regular
5. Mala

77. DON'T KNOW
99. REFUSED

P28. En general, ¿cómo clasificaría la salud mental y conductual global de [display child preferred name] en estos momentos?

1. Excelente
2. Muy buena
3. Buena
4. Regular
5. Mala

P29. En general, ¿cómo clasificaría la salud dental global de [display child preferred name] en estos momentos?

1. Excelente
2. Muy buena
3. Buena
4. Regular
5. Mala

77. DON'T KNOW
99. REFUSED

Las siguientes preguntas se refieren a problemas relacionados con su situación económica.

P30. ¿Cuál de las siguientes afirmaciones describe mejor su situación económica? Usted se ve...

[READ 1-4 -SELECT ONLY ONE]

1. Con mucha seguridad económica
2. Con bastante seguridad económica
3. Sin mucha seguridad económica
4. Sin nada de seguridad económica

77. DON'T KNOW/NOT SURE
99. REFUSED

P31. ¿Qué tan difícil es vivir con los ingresos de su familia en estos momentos? Diría que...

[READ 1-4 - SELECT ONLY ONE]

1. Para nada difícil
2. Bastante difícil
3. Muy difícil
4. Extremadamente difícil

77. DON'T KNOW/NOT SURE
99. REFUSED

P32. Si el mes próximo surgiera un gasto inesperado, ¿cuánta confianza se tiene para conseguir $2,000? Diría que...

[READ 1-4 - SELECT ONLY ONE]

1. Tiene mucha confianza
2. Tiene bastante confianza
3. No tiene demasiada confianza
4. No tiene nada de confianza

77. DON'T KNOW/NOT SURE
99. REFUSED

A continuación, voy a leerle dos afirmaciones expresadas por personas sobre la situación alimentaria. Para cada afirmación, por favor dígame si fue a menudo verdadera, a veces verdadera o nunca

verdadera para su familia en los últimos 30 días.

P33. En los últimos 30 días, nos preocupó quedarnos sin comida antes de tener dinero para comprar más. ¿Diría que esta situación fue a menudo verdadera, a veces verdadera o nunca verdadera?

[DO NOT READ - SELECT ONLY ONE]

1. A MENUDO VERDADERA
2. A VECES VERDADERA
3. NUNCA VERDADERA
77. DON'T KNOW/NOT SURE
99. REFUSED

P34. En los últimos 30 días, la comida que compramos simplemente no alcanzaba y no teníamos dinero para comprar más. ¿Diría que esta situación fue a menudo verdadera, a veces verdadera o nunca verdadera?

[DO NOT READ - SELECT ONLY ONE]

1. A MENUDO VERDADERA
2. A VECES VERDADERA
3. NUNCA VERDADERA
77. DON'T KNOW/NOT SURE
99. REFUSED

Las siguientes preguntas se refieren a los servicios públicos.

P35. En los últimos 30 días, ¿alguna vez no pudo pagar el monto **total** de la factura de un servicio público, por ejemplo, agua, gas, combustible o electricidad, en el momento de su vencimiento?

[DO NOT READ - SELECT ONLY ONE]

1. SÍ
2. NO
77. DON'T KNOW/NOT SURE
99. REFUSED

P36. En los últimos 30 días, ¿le desconectaron alguna vez el teléfono fijo o celular, o se le agotaron los minutos porque no había suficiente dinero?

1. SÍ
2. NO
77. DON'T KNOW/NOT SURE
99. REFUSED

Datos demográficos

¡Gracias por sus respuestas! Estamos a punto de terminar la encuesta. Solo me quedan algunas preguntas sobre usted y finalizaremos. Recuerde que sus respuestas se combinarán con las de otras personas y se eliminará la información identificatoria.

P37. ¿Es [display child preferred name] de raza hispana o latina?
1. HISPANA O LATINA
2. NI HISPANA NI LATINA
77. DON'T KNOW

P38. ¿Cómo describiría la raza de [display child preferred name]? [SELECT ALL THAT APPLY]
1. Indoamericana o nativo(a) de Alaska
2. Asiática
3. Negra o afroamericana
4. Del Medio Oriente o Norte de África
5. Nativo(a) de Hawái o de otra isla del Pacífico
6. Blanca
7. Otra raza u origen étnico [open text]:

77. DON'T KNOW
99. REFUSED

Comentarios
Por último, ¿tiene algún comentario sobre el programa [PLAN NAME] que quisiera compartir con nosotros? [OPEN TEXT].

RECAPITULACIÓN Y CIERRE

Esas son todas las preguntas que tengo para hacerle. Muchas gracias por dedicar tiempo a conversar conmigo hoy. Quisiéramos enviarle veinte dólares en agradecimiento por su participación. Solo necesito confirmar su dirección postal para que podamos hacer ese envío. **[CONFIRM MAILING ADDRESS; IF DIFFERENT, UPDATE ADDRESS]**
[ONCE CONFIRMED] Enviaremos el dinero **por orden de realización de las encuestas,** por lo que debería recibirlo en la correspondencia dentro de las próximas cuatro a seis semanas.

Si tiene preguntas o inquietudes, o si no recibe la tarjeta de obsequio dentro de un plazo razonable, no dude en llamarnos al **855-204-4692**.

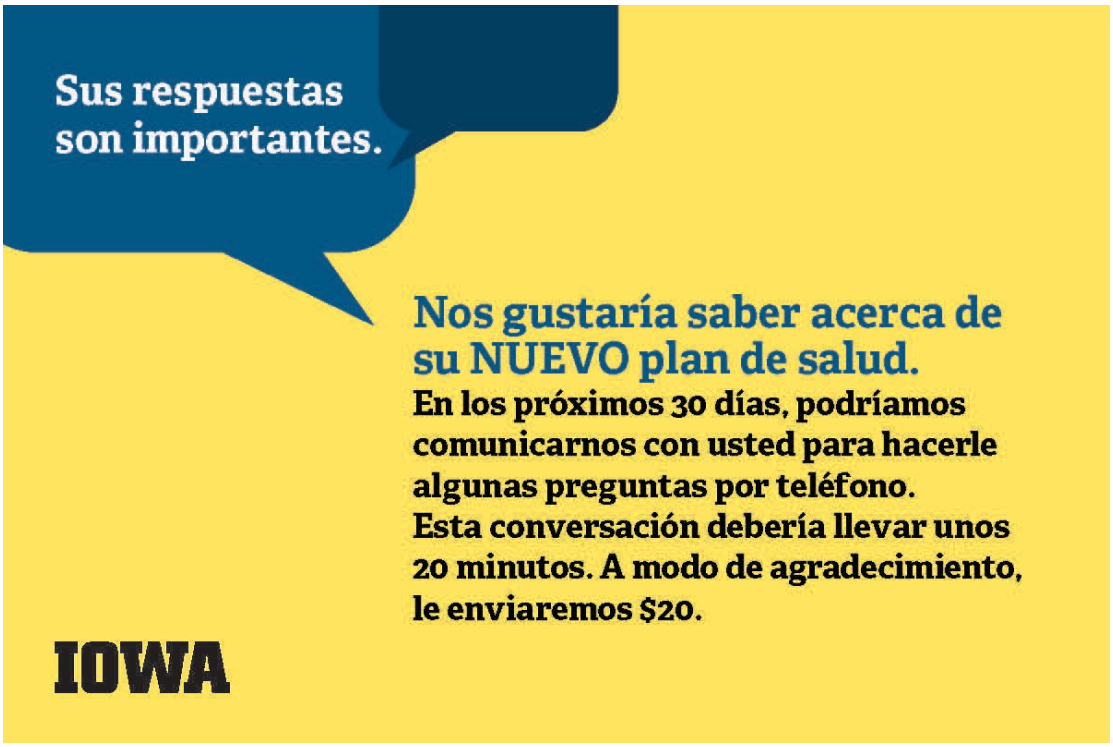
Gracias nuevamente por su ayuda. Que tenga buen día/buenas noches. Adiós.
FIN DE LA ENCUESTA

¡Gracias por su tiempor

Postcards

IOWA
605 E. Jefferson Street
Public Policy Research Building
Iowa City, IA 52242

Researchers at the University of Iowa are working with your new health plan to find out about members' experience with getting on the plan. We may call inviting you to take part in the telephone survey that will take about 20 minutes to complete. We will send you $20 as a thank you once you complete the survey. This survey is voluntary. We will group your answers with others to protect your privacy. If you don't want us to contact you, or if you have questions, call us toll free at 1-855-204-4692.



IOWA

605 E. Jefferson Street
Public Policy Research Building
Iowa City, IA 52242

Los investigadores de la Universidad de Iowa están trabajando junto con los responsables de su nuevo plan de salud para obtener información sobre la experiencia de los miembros al comenzar el plan. Podríamos comunicarnos con usted para solicitarle que participe en la encuesta telefónica, la cual llevará unos 20 minutos. Tras completarla, le enviaremos $20 a modo de agradecimiento. Esta encuesta es voluntaria. Agruparemos sus respuestas con las de otros encuestados para proteger su privacidad. Si no desea que nos comuniquemos con usted o si tiene alguna pregunta, llámenos sin cargo al 1-855-204-4692.

Medicaid Informational Letters: Cost Sharing

Iowa Department of Human Services

Terry E. Branstad, Governor | Kim Reynolds, Lt. Governor | Charles M. Palmer, Director

INFORMATIONAL LETTER NO. 1025

DATE: July 29, 2011

TO: Iowa Medicaid Hospitals (Excluding Indian Health Service Providers)

ISSUED BY: Iowa Department of Human Services, Iowa Medicaid Enterprise (IME)

RE: Emergency Room (ER) Visits: Copayment and Reimbursement Changes

EFFECTIVE: September 1, 2011

Copayment in the ER - Effective September 1, 2011, Medicaid members (Including those on IowaCare) must pay a $3 copayment for each visit to a hospital ER for treatment of a non-emergent** medical condition. The $3 copayment does not apply if the visit to the ER is for an emergent condition and/or results in a hospital admission. The exclusions applicable to all copayments still apply. The most common examples are: members under age 21; members who are pregnant; members presenting with an emergent condition; or members receiving family planning services. See 441 Iowa Administrative Code 79.1(13).

Changes to reimbursement of non-emergent ER services** – Also effective September 1, 2011, if the ER visit does not result in an inpatient hospital admission and does not involve any emergent** condition, the payment depends on the referral (if any) and whether or not the member is participating in either the MediPASS or Lock-in program (note: these changes do not apply to members on IowaCare):

1. **Payment is made at 75 percent of the usual APC amount**:
   a. For members not participating in the MediPASS or Lock-in program who were referred to the ER by appropriate medical personnel (UB04 form locator 76++) or
   b. For members participating in the MediPASS or Lock-in program referred to the ER by their MediPASS or Lock-in primary care physician (UB04 form locator 79++).
2. **Payment is made at 50 percent of the usual APC amount** for members not participating in the MediPASS or Lock-in program who were not referred to the ER by appropriate medical personnel.
3. **No payment will be made** for members participating in the MediPASS or Lock-in program who were not referred to the ER by their MediPASS or Lock-in primary care physician.

The copayment amount (when applicable) will be deducted after the payment reductions have been applied.

No change to reimbursement of ER services - If the ER visit results in an inpatient hospital admission, the visit continues to be paid as part of the inpatient claim. If the ER visit does not result in an inpatient hospital admission but involved an emergent** condition, the ER claim is still paid at the full APC. Triage/assessment codes for any Medicaid member in an ER also continue to reimburse at the full (100%) fee schedule amount **in all cases**.

***A list of the diagnosis codes considered emergent** is posted on the IME website and updated frequently (http://www.ime.state.ia.us/docs/EmergencyDiagnosisCodes.pdf).*

*++**Claim form instructions** are posted on the IME website at: http://www.ime.state.ia.us/docs/UB04_BillingInstructions.pdf.*

If you have any questions, please contact the IME Provider Services Unit, 1-800-338-7909, locally 515-256-4609 or by email at imeproviderservices@dhs.state.ia.us.

Iowa Department of Human Services

Terry E. Branstad, Governor | Kim Reynolds, Lt. Governor | Charles M. Palmer, Director

INFORMATIONAL LETTER NO.1753-MC-FFS

DATE: December 23, 2016

TO: Iowa Medicaid Hospitals (excluding Indian Health Service Providers)

APPLIES TO: Managed Care, Fee-for-Service

FROM: Iowa Department of Human Services (DHS), Iowa Medicaid Enterprise (IME)

RE: Reimbursement of Emergency Room (ER) Visits

EFFECTIVE: April 1, 2016

Informational Letter 1025[1] issued on July 29, 2011, describes changes to the reimbursement of non-emergent ER services*. As a reminder these changes continued with the transition to IA Health Link on April 1, 2016. The reimbursement for non-emergent ER services is as follows:

If the ER visit does not result in an inpatient hospital admission and does not involve any emergent* condition, the payment depends on the referral (if any):

1. Payment is made at 75 percent of the usual Ambulatory Payment Classifications (APCs) amount for Medicaid members who were referred to the ER by appropriate medical personnel.
2. Payment is made at 50 percent of the usual APC amount for Medicaid members who were not referred to the ER by appropriate medical personnel.

If the ER visit results in an inpatient hospital admission, the visit continues to be paid as part of the inpatient claim. If the ER visit does **not** result in an inpatient hospital admission but involved an emergent* condition, the ER claim will paid at the full APC. Triage/assessment codes for any Medicaid member in an ER also continue to reimburse at the full (100%) fee schedule amount **in all cases**. Triage/assessment CPT codes are limited to 99211 and 99218.

**A list of the ICD-10 diagnosis codes considered emergent*[2] *is posted on the IME website and updated frequently.*

If you have any questions, please contact the IME Provider Services Unit at 1-800-338-7909, or by email at imeproviderservices@dhs.state.ia.us.

[1] http://dhs.iowa.gov/sites/default/files/1025_EmergencyRoomVisitsCopaymentandReimbursementChanges.pdf
[2] https://dhs.iowa.gov/sites/default/files/Emergency_Dx.xlsx

Iowa Department of Human Services

Terry E. Branstad, Governor | Kim Reynolds, Lt. Governor | Charles M. Palmer, Director

INFORMATIONAL LETTER NO.1758-MC-FFS

DATE: February 1, 2017

TO: Iowa Medicaid Hospitals (excluding Indian Health Service Providers)

APPLIES TO: Managed Care, Fee-for-Service

FROM: Iowa Department of Human Services (DHS), Iowa Medicaid Enterprise (IME)

RE: Reimbursement of Emergency Room (ER) Visits – CLARIFICATION

EFFECTIVE: April 1, 2016

This Informational Letter (IL) is to provide additional clarification and guidance for IL 1753-MC-FFS[1] issued on December 23, 2016. This IL indicated that triage/assessment CPT codes for use by hospitals in the emergency room were 99211 and 99218. That was incorrect. The only allowable triage/assessment CPT code is 99211. CPT code 99218 is not used for billing triage/assessment services.

The non-emergent ER services reimbursement methodology applies to services provided by critical access hospitals (CAHs). CAHs are reimbursed for outpatient claim service lines using the cost-charge percentage methodology. That percentage is applied to all line items, except for CPT code 99211. Example:

Line #	Revenue Code	Procedure Code	Modifier	Covered Charges	Cost-to-Charge Percentage	Allowed Amount
1	270			$ 20.00	40.00%	$ 8.00
2	320	73080	RT	$120.00	40.00%	$ 48.00
3	320	73090	RT	$ 95.00	40.00%	$ 38.00
4	450	99211		$ 12.00	40.00%	$ 4.80
5	450	99283	25	$300.00	40.00%	$120.00
Total Allowed Amount						**$218.80**
Less: Allowed Amount for Code 99211						$ (4.80)
Amount Subject to Non-Emergent ER Reduction						**$214.00**
Non-Emergent ER Claim Reduction Percentage						50.00%
Subtotal-Adjusted Allowed Amount						**$107.00**
Add: Allowed Amount for Code 99211						$ 4.80
Total-Adjusted Allowed Amount						**$111.80**

If you have any questions, please contact the IME Provider Services Unit at 1-800-338-7909, or by email at imeproviderservices@dhs.state.ia.us.

[1] https://dhs.iowa.gov/sites/default/files/1753-MC-FFS_EmergencyRoomVisits-Reimbursement.pdf

Iowa Department of Human Services

Kim Reynolds, Governor | Adam Gregg, Lt. Governor | Jerry R. Foxhoven, Director

INFORMATIONAL LETTER NO.1901- MC-FFS

DATE: April 23, 2018

TO: All Iowa Medicaid Providers (Excluding Indian Health Service)

APPLIES TO: Managed Care (MC) and Fee-for-Service (FFS)

FROM: Iowa Department of Human Services (DHS), Iowa Medicaid Enterprise (IME)

RE: Emergency Room (ER) Visits and Emergency Diagnosis Codes

EFFECTIVE: July 1, 2018

Informational Letter 1758-MC-FFS[1] reminded providers about Medicaid's 2011 payment policy regarding services performed in the ER. The policy applies to payments made under FFS as well as MC. The conditions for payment of ER claims are described in the Hospital Provider Manual[2], beginning on page 49. This includes a reference to the list of diagnosis codes[3] that are automatically recognized as emergent in nature. If a claim for an emergent service does not contain a diagnosis from that list, payment may be reduced as described in the Provider Manual.

The diagnosis codes listed on the claim should typically reflect whether the situation was an emergency medical condition. However, this may not always be the case when considering the fuller context of the underlying medical record. The process descriptions below indicate how providers can request reconsideration of ER claims if the payment does not match the full context of the specific encounter in the ER.

FFS: The process for further consideration of a reduced payment up to the emergent level is to send in a Provider Inquiry[4] along with related documentation supporting why the claim should be considered emergent in nature. The Provider Inquiry form and submission process is described in the General Program Policies[5] section of the Provider Manual on page 44. When such an inquiry is received, it is reviewed by Medical Services personnel for a potential payment adjustment to the full, emergent rate. Similarly, in any case where a claim is paid at the full amount but the service was not actually considered emergent (such as the presence of an emergent diagnosis that is "historical" and not directly related to the date of service on the claim); providers would be expected to pursue corrections to those claims as well.

UnitedHealthcare Plan of the River Valley, Inc. (UnitedHealthcare) has two processes in place for providers to request review of an ER claim not billed with an emergent diagnosis code for additional reimbursement:

1. If the ER claim is not billed with a defined emergent diagnosis code but meets the Emergency Medical Treatment and Labor Act (EMTALA) prudent layperson standards of an emergency

[1] https://dhs.iowa.gov/sites/default/files/1758-MC-FFS_EmergencyRoomVisits-Reimbursement-Clarification.pdf
[2] http://dhs.iowa.gov/sites/default/files/AHosp.pdf
[3] https://dhs.iowa.gov/sites/default/files/ICD-10_Emergency_Dx_1.pdf
[4] http://dhs.iowa.gov/sites/default/files/470-3744.pdf
[5] http://dhs.iowa.gov/sites/default/files/All-I.pdf

medical condition, the member, member's authorized representative or provider on behalf of the member may submit an appeal to UnitedHealthcare (typically by mail, fax or calling into customer service). Documentation or an explanation of what presenting symptoms constituted an emergency medical condition in the judgment of a prudent layperson must be provided. Additional information on submitting appeals can be found in the UnitedHealthcare Care Provider Manual[6], Chapter 4: Grievances, Appeals and State Fair Hearings.

2. UnitedHealthcare has a Reimbursement Guidelines for Non-Emergent ER Visits[7] bulletin available on the UnitedHealthcare website that outlines the process for providers to request a claim reconsideration to receive reimbursement at 75 percent rather than 50 percent, if the member was referred to the ER.

Amerigroup Iowa, Inc. (Amerigroup): The process for review of ER claims that did not have an emergent diagnosis code can follow one of the options below.

Amerigroup offers two different claim appeal processes, outlined in further detail in the Amerigroup Provider Manual[8]:

1. The Prospective Review Process is available for emergency department (ED) claims that do not have a defined emergent ICD-10 diagnosis code billed on the claim form. This process allows providers and facilities to have their claims and medical records reviewed for medical emergency determination prior to the claim being processed. The provider or facility may attach the complete ED medical record to the claim upon initial claim submission. The claim and records will be pended for clinical review to determine if the services provided are a valid emergency medical condition.

2. The Retro-Prospective Review Process is available for claims that have been filed and processed as not meeting emergency department criteria. This process allows providers and facilities to have their claims and medical records reviewed for medical emergency determination post claims adjudication. Facilities that have filed claims which have been processed and determined to be nonemergency may appeal the denial by using the appeal process. This process is outlined in the Amerigroup manual[9]. Timely filing guidelines will apply.

Please note the existing emergency diagnosis list is under a comprehensive review to remove some codes that are not actually considered emergent or no longer a valid diagnosis code and will be updated to reflect that change effective for claims processed on or after July 1, 2018. In addition, the timing of regular updates to the comprehensive list is also changing, from the current quarterly basis to annually. As such, the next regular update will be made on January 1, 2019, and annually thereafter.

The IME appreciates your continued partnership as we work to improve the claim processing service quality and accuracy. If you have questions, please contact the IME Provider Services Unit at 1-800-338-7909 or email at imeproviderservices@dhs.state.ia.us.

[6] https://www.uhccommunityplan.com/content/dam/communityplan/healthcareprofessionals/provider-admin-manual/IA-Admin/IA_UnitedHealthcare_Provider_Manual.pdf
[7] https://www.uhccommunityplan.com/content/dam/communityplan/healthcareprofessionals/Bulletins/IA-Bulletins/IA-Reimbursement-Guidelines-for-Non-Emergent-ER-Visits.pdf
[8] https://providers.amerigroup.com/ProviderDocuments/IAIA_ProviderManual.pdf
[9] https://providers.amerigroup.com/ia/Pages/ia.aspx

Iowa Department of Human Services

INFORMATIONAL LETTER NO-1919 MC-FFS

DATE: July 6, 2018

TO: All Iowa Medicaid Providers Excluding Individual Consumer Directed Attendant Care (CDAC) Providers

APPLIES TO: Managed Care (MC) and Fee-for-Service (FFS)

FROM: Iowa Department of Human Services (DHS), Iowa Medicaid Enterprise (IME)

RE: Emergency Room (ER) Visits and Emergency Diagnosis Codes

EFFECTIVE: August 1, 2018

Effective for claims with date of service on or after August 1, 2018, a claim for an emergent service must contain an approved emergent diagnosis code in the primary (first) position to receive the full reimbursement amount on the claim. If the primary (first) diagnosis on the claim is not emergent, the member will be responsible for any applicable copay amounts.

Emergency Room claims must include all diagnostic services and diagnosis codes relevant to the emergency department visit and be billed at the appropriate Evaluation and Management (E/M) Level. Correct coding indicates that the primary diagnosis reflects the diagnosis, condition, problem, or other reason for the visit as shown in the medical record to be primarily responsible for the services provided. For example, if a patient presents at the emergency room with shortness of breath and it is determined the shortness of breath was the result of a heart attack, the diagnosis in the primary (first) position would reflect a heart attack. A list of the ICD-10 diagnosis codes considered emergent in nature are posted on the DHS website[1].

As stated in Informational Letter 1901-MC-FFS[2], the next update to the approved list of emergent diagnosis codes will be made on January 1, 2019, and annually thereafter.

If you have questions, please contact the IME Provider Services Unit at 1-800-338-7909 or email questions to IMEProviderServices@dhs.state.ia.us.

[1] https://dhs.iowa.gov/sites/default/files/ICD-10_Emergency_Dx_0.pdf
[2] https://dhs.iowa.gov/sites/default/files/1901-MC-FFS_EmergencyRoomVisitsandEmergencyDiagnosisCodes.pdf

Department of HUMAN SERVICES

INFORMATIONAL LETTER NO. 2062-MC-FFS

DATE: November 18, 2019

TO: All Iowa Medicaid Providers (Excluding Indian Health Service)

Applies To: Managed Care (MC), Fee-for-Service (FFS)

FROM: Iowa Department of Human Services (DHS), Iowa Medicaid Enterprise (IME)

RE: Emergency Room (ER) Visits and Emergency Diagnosis Codes

EFFECTIVE: July 1, 2018

This Letter clarifies Informational Letter 1901-MC-FFS1[1] that reminded providers about Medicaid's payment policy regarding services performed in the ER. The policy applies to payments made under FFS as well as MC. The intent of this letter is to clarify processes for providers in cases where the discharge diagnosis listed on a claim does *not* include code(s) from the list[2] automatically recognized as emergent in nature. In these cases, the claim can still be paid in full if the encounter appeared emergent under the Prudent Layperson Standard, when considering the fuller context of the underlying medical record. The process descriptions below indicate how providers can request this review as part of the original claim consideration.

FFS: The Provider Inquiry form and submission process is described in the General Program Policies section of the Provider Manual[3] on page 44. Such an inquiry should be sent along with related documentation supporting why the claim should be considered emergent in nature. When the claim is received, it is reviewed by Medical Services personnel for a potential payment at the full, emergent rate. *This inquiry process can be utilized as an original step of the claim submission; providers do not need to receive a payment cutback first before sending a claim inquiry in for this type of consideration*.

[1] https://dhs.iowa.gov/sites/default/files/1901-MC-FFS_EmergencyRoomVisitsandEmergencyDiagnosisCodes.pdf?110520191630
[2] https://dhs.iowa.gov/sites/default/files/ICD-10_Emergency_Dx_3.pdf?111520192253
[3] https://dhs.iowa.gov/policy-manuals/medicaid-provider

2. If the emergency room visit does not result in an inpatient hospital admission, but involves an emergent condition, reimbursement shall be made at the full Ambulatory Payment Classification (APC) payment for the treatment provided.

3. If the emergency room visit does not result in an inpatient hospital admission and does not involve an emergent condition, reimbursement depends on whether the member had a referral to the emergency room:

    a. Payment shall be made at 75 percent of the usual APC amount for Medicaid members who were referred to the emergency room by appropriate medical personnel.
    b. Payment shall be made at 50 percent of the usual APC amount for Medicaid members who were not referred to the emergency room by appropriate medical personnel.

A list of the ICD-10-CM diagnosis codes that are considered emergent in nature is available on the DHS website under the Claims and Billing section[1].

If you have questions, please contact the appropriate managed care organization (MCO) or the IME Provider Services Unit at 1-800-338-7909 or by email at imeproviderservices@dhs.state.ia.us.

[1] https://dhs.iowa.gov/ime/providers/claims-and-billing

Department of HUMAN SERVICES

INFORMATIONAL LETTER NO. 2259-MC-FFS

DATE: August 10, 2021

TO: Iowa Medicaid Hospitals (Excluding Indian Health Service Providers)

APPLIES TO: Managed Care (MC), Fee-for-Service (FFS)

FROM: Iowa Department of Human Services (DHS), Iowa Medicaid Enterprise (IME)

RE: Emergency Room Visits and Emergency Diagnosis Codes

EFFECTIVE: September 1, 2021

******This letter replaces previous guidance issued in Informational Letter (IL) 1919-MC-FFS.******

IL 1919-MC-FFS informed providers that in order to receive the full reimbursement amount on a claim for an emergent service, the claim must contain an approved emergent diagnosis code in the primary (first) position only.

Effective for dates of service on or after September 1, 2021, a claim for an emergent service may include an approved emergent diagnosis code in the primary (first) **OR** secondary (second) position to receive the full reimbursement amount. If the primary (first) or secondary (second) diagnosis on the claim is not emergent, the member will be responsible for any applicable copay amounts.

Emergency room claims must include all diagnostic services and diagnosis codes relevant to the emergency department visit and be billed at the appropriate Evaluation and Management (E/M) Level. It is appropriate for the first-listed diagnosis to be the primary reason for the encounter/visit, and may be a symptom if a diagnosis has not been established (confirmed) by the physician or other qualified healthcare professional and if a definitive diagnosis has not been established by the end of the encounter.

As a reminder, the reimbursement of emergency room services is as follows:

1. If the emergency room visit results in an inpatient hospital admission, the visit is paid for as part of the inpatient claim.

2. If the emergency room visit does not result in an inpatient hospital admission, but involves an emergent condition, reimbursement shall be made at the full Ambulatory Payment Classification (APC) payment for the treatment provided.

3. If the emergency room visit does not result in an inpatient hospital admission and does not involve an emergent condition, reimbursement depends on whether the member had a referral to the emergency room:

    a. Payment shall be made at 75 percent of the usual APC amount for Medicaid members who were referred to the emergency room by appropriate medical personnel.
    b. Payment shall be made at 50 percent of the usual APC amount for Medicaid members who were not referred to the emergency room by appropriate medical personnel.

A list of the ICD-10-CM diagnosis codes that are considered emergent in nature is available on the DHS website under the Claims and Billing section[1].

If you have questions, please contact the appropriate managed care organization (MCO) or the IME Provider Services Unit at 1-800-338-7909 or by email at imeproviderservices@dhs.state.ia.us.

[1] https://dhs.iowa.gov/ime/providers/claims-and-billing