

HEALTHY INDIANA PLAN

DRAFT Evaluation Design

6/1/2015

The Draft Evaluation Design details the states draft design for the evaluation of the HIP Program. When the State's independent evaluator's contract begins, this draft design will be used to inform the final evaluation design of the HIP program.

Table of Contents

- Demonstration Overview..... 4
- HIP 2.0 Eligibility and Program Features..... 4
- Evaluation Approach..... 6
- Evaluation Overview 6
- Evaluation Strategy 7
 - Refine Research Questions 7
 - Gathering Data..... 7
- Data Sources 8
- External Data Sources 8
 - Current Population Survey..... 8
 - American Community Survey 9
 - Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey..... 9
- Internal Data Sources..... 9
 - Indiana Medicaid Historical Data 9
 - HIP Benefit Plan Data..... 10
 - Managed Care Entity (MCE) Health Plan Network and Geo-access Data..... 10
 - Member Eligibility, Application, and Enrollment Data 10
 - Employer Eligibility, Application, and Enrollment Data..... 10
 - Member and Previous Member Survey Data 10
 - Non-member Survey Data 12
 - Provider Enrollment and Survey Data 12
 - Claims/Encounter Data 12
 - Administrative Data 13
 - Internal Financial Data 14
 - Analyzing Data 14
 - Mechanisms to Ensure Quality Data and Reporting..... 15
- Generalizability of Results..... 15
- Evaluation Deliverables..... 16
- Draft Design 16
- Quarterly Reports – Overview and Timelines..... 16
- Annual Reports – Overview and Timelines 17
- Interim and Final Reports – Overview and Timelines..... 18
- Policy-specific Reports – Overview and Timelines..... 18
- Evaluation Structure 21
- Goal 1: Reduce the Number of Uninsured Low Income Indiana Residents and Increase Access to Health Care Services..... 22
 - 1.1. HIP Will Reduce the Number of Uninsured Indiana Residents with Income Under 138% FPL Over the Course of the Demonstration 22
 - 1.2. HIP will Increase Access to Health Care Services Among the Target Population 23

1.3. POWER Account Contributions (PACs) for Individuals in the HIP Plus Plan are Affordable and Do Not Create a Barrier to Health Care Access	23
1.4. Presumptive Eligibility (PE) and Fast-track Prepayments Will Provide the Necessary Coverage so as Not to have Gaps in Health Care Coverage	24
1.5. Waiver of Non-emergency Transportation to the Non-pregnant and Non-medically Frail Population Does Not Pose a Barrier to Accessing Care.....	25
Goal 2: Promote Value-based Decision Making and Personal Health Responsibility.....	31
2.1. HIP Policies will Encourage Member Compliance with Required Contributions and Provide Incentives to Actively Manage POWER Account Funds	31
2.2. HIP Plus Members will Exhibit More Cost-conscious Health Care Consumption Behavior than: a) HIP Basic Members; and b) Traditional Hoosier Healthwise Members in the Areas of Primary, Specialty, and Pharmacy Service Utilization Without Harming Beneficiary Health	32
2.3. HIP’s (i) Graduated Copayments Required for Non-emergency Use of the Emergency Department (ED), (ii) ED Prior Authorization Process, and (iii) Efforts to Expand Access to Other Urgent Care Settings will Together Effectively Deter Inappropriate ED Utilization Without Harming Beneficiary Health.....	33
Goal 3: Promote Disease Prevention and Health Promotion to Achieve Better Health Outcomes	39
Goal 4: Promote Private Market Coverage and Family Coverage Options to Reduce Network and Provider Fragmentation within Families.....	42
4.1. HIP’s Defined Contribution Premium Assistance Program (HIP Link) will Increase the Proportion of Indiana Residents Under 138% FPL Covered by Employer-sponsored Insurance (ESI).....	42
4.2. HIP’s ESI Premium Assistance Option for Family Coverage will Increase the Number of Low Income Families in which the Parents and Children have Access to the Same Provider Network	43
Goal 5: Provide HIP Members with Opportunities to Seek Job Training and Stable Employment to Reduce Dependence on Public Assistance	48
Goal 6: Assure State Fiscal Responsibility and Efficient Management of the Program.....	51
Appendix A – Summary Table of Research Questions, Analytic Methods, and Data Metrics.....	55
Appendix B – HIP Enrollee Survey.....	79

Demonstration Overview

Traditional Medicaid programs offer coverage to vulnerable individuals, but numerous studies indicate poor health outcomes in spite of high spending. A University of Virginia study found that Medicaid patients are almost twice as likely to die after an inpatient surgery, stay in the hospital 42% longer, and cost 26% more than individuals with private insurance.¹ A study conducted by Johns Hopkins similarly found higher mortality rates among Medicaid patients, indicating they are 29% more likely to die within three years following receipt of a lung transplant.²

The Healthy Indiana Plan (HIP) model was developed as an alternative to traditional Medicaid. HIP, which passed the Indiana General Assembly in 2007 with bipartisan support, builds upon the state's long and successful history with consumer-driven health plans. Indiana pioneered the concept of medical savings accounts in the commercial market and is also the first and only State to apply the consumer-driven model to a Medicaid population. Provided by private health insurance carriers, HIP offers its member a High Deductible Health Plan (HDHP) paired with the Personal Wellness and Responsibility (POWER) account, which operates similarly to a Health Savings Account (HSA).

The private health insurance experience provides an alternative to traditional Medicaid and promotes consumerism by requiring members to make contributions into their accounts. The contributions are designed to preserve dignity among members receiving public assistance and provide them with "skin in the game," which empowers them to demand price and quality transparency as they make cost-conscious health care decisions and take responsibility for improving their health. In addition, the infusion of market principles works to educate members and prepare them to participate in the private market when they are able to transition off the program. Additional detail on program eligibility, benefit, and financing are provided in the following table:

HIP 2.0 Eligibility and Program Features

After six years of demonstrated success, CMS granted the State of Indiana the opportunity to replace traditional Medicaid for all non-disabled adults ages 19-64 and expand HIP to those who fall below 138% of the federal poverty level (FPL). This section 1115 demonstration, known as HIP 2.0, seeks to further HIP's core goals:

1. Reduce the number of uninsured low income Indiana residents and increase access to health care services.
2. Promote value-based decision making and personal health responsibility.
3. Promote disease prevention and health promotion to achieve better health outcomes.
4. Promote private market coverage and family coverage options to reduce network and provider fragmentation within families.
5. Provide HIP members with opportunities to seek job training and stable employment to reduce dependence on public assistance.

¹ Avik, Roy. (2012). The Medicaid Mess: How Obamacare Makes it Worse. Retrieved from http://www.manhattan-institute.org/html/ir_8.htm.

² *Id.*

6. Assure State fiscal responsibility and efficient management of the program.

These six goals address various aspects of the Centers for Medicare and Medicaid Services (CMS) Three-Part Aim of better care, better health, and reduced costs; and the success of those goals will be evaluated through the hypotheses detailed in the following table.

#	Goal	Hypotheses
1	Reduce the number of uninsured low income Indiana residents and increase access to health care services	<p>1.1 HIP will reduce the number of uninsured Indiana residents with income under 138% FPL over the course of the demonstration (HIP 2.0 Waiver, Section 5 and STCs, Section XIII, Paragraph 3i).</p> <p>1.2 HIP will increase access to quality health care services among the target population (HIP 2.0 Waiver, Section 5 and STCs, Section XIII, Paragraph 3ii).</p> <p>1.3 POWER account contributions for individuals in the HIP Plus plan are affordable and do not create a barrier to health care access (STCs, Section XIII, Paragraph 3v).</p> <ul style="list-style-type: none"> • Few individuals will experience the lock-out period because the policy will deter nonpayment of POWER account contributions policy for HIP Plus beneficiaries (STCs, Section XIII, Paragraph 3vi). <p>1.4 Presumptive eligibility and fast-track prepayments will provide the necessary coverage so as not to have gaps in health care coverage (STCs, Section XIII, Paragraph 3vii).</p> <p>1.5 Waiver of non-emergency transportation to the non-pregnant and non-medically frail population does not pose a barrier to accessing care (STCs, Section XIII, Paragraph 3ix).</p>
2	Promote value-based decision making and personal health responsibility	<p>2.1 HIP policies will encourage member compliance with required contributions and provide incentives to actively manage POWER account funds (HIP 2.0 Waiver, Section 5), including:</p> <ul style="list-style-type: none"> • HIP policies surrounding rollover and preventive care will encourage beneficiaries' compliance with required contributions and provide incentives to actively manage POWER account funds (STCs, Section XIII, Paragraph 3viii). <p>2.2 HIP Plus members will exhibit more cost-conscious healthcare consumption behavior than: a) HIP Basic members; and b) traditional Hoosier Healthwise members in the areas of primary, specialty, and pharmacy service utilization without harming beneficiary health (HIP 2.0 Waiver, Section 5 and STCs, Section XIII, Paragraph 3iv).</p> <p>2.3 HIP's (i) graduated copayments required for non-emergency use of the emergency department (ED), (ii) ED prior authorization process, and (iii) efforts to expand access to other urgent care settings will together effectively deter inappropriate ED utilization without harming beneficiary health (HIP 2.0 Waiver, Section 5).</p> <ul style="list-style-type: none"> • The graduated copayment structure for non-emergency use of the emergency department will decrease inappropriate ED

#	Goal	Hypotheses
		utilization without harming beneficiary health (STCs, Section XIII, Paragraph 3x). <ul style="list-style-type: none"> • The prior authorization process for hospital emergency department use and efforts to expand access to other urgent care settings will decrease inappropriate ED utilization without harming beneficiary health (STCs, Section XIII, Paragraph 3xi).
3	Promote disease prevention and health promotion to achieve better health outcomes	3.1 HIP will effectively promote member use of preventive, primary, and chronic disease management care to achieve improved health outcomes (HIP 2.0 Waiver, Section 5 and STCs, Section XIII, Paragraph 3iii).
4	Promote private market coverage and family coverage options to reduce network and provider fragmentation within families	4.1 HIP’s defined contribution premium assistance program (HIP Link) will increase the proportion of Indiana residents under 138% FPL covered by employer-sponsored insurance (ESI) (HIP 2.0 Waiver, Section 5 and STCs, Section XIII, Paragraph 3xii). 4.2 HIP’s ESI premium assistance option for family coverage will increase the number of low income families in which the parents and children have access to the same provider network (HIP 2.0 Waiver, Section 5).
5	Provide HIP members with opportunities to seek job training and stable employment to reduce dependence on public assistance	5.1 Referrals to Department of Workforce Development (DWD) employment resources at the time of application will increase member employment rates over the course of the demonstration (HIP 2.0 Waiver, Section 5).
6	Assure State fiscal responsibility and efficient management of the program	6.1 HIP will remain budget-neutral for both the federal and state governments (HIP 2.0 Waiver, Section 5).

Evaluation Approach

Evaluation Overview

Throughout the HIP 1.0 1115 demonstration, the State tracked meaningful measures of quality, access to care, health outcomes, member satisfaction, and budget neutrality. The State of Indiana looks to leverage this experience and data as a part of its evaluation plan for HIP 2.0. The State will gather and review many of the same data metrics it used in HIP 1.0, using existing evaluation tools such as the member survey provided in Appendix B. Data collected as a part of HIP 1.0 will serve as baseline data against which HIP 2.0 will be compared to as appropriate and will provide insights on the generalizability of core program goals.

In addition to HIP 1.0 data, the State will also use data from its traditional Medicaid populations, as well as data from state and national studies and other publicly available data. This data will serve as additional points of comparison to indicate the demonstration’s success in meeting its goals. The

evaluation will also look at current data sources and collect its own data to evaluate processes and outcomes throughout the demonstration. The State will build quality control (QC) measures into all phases of data collection, as well, including CATI development, data collection, data coding and editing, and final file production.

Evaluations of this demonstration and reports will be released on three different time intervals: quarterly, annually, a final culminating report. There will also be some policy-specific reports released outside of the standard reporting schedule in accordance with the Special Terms and Conditions (STCs).

Evaluation Strategy

To ensure an unbiased evaluation of the program aims, the State will commit an estimated \$3.6 million to contract with a third party that will be selected through a competitive bidding process. The evaluation will include the goals, hypotheses, and domains of focus detailed in the HIP 2.0 waiver and Special Terms and Conditions (STCs), refine research questions, gather and analyze data, and present that data in regular and ad hoc reports required by the State and/or Centers for Medicare and Medicaid Services (CMS).

The evaluation will use a combination of qualitative and quantitative data to evaluate HIP 2.0, including the use of eligibility and enrollment, claims/encounter, and survey data to report metrics such as program enrollment and service utilization. The evaluation will also include a series of comparisons, using data metrics for the HIP 2.0 population and comparing those metrics internally (e.g. HIP Plus member characteristics vs. HIP Basic member characteristics) and externally (e.g. HIP 2.0 member characteristics vs. HIP 1.0 members, traditional Medicaid members, etc.).

Refine Research Questions

Currently, the HIP 2.0 waiver and CMS STCs contain six defined goals and a series of hypotheses and domains of focus the demonstration will address. Within each hypothesis and domain of focus, the evaluation contractor, in collaboration with the State, will further refine the suggested research questions.

Gathering Data

As the evaluation gathers data, it will consider a number of different factors, including the populations under consideration for each data metric and comparison to ensure the evaluation is able to draw accurate and representative conclusions from the data. Some particular populations and subgroups the evaluation will need to consider include:

- **Health plan differences:** HIP Plus, HIP Basic, HIP Link
- **Benefit package differences:** State plan benefits for groups like the Medically Frail
- **Cost sharing differences:** No cost sharing for groups like Pregnant Women and American Indian/Alaska Native, POWER account contributions for HIP Plus, copayments for HIP Basic, premium payments for HIP Link
- **Enrollment differences:** Eligible individuals selecting HIP Plus, HIP Basic, HIP Link, or choosing not to enroll

- **Socio-demographic differences:** Behavior variation across socio-demographic metrics

Further definition of populations or selection of samples will be contingent on the specific evaluations and research questions explored. When primary data collection (e.g., surveys) is necessary, the evaluation will implement a probability-based sampling method. When sufficient for a given question, the evaluation will employ methods such as simple random sampling (e.g., all sampling units have an equal probability of selection). If a more sophisticated method is required (e.g., to ensure specific subgroups are oversampled) the evaluation will employ alternate sampling methods (e.g., stratified random sampling, etc.).

Data Sources

The evaluation design will use a variety of data sources from both external and internal entities. External data sources include information generated by federal and local authorities that are not affiliated with the State of Indiana, including the Current Population Survey, the American Community Survey, the Consumer Assessment of Healthcare Providers and Systems Survey (CAHPS), Medicaid reports generated by other states, and data from other regulatory authorities. Internal data sources will include data generated and owned by the State of Indiana, including, but not limited to, historical Medicaid data; managed care entity plan network and geo-access data; HIP 2.0 eligibility, application, and enrollment data; member, non-member, and provider survey data; claims/encounter data; administrative data; and internal financial data. The combination and comparison of these different data sources will contribute to a detailed analysis that will answer a series of research questions associated with each demonstration goal. Each research question will include analysis at the member, provider, and aggregate program level, as appropriate, and include population stratifications to the extent feasible, for further depth and to glean potential non-equivalent effects on different sub-groups.

External Data Sources

Current Population Survey

The Current Population Survey (CPS), sponsored jointly by the U.S. Census Bureau and the U.S. Bureau of Labor Statistics (BLS), is a monthly survey of households the United States. The CPS is the source of numerous high-profile socio-economic statistics, including rates of health insurance coverage. The CPS also collects extensive demographic data that complements and enhances the State's understanding of health insurance coverage in the nation overall, and across many different populations according to race, ethnicity, gender, education, income, and geographic location.³

The Current Population Survey will be used to assess the following data metrics:

- Health insurance coverage estimates, by age and by income;
- Total health insurance coverage estimates (all ages and income levels); and
- Employer sponsored insurance (ESI) coverage rate estimates (all ages).

³ U.S. Census. Current Population Survey. Available at <http://www.census.gov/cps/>. Accessed 05/07/15.

American Community Survey

The American Community Survey (ACS), sponsored jointly by the U.S. Census Bureau and the U.S. Department of Commerce, is a nationwide survey that collects and produces information on demographic, social, economic, and health insurance coverage characteristics of the U.S. population each year. Information from the survey generates data that help determine how more than \$400 billion in federal and state funds are distributed each year.⁴

The American Community Survey will be used to assess the following data metrics:

- Health insurance coverage estimates, by age and by income; and
- Total health insurance coverage estimates (all ages and income levels); and
- Employer sponsored insurance (ESI) coverage rate estimates (all ages).

Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey

Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys, developed and implemented by CMS, ask patients about their experiences with, and ratings of, their health care providers and plans, including hospitals, home health care agencies, doctors, and health and drug plans, among others. CAHPS surveys follow scientific principles in survey design and development. The surveys are designed to reliably assess the experiences of a large sample of patients. They use standardized questions and data collection protocols to ensure information can be compared across healthcare settings, and are statistically adjusted to correct for differences in the mix of patients across providers and the use of different survey modes.⁵

The CAHPS Survey will be used to assess the following data metrics (member ratings):

- Rating of plan overall;
- Ability to get needed care quickly;
- Provider communication;
- Coordination of care; and
- Other relevant CAHPS indicators.

Internal Data Sources

Indiana Medicaid Historical Data

Indiana historical data refers to data which the State has developed over previous assessments and evaluations, either directly or through contracted services for the HIP 1.0 population. The evaluation will use data from previous HIP evaluations on a variety of metrics including POWER account, enrollment and utilization. The historical data will include claims, enrollment and other HIP specific data.

⁴ American Community Survey Information Guide. Available at http://www.census.gov/acs/www/about_the_survey/acs_information_guide/. Accessed 05/07/15.

⁵ Center for Medicare and Medicaid Services (CMS). Consumer Assessment of Healthcare Providers & Systems (CAHPS). Available at <https://www.cms.gov/Research-Statistics-Data-and-Systems/Research/CAHPS/index.html?redirect=/cahps/>. Accessed 05/11/15.

The HIP 2.0 population will not only include the “new adult” population created by the Affordable Care Act, but will also include several populations previously covered by the traditional Medicaid program. These populations include those accessing family planning services, parents and caretakers, and 19 and 20 year olds. As these groups have been covered by traditional Medicaid for years, there are years of enrollment and encounter data against which the evaluation will compare HIP 2.0 enrollment and encounter data.

HIP Benefit Plan Data

HIP Benefit Plan Data refers to data from HIP programs which run concurrent with HIP 2.0, such as Hoosier Healthwise (HHW). The evaluation will use data from these companion programs to report on a variety of metrics, in particular, claims and utilization data.

Managed Care Entity (MCE) Health Plan Network and Geo-access Data

HIP health plan network and geo-access data will be used to measure geo-access standards for primary and specialty care for all health plans. The evaluation will use geo-access data to identify and measure metrics such as the proximity of primary and specialty care providers to members, the proximity of dental care providers to members, and related measures.

Member Eligibility, Application, and Enrollment Data

Member application and enrollment data will be used in this evaluation to understand the size and socio-demographic makeup of HIP 2.0 enrollees. Member data from HIP enrollment figures will be used to identify and measure key member metrics such as monthly and annual enrollment counts, the length of time individuals are remaining in the program, the unique number of Indiana residents under 138% FPL, and related member information.

Employer Eligibility, Application, and Enrollment Data

Employer application and enrollment data will be used within this evaluation to understand the characteristics of employers who apply for, and are approved to participate in HIP Link. Employer data from HIP Link enrollment figures will be used track and assess data metrics such as employer size, employer industry type, employer sponsored insurance (ESI)/health plan information, number of HIP Link employees, and related employer information.

Member and Previous Member Survey Data

Surveys will play a significant role in the evaluation process. Participants must be selected at random and the sample size must be statistically significant. The surveys will cover a range of topics, but some of the most likely questions will address items such as:

- **Recent history of health insurance coverage**, to distinguish chronically uninsured enrollees from other enrollees (new enrollees only and how long they were uninsured);
- **Health status overall**, including both physical and mental health status, chronic conditions, receipt of disability benefits, and work-related health limitations;

- **Access to care**, such as having a personal doctor during the previous six months (for new enrollees, this question referred to the period before enrollment);
- **Utilization of care**, including preventive and specialty care, prescription medications and emergency room visits during the previous 6 or 12 months (for new enrollees, this question referred to the period before enrollment);
- **Unmet health care needs and barriers to utilization** of health care (for new enrollees, this question will refer to the six months before enrollment);
- **Satisfaction** with HIP;
- **POWER accounts**, including knowledge of how the account works and program incentives; and
- **Demographic characteristics** such as gender, age, race/ethnicity, education, household size, household income, and employment status.
- **Cost Sharing**, payment of copays and perceptions on affordability

The HIP 1.0 evaluation utilized a survey addressing most of these topics (Appendix B), and the HIP 2.0 evaluation anticipates utilizing many of the same questions to ensure assessment continuity and provide more accurate comparisons between HIP 1.0 and HIP 2.0. The new survey, however, will need to have some new sections added, as well, to address several of the policies new to HIP 2.0, including the HIP Basic and HIP Plus cost sharing models, payment of ER copays, and other copayments, as well as the new HIP Link option.

As in previous surveys, the evaluation will consider the following:

- **Preparing individuals to participate:** To encourage survey participation, the evaluator will reach out to participants in advance of the actual survey, explaining what potential survey participants may expect and why their participation is important.
- **Delivery method:** One popular survey method is computer-assisted telephone interviewing (CATI) because it takes advantage of the skip pattern logic to reduce confusion and errors in completing the survey while promoting data consistency and accuracy through close-ended questions and data range checks. Hard copy surveys will also be sent to members.
- **Language options:** After English, Spanish is the second most commonly spoken language in Indiana. To capture a larger and more representative survey sample, the evaluation will offer the survey in both English and Spanish.
- **Increasing response rates:** To encourage responsiveness, the evaluator will consider financial incentives for participation to ensure that hard-to-reach populations are not being under-represented; and will need to assess the most appropriate ways to contact those individuals, including directory assistance or national databases.
- **Quality:** Supervisors will monitor a sample of interviews as they take place to ensure interviewers are appropriately explaining the survey, encouraging participation, responding to member questions appropriately, reading and recording the questions and responses, and acting in a non-biased way. Evaluation supervisors will consider re-calling a select sample of respondents to re-ask a few questions as a means of verifying the individual's answers.

Non-member Survey Data

Several hypotheses require data on HIP member perceptions of the program, contrasting the perceptions with those of non-members. To address those hypotheses, the evaluation will need to conduct surveys with both members and non-members. Non-member surveys will need to target different sub-populations, including individuals who (i) were eligible but never applied for coverage, (ii) applied and were determined eligible, but never made the initial POWER account contribution (income over 100 percent FPL), (iii) were members but were locked out for non-payment of the POWER account contribution, (iv) were members but left the program due to a change in eligibility, and other reasons.

Surveys will also require evaluation based on certain demographics or other characteristics, including income, age, gender, county of residence, HIP Plus vs. HIP Basic enrollment, etc. The surveys will also consider several of these factors simultaneously as a means of understanding specific sub-populations; for example, the evaluation will consider non-emergency medical transportation access for HIP Plus members with income below 100 percent FPL within a given county or region.

Provider Enrollment and Survey Data

The State will review the number of new providers in the Medicaid program as well as within the HIP health plans. The State will also conduct a provider survey to gather information on copay protocols, uncompensated care and other aspects of the program.

While HIP 2.0 members will make up the majority of survey participants, the evaluation will also include provider surveys as a means to address several quality and access hypotheses. For example, Medicaid has traditionally used presumptive eligibility assessments and applications to expedite enrollment for limited populations. With the expansion of HIP 2.0, the program is also expanding presumptive eligibility assessments and enrollments to new providers and new populations. The evaluation will survey health care providers to gain a better understanding of provider perceptions of presumptive eligibility, copay protocols, non-emergency transportation and uncompensated care.

Particular provider groups of interest:

- **Presumptive eligibility application entities:** Traditionally, Indiana Medicaid offered limited presumptive eligibility application through registered hospitals. With the expansion of HIP, the State will also expand the criteria for organizations to be eligible to assess individuals as presumptively eligible for HIP 2.0. As a part of this effort, Indiana will be tracking the numbers and types of entities eligible to perform this eligibility assessment and compare that data with the numbers and types of entities approved and enrolled to serve this function.

Claims/Encounter Data

The claims/encounter records that the health plans submit to the State will be a critical source of information about the health care utilization patterns of all HIP enrollees to help test several of the hypotheses. The State will also utilize historical claims data for populations that were moved into HIP and the previous HIP population for comparison purposes on a number of metrics. Information about how HIP enrollees and comparable Medicaid beneficiaries use care, the type of care they receive, and

their diagnoses will be used to assess several HIP goals. In addition, information from these records will be used to identify eligible HIP providers for telephone interviews in order to better understand the provider effects of the programs. The diagnosis codes on these records will also be used to identify people with chronic conditions.

The evaluation will also combine claims/encounter data with POWER account data to look for health care utilization patterns associated with particular socio-demographic groups. Understanding the links between use and other population characteristics could be useful in refining and developing new policies and procedures to further improve member utilization and health outcomes.

In addition, the evaluation will assess claims and utilization data by specific category. Some of the more salient claims and utilization categories include emergency department (ED) utilization (both emergency use and non-emergency use), primary care, specialty care and chronic disease management. The information generated from these category-specific claims and utilization assessments will be used to provide a more complete and comprehensive analysis of the effects of policies such as graduated ED copayments and programs such as HIP Link.

Administrative Data

Administrative data refers to the internal participant-level data generated from member activity. Data such as POWER account contributions, out-of-pocket payments, and third-party contributions (e.g., not for profit organization contributions to member POWER account payments) are all forms of administrative data which will be used within the evaluation.

POWER Account Data

The HIP 2.0 managed care entities (MCEs) maintain participant-level records on monthly POWER account contributions, usage of POWER account funds, and annually calculate and record whether enrollees qualified for rollover of their POWER accounts. This data will link them with other data—for example, application files and claims/encounter data files. Combining POWER account information with other data sources will allow more in depth analysis of whether the POWER account can be linked to health care utilization, to evaluate if HIP enrollees engage in value-based purchasing and increased use of preventive services and/or other utilization patterns compared to other Medicaid populations. The evaluation will also use the POWER account data to compare utilization across current members based on their benefit plan (Basic or Plus) and to compare utilization differences between HIP 1.0 and HIP 2.0 members.

The State will examine the link between the different types of rollover option and preventive service utilization, as well as the link between rollover and changes in benefit plan enrollment from HIP Basic to HIP Plus.

In addition, HIP 2.0 allows employers and not-for-profit organizations to make contributions on behalf of HIP 2.0 members. The evaluation will also review these payments and use the information to gauge the impact of third party contributions on access to health coverage.

To complete planned analyses, the evaluation requires several types of secondary data, much of which from the participating health plans and several State offices, including health plan procedural data and plan monitoring reports to assess plans' operational performance.

Internal Financial Data

Internal financial data refers to data collected by the State which describe revenues and expenditures related to HIP programs. The internal financial data that will be used within this evaluation include (but are not limited to):

- Expenditure information for HIP programs (e.g., HIP 1.0 & 2.0, Hoosier Healthwise, HIP Link, etc.);
- The approved budget neutrality agreement with CMS, and any future changes to that agreement;
- Financial assessment data provided by Milliman (the State's actuarial consultant, contracted to assess and track waiver budget neutrality);
- Revenue data, including cigarette tax and dedicated funds that support HIP; and related financial data.

These (and related) financial data will be used to assess costs related to the demonstration, by sub populations, including Section 1931, the new adult population, and HIP link participants.

The State will submit quarterly reports on expenditures, utilizing Form CMS-64, CMS-64.9 Waiver, CMS-64.9P Waiver, and/or CMS-37, as applicable. These reports will track a number of financial data elements, as required by Section XI, Paragraph 2 of the STCs.

Analyzing Data

The evaluation will use a series of univariate, bivariate, and multivariate analyses to test the hypotheses associated with the goals of the HIP program and the related research questions therein.

- **Univariate analyses** will be used to compute measures such as central tendency (i.e., mean, median and mode), dispersion (i.e., range, variance, max, min, quartiles and standard deviation) and frequency distributions.⁴
- **Bivariate analyses** will be used to describe the relationship between two variables (i.e., the effect that a change in variable X has on variable Y).⁵
- **Multivariate analyses** will be used to describe the relationship between two variables, into account the effects of other (confounding) variables on the responses of interest.⁸

The evaluation summary table (Appendix A) indicates how univariate, bivariate and multivariate will be used within the evaluation.

⁴ Babbie E. The Practice of Social Research (2009;12th edition). Wadsworth Publishing. ISBN 0-495-59841-0.

⁵ Johnson R and Wichern D. Applied Multivariate Statistical Analysis (2007; 6th edition). Prentice Hall. ISBN 978-0-13-187715-3.

Mechanisms to Ensure Quality Data and Reporting

Adjusting for Cofounders

The STCs require that the evaluation design will control for various confounding factors in the demonstration. Adjusting the data for cofounders will increase the internal validity of the evaluation, which will help ensure the accuracy of the findings. Examples of the types of confounding factors for which the HIP 2.0 evaluation will control include, but are not limited to:

- Health status;
- Socio-demographic factors (e.g., poverty level, geographic region, age, sex, ethnicity, education, etc.); and
- HIP benefit status (Plus, Basic or State Plan).

Controlling for Bias

Data and observations used within the evaluation will be weighted to adjust for the probability of selection bias, including nonresponse bias.

Ensuring Appropriate Comparison between Study Groups

In an effort to ensure that there is appropriate comparison between study groups, the State will assign members to control groups using the same formula that the Centers for Medicare and Medicaid Assistance (CMS) uses to select its five percent (5%) samples from standard analytical files using health insurance claims. This will be used in particular for the non-emergency use of the emergency room graduated copayment evaluation protocol, which, per the STCs, will include at least 5,000 members, but large sample sizes will be applied in other areas, as well.

American Indians/Alaska Natives

American Indian/Alaska Native members and pregnant members will be excluded from most samples, as neither group is subject to the cost sharing requirements. Women who are selected and become pregnant will be removed from the sample as they will have no copayments applied for the remainder of their pregnancy.

Availability of Claims/Encounter Data

Claims/encounter data MCEs are submitting the State will underpin many of the planned analyses within the evaluation, particularly those which assess HIP's effects on personal responsibility, preventive care, and prevention of disease progression. Currently, health care providers have up to a year to submit their claims for reimbursement. Delays in submission of claim information produce data deficiencies that can impact report data, particularly for rapid assessments such as the monthly monitoring calls, and monthly and quarterly reports due to CMS.

Generalizability of Results

In accordance with Section XIII, Paragraph 1 of the STCs, the evaluation will consider the potential for generalizing the results of the HIP 2.0 demonstration. With a series of policy firsts for the Medicaid population, the HIP 2.0 demonstration will indicate just how successfully certain consumer-driven healthcare principles can be applied across a broader population. Evaluations of the HIP 1.0

demonstration indicated success in applying commercial health care concepts to a limited group of enrollees, HIP 2.0 will expand the application of those principles, as well as new policies, throughout Indiana, which will help demonstrate that the outcomes and experiences associated with HIP members are generalizable to populations across the State.

Evaluation Deliverables

While the general reporting time frame is known and indicated the following section, the evaluation will utilize and adhere to all dates/deadlines as indicated within the STCs. These deadlines will be centered on quarterly and annual reports, as well as an interim and a final report. In addition, the State expects to hold regular monthly calls with CMS, during which time it will discuss, among other possible topics, data metrics that will be produced as a part of the State's compliance with rapid cycle assessment requirements.

Draft Design

The State has developed the initial draft design, and CMS will provide comments on the draft design and the draft HIP 2.0 evaluation strategy. The evaluation contractor will work with the State to finalize the evaluation design and the State will submit a final design to CMS within 60 days of receipt of CMS's comments. The state must implement the evaluation design and submit its progress in each of the quarterly and annual progress reports.

Quarterly Reports – Overview and Timelines

All quarterly reports will be required to include a discussion of events occurring during that quarter and events anticipated to occur in the near future that will impact health care delivery, enrollment, quality of care, access, health plan financial performance relevant to the demonstration, benefit package, and other operational issues. These reports will also discuss any challenges faced in the quarter, as well as a discussion of the underlying causes of the challenges, how the challenges are being addressed, key achievements, and to what conditions and efforts those successes can be attributed. Additionally, quarterly reports will discuss the HIP Link program operations, challenges, and grievances and will investigate MCO collection activities, assessing the number of individuals subject to collection, the number of individuals with POWER account debt, the amounts due, and the amounts paid. Finally, quarterly reports will address the status of the Non-Emergency Medical Transportation (NEMT) evaluation and POWER account Contributions and Payment monitoring, with several specific data elements listed in Appendix A.

In addition to enrollment information, quarterly reports must also include expenditure information for the quarter, utilizing Form CMS-64, CMS-64.9 Waiver, CMS-64.9P Waiver, and/or CMS-37, as applicable. These reports should track a number of financial data elements, as required by Section XI, Paragraph 2 of the STCs.

Quarterly reporting to CMS

	Demonstration Year 2015 2/1/2015 – 1/31/2016		Demonstration Year 2016 2/1/2016 – 1/31/2017		Demonstration Year 2017 2/1/2017 – 1/31/2018	
Quarter	Data Reporting Period	Report Due Date	Data Reporting Period	Report Due Date	Data Reporting Period	Report Due Date
Q1	2/1/15 – 4/30/15	6/30/15	2/1/16 – 4/30/16	6/30/16	2/1/17 – 4/30/17	6/30/17
Q2	5/1/15 – 7/31/15	9/30/15	5/1/16 – 7/31/16	9/30/16	5/1/17 – 7/31/17	9/30/17
Q3	8/1/15 – 10/31/15	12/31/15	8/1/16 – 10/31/16	12/31/16	8/1/17 – 10/31/17	12/31/17
Q4	11/1/15 – 1/31/16	3/31/16	11/1/16 – 1/31/17	3/31/17	11/1/17 – 1/31/18	3/31/18

Quarterly **financial** reports due to CMS

	Demonstration Year 2015 2/1/2015 – 12/31/2016		Demonstration Year 2016 2/1/2016 – 1/31/2017		Demonstration Year 2017 2/1/2017 – 1/31/2018	
Quarter	Data Reporting Period	Report Due Date	Data Reporting Period	Report Due Date	Data Reporting Period	Report Due Date
Q1	2/1/15 – 4/30/15	5/30/15	2/1/16 – 4/30/16	5/30/16	2/1/17 – 4/30/17	5/30/17
Q2	5/1/15 – 7/31/15	8/31/15	5/1/16 – 7/31/16	8/31/16	5/1/17 – 7/31/17	8/31/17
Q3	8/1/15 – 10/31/15	12/31/15	8/1/16 – 10/31/16	11/30/16	8/1/17 – 10/31/17	11/30/17
Q4	11/1/15 – 12/31/15	1/31/16	11/1/16 – 1/31/17	2/28/17	11/1/17 – 1/31/18	2/28/18

Annual Reports – Overview and Timelines

Annual reports, detailed in Section X, Paragraph 5 of the STCs, are intended to summarize the data collected in the quarterly reports. To fulfil this requirement, the State will review the four quarterly reports for the demonstration year, consolidating the information to facilitate a longer range view of the data and assessing the data for possible trends. The annual report will also include a summary of the operations and activities performed in the demonstration year, as well as the data elements in the following table.

In addition to the general summary of performance metrics, the State will also include a specific assessment of its expanded presumptive eligibility program annually and an assessment of its waiver of retroactive coverage as a part of its first annual report.

Annual reports due to CMS

Demonstration Year	Report Due Date
2015	4/30/16
2016	4/30/17
2017	4/30/18

Interim and Final Reports – Overview and Timelines

CMS will require an interim and final report, which will serve as comprehensive presentations of all of the key components of the demonstration addressed in quarterly and annual reports. These reports will include data collected since the beginning of the demonstration, incorporating feedback from CMS as required in Section X, Paragraph 6 of the STCs.

The State will submit both an interim and final report, which will serve as comprehensive presentations of the key components of the demonstration. The interim report will be included either as a part of a waiver renewal request or as a midpoint evaluation if the State opts not to extend the demonstration. The final report will summarize data from the demonstration from beginning to end, consolidating information from all of the quarterly and annual reports submitted throughout the demonstration.

Interim and final reports due to CMS

	Report Due Date
Interim Report	No later than June 30, 2016
Final Report	March 27, 2018

Policy-specific Reports – Overview and Timelines

The State will have some reports that are only required once within the STCs and that same information will not be included in subsequent reports. These reports include:

- **Retroactive coverage data:** The State will file two separate reports related to this policy within the first year of the demonstration. The first report will examine the automatic renewal process and the population’s responsiveness when their eligibility is terminated for failure to respond to their renewal and will contain data on uncompensated care related to the lack of retroactive coverage. The second report will analyze data on the prior claims payment for a subsection of the Section 1931 group.
- **Presumptive Eligibility (PE) Data:** The State will submit monthly and two separate reports related to this policy, in accordance with STCs Section IV, Paragraphs 6a and 6d. Monthly reports will cover basic application and eligibility statistics around PE applications. Another report will address the number of entities potentially eligible to assess for PE, ensuring that interested entities are able to assess for PE. The second report compares HIP eligibility for PE enrollees with HIP eligibility across the entire applicant population.
- **Non-Emergency Medical Transportation (NEMT):** The State will assess the impact of its waiver of non-emergency medical transportation for members.

- **Non-Emergency use of the Emergency Department (ED):** The State will assess the impact of its policy to increase the required copayment for individuals utilizing the ED without an emergency condition more than once.
- **Provider Payment Rates:** The State will file three reports over the course of the demonstration—one per year—to assess whether enhanced pay for HIP 2.0 health care providers results in unequal treatment across Medicaid categories. If the study indicates this is the case, the State will need to provide corrective actions to ensure equal access and quality of care for all Medicaid enrollees.
- **HIP Plus POWER account Contribution (PAC):** The State will submit a report addressing the perceived affordability of the PAC and will examine the impact of the lockout policy on HIP Plus members who are disenrolled for failure to make the contribution.

Summary of policy-specific reports and their timelines

Topic	Description	Report Due Date
Retroactive Coverage Data, per Section IV, Paragraph 4 of the STCs	Indiana will conduct an independent evaluation of the retroactive coverage waiver to allow for evaluation of whether there are gaps in coverage that would be remediated by the provision of retroactive coverage. As part of the evaluation: <ol style="list-style-type: none"> a. The state will submit a description of its renewal process; b. The state will provide data on its new passive verification renewal process, conducted in accordance with 42 CFR §435.916, by September 1, 2015. c. The state will provide data on uncompensated care reported by providers as it relates to the lack of retroactive coverage. d. The State will implement a transition program for the Section 1931 group that will reimburse providers for costs for services provided prior to their effective date of coverage. 	September 1, 2015
	The State will provide data regarding the 1931 group, including: <ol style="list-style-type: none"> i. The number of individuals with costs paid under the program; ii. The total amount of costs paid; iii. The average cost per person; iv. The number and type of providers paid; v. The type of costs incurred, including the specific conditions with which they are associated; and vi. Survey data from beneficiaries and providers about unreimbursed costs for this population, including amounts not reimbursed under this program. 	November 1, 2015

Topic	Description	Report Due Date
Presumptive Eligibility (PE) Data, per Section IV, Paragraph 6 of the STCs	Monthly reports will be abbreviated reports with the information targeted to meet specific STC requirements. One such report relates to presumptive eligibility (PE). Monthly PE reports will include the following information, as required in Section IV, Paragraph 6 of the STCs	Monthly
	Percentage of potentially qualifying entities trained and participating in the HIP 2.0 PE assessment, noting that entities that have refused or not responded to opportunities to participate will not be included in the assessment.	September 1, 2015
	State assesses the percentage of eligibility determinations following a PE period as a share of eligibility determinations made on all types of applications and uses the information to propose a minimum standard effective in calendar year 2016.	December 1, 2015
Non-Emergency Medical Transportation (NEMT), per Section V, Paragraph 1 of the STCs	Within the first demonstration year, the State will conduct an assessment of the NEMT waiver, evaluating the impact on access to care. The evaluation must include hypotheses, and address at a minimum the following questions: <ol style="list-style-type: none"> a. What is the effect of no access to NEMT on missed appointments by income level? b. Are there parts of the state that are more affected by no access to NEMT? c. How does not having access to NEMT affect preventive care and overall health outcomes? d. What is the impact of no access to NEMT as viewed by the providers and beneficiaries? 	November 1, 2015
Non-Emergency use of the Emergency Room, per Section VIII, Paragraphs 2-5 of the STCs	As a condition of the waiver, the State has created a graduated copayment structure for non-emergency use of the emergency room (ER). To test the effectiveness of this policy, the State will need to assess whether the graduated payment successfully deterred unnecessary use of the ER without causing harm to HIP members. To conduct this assessment, the State will comply with the Emergency Room Copay Protocol.	December 1, 2016
Provider Payment Rates, per Section IX, Paragraph 8 of the STCs	The State will submit three reports regarding managed care organization (MCO) provider payment rates, with each including: <ol style="list-style-type: none"> i. An evaluation of whether the differential in MCO provider payment rates between the HIP 2.0 program and the Hoosier Healthwise (HHW) program has resulted in unequal access to health care services, either in the number of providers 	December 30, 2015; September 30, 2016; September 30, 2017

Topic	Description	Report Due Date
	<p>available to beneficiaries, the number of providers accepting new beneficiaries, or in the time required to access care;</p> <ul style="list-style-type: none"> ii. A description of corrective actions implemented if evaluation shows access between programs is not equal; iii. A description of any incremental changes to the provider payment rates in either the HHW and/or HIP 2.0 programs the state will be making for the upcoming rating period; and iv. Changes reported in the annual actuarial rate certification for the rating period. 	
<p>HIP Plus POWER Account Contribution, per Section XIII, Paragraph 5 of the STCs</p>	<ul style="list-style-type: none"> i. The State will evaluate the impact of the HIP Plus POWER account contribution on members, including topics such as: How many individuals were disenrolled by income level? ii. What are the reasons beneficiaries did not make contributions? iii. What health care needs did individuals have while they were in the lockout period and how did they address those needs? 	<p>March 31, 2017</p>

Evaluation Structure

Within the regular reports to CMS, the State will analyze the hypotheses presented in the HIP 2.0 waiver and domains of focus listed in the STCs, separated into the six HIP 2.0 goals. Each analysis will consist of several core components: (i) research questions, (ii) an analytic approach with potential comparison, (iii) data sources, and (iv) data metrics. The research questions serve as a starting point from which the evaluation will build. The analytic approach lists evaluation approaches to answer the research questions. The data sources list some of the most likely origins of information that will address the analytic approach; and the data metrics include a list of data elements the evaluation will need or want to address as a part of the analysis.

Goal 1: Reduce the Number of Uninsured Low Income Indiana Residents and Increase Access to Health Care Services

HIP 2.0 expands coverage options for hundreds of thousands of currently uninsured Indiana residents. With additional coverage options available, the rate of uninsured individuals in Indiana should decrease over the course of the demonstration. Within the first goal, the State, with the assistance of the evaluation contractor, will analyze five separate hypotheses, including:

1. HIP will reduce the number of uninsured Indiana residents with income under 138% FPL over the course of the demonstration (HIP 2.0 Waiver, Section 5 and STCs, Section XIII, Paragraph 3i).
2. HIP will increase access to health care services among the target population (HIP 2.0 Waiver, Section 5 and STCs, Section XIII, Paragraph 3ii).
3. POWER account contributions for individuals in the HIP Plus plan are affordable and do not create a barrier to health care access (STCs, Section XIII, Paragraph 3v).
 - Few individuals will experience the lockout period because the policy will deter nonpayment of POWER account contributions policy for HIP Plus beneficiaries (STCs, Section XIII, Paragraph 3vi).
4. Presumptive eligibility (PE) and fast-track prepayments will provide the necessary coverage so as not to have gaps in health care coverage (STCs, Section XIII, Paragraph 3vii).
5. Waiver of non-emergency transportation to the non-pregnant and non-medically frail population does not pose a barrier to accessing care (STCs, Section XIII, Paragraph 3ix).

1.1. HIP Will Reduce the Number of Uninsured Indiana Residents with Income Under 138% FPL Over the Course of the Demonstration

Reduction in uninsurance rates has long been a goal for the HIP program. HIP 2.0 will continue to work to reduce current uninsurance rates in the state; and to identify the demonstration's success in meeting this goal, the State will evaluate the following research questions:

- How many Indiana residents with income under 138% FPL have insurance relative to the total Indiana resident population and how many have Medicaid/HIP coverage in this population group?
- Are there socio-demographic differences in the health insurance coverage/HIP coverage among Indiana residents with income under 138% (e.g., differences by age, education, income, etc.)?
- How many insured Indiana residents with income under 138% were previously uninsured before the implementation of HIP (i.e., newly enrolled)?

To sufficiently address these questions, the evaluation will perform several different analyses. First, the evaluation will track and provide insurance rates among different populations, based on their income and county and/or region. Next, the evaluation will address the number of Indiana residents served by the HIP program over the reporting period. To compare HIP 2.0 to other health coverage options, the evaluation will also review enrollment data from HIP 1.0, as well as data from comparable populations in other states to better understand program-related impacts on uninsurance rates.

To conduct this assessment, the evaluation will rely on data from the HIP 2.0 eligibility and enrollment system, as well as state and local insurance market assessments such as the Current Population Survey and American Community Survey.

In addition to impacting insurance and uninsurance rates in the State, Indiana will perform an analysis on individuals who leave HIP to understand the reasons for leaving the program. Departure from the program may be due to no longer needing public assistance or an eligibility change, in which case the eligibility system may be sufficient to capture all of the information needed; however, reasons for leaving may be more complex, and the evaluation will conduct a survey that includes questions of why the individuals left HIP and how they accessed care after leaving. Understanding where individuals are accessing care will provide insight into the success of other HIP policies (for example, individuals leaving after getting a job with insurance through the DWD referral process) and will indicate where and how unmet health care needs are being met, providing an opportunity for State outreach.

1.2. HIP will Increase Access to Health Care Services Among the Target Population

Health care access is crucial to improving health outcomes. To identify the program's success in this aim, the State will research the following questions:

- How do member perceptions of access to health care change before and after fully enrolling in HIP?
- How does perceived access to care differ between HIP members and individuals who are eligible but have not applied and/or enrolled in HIP?

To understand the differences in member and non-member perception of access to care, the evaluation anticipates tracking member feedback for perceived access to different types of health care services before and after enrollment in the HIP program. To validate the survey data, the evaluation will compare member and non-member responses with geo-access standards and realities for primary and specialty care for all health plans. The evaluation will also include claims/encounter data and CAHPS surveys to review different provider networks and access indicators, such as appointment wait time, distance between member and provider, and others.

1.3. POWER Account Contributions (PACs) for Individuals in the HIP Plus Plan are Affordable and Do Not Create a Barrier to Health Care Access

Evaluating HIP 1.0, an overwhelming number of surveyed HIP members expressed preference for a set monthly contribution amount over the unpredictable copayment costs. With the monthly contribution, individuals could include the contribution amount in their budget calculations and better-predict their out-of-pocket health care costs. HIP 2.0 has subsequently applied this cost sharing policy to its HIP Plus benefit plan, requiring HIP Plus members to contribute approximately 2 percent⁶ of their household income to a health savings-like POWER account in order to stay in the benefit plan. If individuals with household income under 100 percent FPL fail to make the contribution, they will be moved to HIP Basic,

⁶ All HIP Plus members are required to contribute at least \$1 per month to the POWER account.

where they will pay a copayment for each service. Individuals with household income over 100 percent FPL who fail to make the POWER account contribution (PAC) will be subject to a lockout period. Prior to lockout, members will receive a grace period and reminder notices to ensure they are informed of the policy before it is implemented.

To address issues of affordability and program lockout, the evaluation will address several research questions, including:

- How many members will be impacted by employers and not-for-profit organizations paying all or part of their PAC?
- How do HIP 2.0 enrollees perceive the affordability of the PAC and non-payment penalties?
- How many individuals lost HIP Plus coverage due to non-payment of the PAC?
- How many individuals requested a waiver from the six month lockout?
- How are individuals accessing healthcare if they are locked out due to non-payment of the PAC?
- Was the lockout period a deterrent for individuals over 100% FPL to miss a PAC?

The evaluation will address these research questions by tracking a series of data points around member POWER account contributions over the course of the demonstration, including PAC timeliness, the entity making the PAC, and the number of individuals failing to make the PAC, examining all data elements by member household income level. The evaluation will review the populations subject to the POWER account contribution, using POWER account data, eligibility, and enrollment data to assess the number of people making the contribution and the number moving from HIP Plus to HIP Basic or lockout due to non-payment. HIP 1.0 data will serve as a point of comparison for non-payment rates.

The evaluation will also use member surveys to better understand member perceptions of the POWER account contribution requirement, including affordability and the six month lockout. The survey will also provide information about whether individuals over 100 percent FPL felt as though the lockout policy was a deterrent for non-payment, and how individuals who were locked out of the program for non-payment accessed health care during that period of time. Surveys with current and former HIP members, as well as non-members will indicate common perception trends. These responses, in addition to POWER account data, will also allow for comparisons of perceived affordability among different sub-populations, including a comparison between HIP 1.0 and HIP 2.0 members.

In addition to the limited PAC, HIP does allow employers and not-for-profit agencies to contribute to the POWER account on behalf of the member. The evaluation will review data sources such as POWER account payment data and member surveys to identify these third party contributions.

1.4. Presumptive Eligibility (PE) and Fast-track Prepayments Will Provide the Necessary Coverage so as Not to have Gaps in Health Care Coverage

Presumptive eligibility, while available to several traditional Medicaid populations in the past, will now be available to potential HIP enrollees. This policy will allow individuals assessed potentially eligible for HIP to access care before their full HIP application is filed and POWER account contribution (as applicable) is made to expedite coverage. The policy to accept prepayments is intended to help

potentially eligible individuals reduce their gap in coverage, as well. To assess the impact of these two policies, the evaluation will address the following research questions:

- How does the waiver of retroactive coverage impact uncompensated care costs?
- What is the number of PE applications vs. traditional applications?
- How many PE members go to HIP vs. HIP Plus?

To address these questions, the evaluation will rely on eligibility and enrollment data, noting the individuals and types of entities participating in the presumptive eligibility assessment option. The evaluation will then track presumptive eligibility and fast-track prepayment participation over the course of the demonstration.

The evaluation will also use surveys to collect additional information from members and providers, including PE entities. The surveys will also provide information about uncompensated care costs and their overall PE experience. Eligibility data will provide information to compare the benefit start dates between members who participated in PE and/or made fast-track prepayments and those who did not. Claims/encounter data will also provide insight surrounding care that was both accessed and covered as a result of the expanded PE policy and/or fast-track prepayment policy.

1.5. Waiver of Non-emergency Transportation to the Non-pregnant and Non-medically Frail Population Does Not Pose a Barrier to Accessing Care

With a few exceptions (for example, medically frail individuals), most HIP 2.0 members will not be offered non-emergency transportation. The original HIP program did not provide this benefit and surveys indicated that this was not a concern to the HIP population. The evaluation will address the following research questions—listed in the STCs (Section XIII, Paragraph 4)—to verify that the waiver of transportation coverage does not create a barrier to care and to assess sub-populations for policy impact in HIP 2.0.

- What is the effect of the NEMT waiver of coverage on missed appointments by income level for individuals who are neither pregnant nor medically frail?
- Are there parts of the state that are more affected by no access to NEMT?
- How does not having access to NEMT affect preventive care and overall health outcomes?
- What is the impact of no access to NEMT as viewed by the providers and beneficiaries?

To address these questions, the evaluation will rely on survey data from members and providers. The evaluation will track survey responses over the course of the demonstration to identify any changes in response trends and will compare the results across member receiving state plan benefits that include NEMT and HIP 1.0 beneficiaries. The evaluation will also compare the perceptions of those with NEMT coverage with those who do not have the coverage, controlling for factors such as county of residence and income.

The following tables include a series of research questions, analytic approaches, comparison groups, data sources, and metrics which the evaluation will use to assess the hypotheses therein. Cells written in italics and highlighted pink are requirements from the STCs and/or HIP 2.0 waiver.

GOAL 1 evaluation approach summary

#	Hypothesis	Research Questions	Analytic Approach	Data Source	Metric
Goal 1: Reduce the number of uninsured low income Indiana residents and increase access to health care services.					
1.1	HIP will reduce the number of uninsured Indiana residents with income under 138% FPL over the course of the demonstration (HIP 2.0 Waiver, Section 5 and STCs, Section XIII, Paragraph 3i).	<ol style="list-style-type: none"> How many Indiana residents with income under 138% FPL have insurance relative to the total Indiana resident population and how many have Medicaid/HIP coverage in this population group? Are there socio-demographic differences in the health insurance coverage/HIP coverage among Indiana residents with income under 138% (e.g., differences by age, education, income, etc.)? How many insured Indiana residents with income under 138% were previously uninsured before the implementation of HIP (i.e., newly enrolled)? 	<p>Track rates of uninsured Indiana residents by income:</p> <ul style="list-style-type: none"> Under 138% FPL; 100-138% FPL; and Under 100% FPL. <p>Track the number of Indiana residents served by the HIP program over the course of the demonstration.</p> <p>Track rates of uninsured Indiana residents by county and/or region.</p> <p>Use univariate and bivariate analysis to describe and compare the number of insured versus uninsured Hoosiers.</p> <p>Use multivariate analysis to describe and compare insured versus uninsured Hoosiers, controlling for confounding factors.</p> <p>Comparison Group: Enrollment data from previous demonstration period (HIP 1.0), and comparable populations from other states.</p>	Enrollment and US Census data	Total # enrolled by income level and HIP Plus vs. HIP Basic plan
					Unique # of Indiana residents enrolled
					Total # of enrollments for the demonstration year
					Length of time individuals enrolled in HIP 2.0
					Reason for leaving HIP 2.0
					Total # enrolled who have had HIP coverage before
					Total # enrolled by race and HIP Plus vs. HIP Basic plan
					Total # enrolled by sex/gender and HIP Plus vs. HIP Basic plan
					Total # enrolled by age and HIP Plus vs. HIP Basic plan
					Total # enrolled by county and HIP Plus vs. HIP Basic plan
					Estimated # eligible for HIP by county
1.2	HIP will increase access to health care services among the target population (HIP 2.0 Waiver,	<ol style="list-style-type: none"> How do member perceptions of access to health care change 	Track member feedback for perceived access to different types of health care services before and after enrollment in the HIP program.	Member and provider survey data on retroactive coverage for Section 1931 group transitioning to HIP	Health insurance coverage estimates, by age, by county, and by income
					Total health insurance coverage estimates (all ages, counties, and income levels)
					How individuals access coverage after leaving HIP
					Unreimbursed retroactive service costs for Section 1931 group transitioning to HIP

#	Hypothesis	Research Questions	Analytic Approach	Data Source	Metric
	Section 5 and STCs, Section XIII, Paragraph 3ii).	<p>before and after fully enrolling in HIP?</p> <p>2. How does perceived access to care differ between HIP members and individuals who are eligible but have not applied and/or enrolled in HIP?</p>	<p>Measure geo-access standards for primary and specialty care for all health plans.</p> <p>Measure member health plan satisfaction indicators.</p> <p>Use univariate and bivariate analysis to describe a) member feedback for perceived access to different types of health care services, b) geo-access standards for primary and specialty care, and c) member health plan satisfaction indicators.</p> <p>Comparison Group: Survey responses for HIP members and non-members</p>	<p>Members and non-member survey data</p> <p>MCE health plan network and geo-access data</p> <p>CAHPS survey</p> <p>Historical data and current encounter data (for PCP, OB/GYN, most commonly used adult specialty providers)</p>	<p>% of members who report having a usual source of care</p> <p>Measure of ability to obtain primary care visit</p> <p>Measure of ability to obtain specialty care visit</p> <p>Utilization of primary care vs. specialty care vs. emergency department services</p> <p>Measure of ability to obtain a prescription</p> <p>Proximity of primary care providers for all members</p> <p>Proximity of specialist types for all members</p> <p>Rating of plan overall</p> <p>Ability to get needed care quickly</p> <p>Provider communication</p> <p>Coordination of care</p> <p>Other relevant CAHPS indicators</p> <p>Change in # of providers available to HIP 2.0 members vs. Hoosier Healthwise (HHW) members</p> <p>Change in # of providers accepting new HIP 2.0 members vs. HHW</p> <p>Change in time to access care for HIP 2.0 members vs. HHW</p>
1.3	<p>POWER account contributions for individuals in the HIP Plus plan are affordable and do not create a barrier to health care access (STCs, Section XIII, Paragraph 3v).</p> <p>Few individuals will experience</p>	<p>1. How many members will be impacted by employers and not-for-profit organizations paying all or part of their POWER account contributions?</p> <p>2. How do HIP 2.0 enrollees perceive the affordability of</p>	<p>Track member POWER account payment rates over the course of the demonstration.</p> <p>Track the impact of fast-track payments on member application start date.</p> <p>Track HIP members making initial and subsequent flat-rate POWER account contributions:</p> <ul style="list-style-type: none"> • Overall; • Above 100% FPL 	POWER account data	<p># individuals subject to PAC (by income level)</p> <p># of individuals receiving POWER account contributions (PAC) from employers and/or not-for-profit entities (by entity type)</p> <p>Average amount paid by employer and/or not-for-profit (by member income level)</p> <p># individuals in HIP Basic</p> <p># individuals approved for HIP and over 100% FPL who do not pay first PAC</p> <p># of months PAC paid, average per member</p>

#	Hypothesis	Research Questions	Analytic Approach	Data Source	Metric
	the lock-out period because the policy will deter nonpayment of POWER account contributions policy for HIP Plus beneficiaries (STCs, Section XIII, Paragraph 3vi).	<p>the PAC and non-payment penalties?</p> <p>3. How many individuals lost HIP Plus coverage due to non-payment of the PAC?</p> <p>4. How many individuals requested a waiver from the six month lockout?</p> <p>5. How are individuals accessing healthcare if they are locked out due to non-payment of the PAC?</p> <p>6. Was the lockout period a deterrent for individuals over 100% FPL to miss a PAC?</p>	<ul style="list-style-type: none"> Under 100% FPL. <p>Use univariate and bivariate analysis to describe and compare the number of members who do and do not experience a lock-out period for failure to make POWER account contributions.</p> <p>Use multivariate analysis to describe and compare members who experience a lock out period for failure to make POWER account contributions, controlling for confounding factors</p> <p>Comparison Group: Enrollment data from previous demonstration period (HIP 1.0), and comparable populations from other states, examined by FPL.</p> <p>Non-payment rates from HIP 1.0 and HIP 2.0 populations, examined by FPL</p>	<p>Administrative data</p> <p>Member eligibility data</p> <p>Member Enrollment data, by income level</p> <p>Member and non-member survey data</p>	Timing of eligibility change due to non-payment (transition to Basic or lockout), by # of months paid and by month in the year
					Rate of non-payment of PAC, by FPL
					# individuals with overdue PAC (less than and greater than 60 days)
					# individuals requesting waiver of lockout
					# individuals granted waiver of lockout
					# individuals subjected to 6 mo. lockout, by FPL
					Rate of disenrollment for failure to pay PAC
					# individuals exempted from PAC
					# individuals meeting qualifying event criteria
					# individuals disenrolled
					# of individuals making fast-track payments, by FPL
					Timing of fast-track payment submission
					Reasons for non-payment of PAC
					Perception of ability to make POWER account contribution
Member aware of non-payment penalties? (Y/N)					
Perceived affordability of the PAC, by income level					
Reasons individual did not make contribution, by income level					
Individual health care needs during lockout period, by income level					
How health care needs addressed during lockout period, by income level					
1.4	Presumptive eligibility (PE) and fast-track prepayments will provide the necessary coverage so as	<p>1. How does the waiver of retroactive coverage impact uncompensated care costs?</p>	<p>Track presumptive eligibility and fast-track prepayments over the course of the demonstration.</p> <p>Use univariate and bivariate analysis to describe and compare the number</p>	Member eligibility data	Average # of days between submission of app and eligibility determination
					Average # of days between eligibility determination and HIP 2.0 plan enrollment, by payment of PAC or 60-day default into HIP Basic for members under 100% FPL
					# of individuals determined eligible using ex parte

#	Hypothesis	Research Questions	Analytic Approach	Data Source	Metric
	not to have gaps in health care coverage (STCs, Section XIII, Paragraph 3vii).	2. What is the number of PE applications vs. traditional applications? 3. How many PE members go to HIP vs. HIP Plus?	of members who experience a coverage gap. Comparison Group: Members who do not obtain PE and who do not make fast-track payments.		<i># of individuals receiving prepopulated renewal form</i>
				<i># of individuals responding to prepopulated renewal form</i>	
				<i># of responders determined eligible</i>	
				<i># of individuals who reapply within (a) 90 days or less, (b) 6 months, (c) 1 year, following a termination for failure to respond</i>	
				<i>% of all applications coming through PE</i>	
				<i>% of eligibility determinations following PE period vs. determinations on all applications</i>	
Administrative data				<i># of PE individuals making fast-track payments</i>	
Enrollment data				<i># entities participating in PE (by type, # of PE applications filed, # full apps filed, # determined eligible, by entity)</i>	
				<i>% of potentially qualifying entities trained and participating in HIP 2.0 PE assessment (not counting entities that have refused or not responded to opportunities to participate)</i>	
				<i>Re-enrollment rates</i>	
				<i>Length of PE period before making PAC, by FPL</i>	
				<i># of PE-eligible individuals enrolling in HIP Plus vs. HIP Basic, by income</i>	
Survey data - PE providers				<i>Perceptions of the effectiveness of the PE process</i>	
Claims/Enrollment data				<i>Service utilization during PE period (primary care vs. specialty care vs. emergency care), by income</i>	
Survey data - Providers				<i>Cost of uncompensated care for individuals who would have been eligible for retroactive coverage</i>	
	<i>Level of uncompensated care</i>				
	<i>Copayment policies and collection rates</i>				

#	Hypothesis	Research Questions	Analytic Approach	Data Source	Metric
1.5	Waiver of non-emergency transportation to the non-pregnant and non-medically frail population does not pose a barrier to accessing care (STCs, Section XIII, Paragraph 3ix).	<ol style="list-style-type: none"> 1. <i>What is the effect of the NEMT waiver of coverage on missed appointments by income level for individuals who are neither pregnant nor medically frail? Are there parts of the state that are more affected by no access to NEMT?</i> 2. <i>How does not having access to NEMT affect preventive care and overall health outcomes?</i> 3. <i>What is the impact of no access to NEMT as viewed by the providers and beneficiaries?</i> 	<p>Track member perception over the course of the demonstration.</p> <p>Use univariate and bivariate analysis to describe and compare the number of missed appointments with current Indiana utilization trends.</p> <p>Comparison Group: Compare populations in HIP receiving State Plan Benefits to HIP recipient receiving HIP Plus/HIP Basic benefits that do not include NEMT..</p> <p>Compare survey results between HIP 1.0 and HIP 2.0.</p>	Provider and Member survey data, using questions from HIP 1.0 survey	Perceptions about impact of access to NEMT
				Member survey data	% of respondents reporting challenges in keeping appointments due to lack of transportation, by income level and by county
					Estimated # of missed appointments, by income level and with NEMT vs. without NEMT

Goal 2: Promote Value-based Decision Making and Personal Health Responsibility

One of HIP's principle aims is to foster members' sense of personal responsibility by encouraging positive health behaviors and financial responsibility.

1. HIP policies will encourage member compliance with required contributions and provide incentives to actively manage POWER account funds (HIP 2.0 Waiver, Section 5).
 - HIP policies surrounding rollover and preventive care will encourage beneficiaries' compliance with required contributions and provide incentives to actively manage POWER account funds (STCs, Section XIII, Paragraph 3viii).
2. HIP Plus members will exhibit more cost-conscious healthcare consumption behavior than: a) HIP Basic members; and b) traditional Hoosier Healthwise members in the areas of primary, specialty, and pharmacy service utilization without harming beneficiary health (HIP 2.0 Waiver, Section 5 and STCs, Section XIII, Paragraph 3iv).
3. HIP's (i) graduated copayments required for non-emergency use of the emergency department (ED), (ii) ED prior authorization process, and (iii) efforts to expand access to other urgent care settings will together effectively deter inappropriate ED utilization without harming beneficiary health (HIP 2.0 Waiver, Section 5).
 - The graduated copayment structure for non-emergency use of the emergency department will decrease inappropriate ED utilization without harming beneficiary health (STCs, Section XIII, Paragraph 3x).
 - The prior authorization process for hospital emergency department use and efforts to expand access to other urgent care settings will decrease inappropriate ED utilization without harming beneficiary health (STCs, Section XIII, Paragraph 3xi).

2.1. HIP Policies will Encourage Member Compliance with Required Contributions and Provide Incentives to Actively Manage POWER Account Funds

HIP Plus members are able to take advantage of several incentives if they continue to make their required POWER account contributions and manage their POWER account funds well. They have access to an enhanced benefits package that includes vision and dental coverage; and HIP Plus members are able to not only roll over remaining POWER account contributions to reduce future contributions, but they are also able to increase that rollover by accessing preventive care.

To assess the impact of HIP Plus incentives and the disincentives, the evaluation will analyze:

- What are the differences in utilization behaviors for individuals that make PAC contributions and those that do not (difference between HIP Plus/HIP Basic) or those that receiving rollover vs. those who do not? How are these variables impacted by member income level?
- Are there differences in utilization and POWER account management among members related to health status, (e.g., diabetes, or other chronic diseases)?
- Are there differences in utilization and POWER account management between individuals paying a PAC and those who do not?

The evaluation will build on the data collected around compliance with PAC payment rates in Goal 1. In addition to this Goal, the analysis will compare the HIP Plus population with the HIP Basic population. The evaluation will look at the population by income level and track the timeliness of POWER account contributions over the course of the demonstration for the total HIP Plus member group, those with income over 100 percent FPL, and those with income under 100 percent FPL.

The evaluation will also compare HIP POWER account balances across different member groups, including 1) HIP Plus members, 2) HIP Basic members, 3) HIP members transitioning from traditional Medicaid to HIP (e.g. Section 1931 low-income parents and caretakers), and 4) Medically Frail. Among HIP Basic members transitioning to HIP Plus, the evaluation will also track the average amount by which required contributions are discounted for the transition to HIP Plus at redetermination.

Among HIP Plus members, the evaluation will also use POWER account administrative data to review the pro-rata share of balance POWER account rollover rates and the average amount by which contributions are reduced in the next benefit period for base rollovers (100% of member pro-rata share of balance) and preventive care rollovers (200% of member pro-rata share of balance).

In addition to current HIP member comparisons, the evaluation will also use external populations for comparison, including POWER account management differences between HIP 1.0 and HIP 2.0 members.

2.2. HIP Plus Members will Exhibit More Cost-conscious Health Care Consumption Behavior than: a) HIP Basic Members; and b) Traditional Hoosier Healthwise Members in the Areas of Primary, Specialty, and Pharmacy Service Utilization Without Harming Beneficiary Health

At the core of effective POWER account management lays cost-conscious health care consumption behaviors. Given the additional incentives for HIP Plus members to exhibit these behaviors, the evaluation will compare the health care utilization of HIP Plus members to other populations by analyzing the following questions:

- Are HIP Plus members more likely to exhibit cost-conscious consumption behavior? In what area(s)?
- Are HIP Plus members less likely to reach the 5 percent threshold?

To address these research questions, the evaluation will examine claims/encounter data, tracking health service utilization rates for HIP Plus, HIP Basic, traditional Hoosier Healthwise members, the medically frail, and previous utilization data for those who have transitioned from traditional Medicaid to HIP coverage. To reduce confounding factors, the evaluation will attempt to control for health status, age, income, and other relevant variables. Claims/enrollment data should include a variety of service types and settings, including primary care, specialty care, and generic vs. brand name medication utilization.

To further refine the study of utilization trends within the HIP 2.0 member population, the evaluation will compare utilization patterns with other populations that do not share the same incentive policies offered by HIP 2.0. Example comparison groups include HIP 1.0 members, traditional Medicaid members transitioning to HIP 2.0, and new adult groups in other states.

In addition to comparing service utilization between HIP Plus and HIP Basic members, the evaluation will also compare the average out-of-pocket cost for HIP Plus members compared to HIP Basic members. To make this comparison, the evaluation will utilize administrative data, collecting the POWER account contribution information and projecting copayment costs for HIP Basic members.

2.3. HIP's (i) Graduated Copayments Required for Non-emergency Use of the Emergency Department (ED), (ii) ED Prior Authorization Process, and (iii) Efforts to Expand Access to Other Urgent Care Settings will Together Effectively Deter Inappropriate ED Utilization Without Harming Beneficiary Health

To discourage non-emergency use of the emergency department (ED), the State has proposed a graduated copayment, costing \$8 for the first non-emergency visit and \$25 for subsequent non-emergency visits. To triage potential urgent care needs, HIP 2.0 has decided to utilize a Nurse Hotline to serve as a prior authorization process and is working to expand access to alternative urgent care settings as an alternative to the ED. To assess the effectiveness of this policy and ensure that beneficiary health is not harmed, the State will create a control group, as specified by the STCs, that will only have the \$8 copay obligation, regardless of the number of non-emergency ED visits. The State will compare ED, primary care, and urgent care utilization across members, tracking based on participation in the control group or graduated copay group. In addition, the evaluation will consider the following research questions:

- What is the rate of non-emergency use of the ED among individuals in the control group vs. the graduated copay group?
- What portion of individuals calling the Nurse Hotline are recommended to go to the ED and what portion of individuals use the ED in spite of the Nurse Hotline advising a different course of action?
- What portion of individuals are accessing urgent care settings outside of the ED?

To assess how the graduated copayment policy impacts health behaviors, the evaluation will compare annual rates of non-emergency ED utilization between HIP 1.0, HIP 2.0 (HIP Plus vs. HIP Basic), and populations receiving state plan benefits (e.g. medically frail, transitional medical assistance, etc.), stratifying the population by income. Other state Medicaid populations and their non-emergency ED utilization trends will also serve as an additional point of comparison. Claims/enrollment data will also be used to compare annual rates of alternative urgent care setting utilization (e.g. retail clinics) before and after the graduated copayment policy effective date; and administrative data will provide information about the individuals seeking prior authorization via the Nurse Hotline, including the number of individuals calling the hotline, the number of individuals approved for ED care, and the number denied. Administrative data will be combined with claims/enrollment data to assess how many individuals calling the Nurse Hotline went to the ED—with or without prior authorization.

In addition to claims/enrollment data, member surveys will gather data on whether the copayment for non-emergency use of the ED caused members to seek services with their primary care physician or in an alternative urgent care setting. Provider surveys will offer information on ED copayment collection rates and policies

Goal 2 evaluation summary table

#	Hypothesis	Research Questions	Analytic Approach	Data Source	Metric
Goal 2: Promote value-based decision making and personal health responsibility.					
2.1	<p>HIP policies will encourage member compliance with required contributions and provide incentives to actively manage POWER account funds (HIP 2.0 waiver, Section 5).</p> <p>HIP policies surrounding rollover and preventive care will encourage beneficiaries' compliance with required contributions and provide incentives to actively manage POWER account funds (STCs, Section XIII, Paragraph 3viii).</p>	<p>1. What are the differences in utilization behaviors for individuals that make PAC contributions and those that do not (difference between HIP Plus/HIP Basic) or those that receiving rollover vs. those who do not? How are these variables impacted by member income level?</p> <p>2. Are there differences in utilization and POWER account management among members related to health status, (e.g., diabetes, or other chronic diseases)?</p> <p>1. Are there differences in utilization and POWER account management between</p>	<p>Track initial HIP Plus vs. HIP Basic enrollment by FPL.</p>	Member survey data	Reported health status, by eligibility for POWER account rollover
			<p>Track and compare average remaining POWER account balances at the end of a benefit period between:</p> <p>a) HIP Plus members;</p> <p>b) HIP Basic members who enroll in HIP Plus at the end of their benefit period; and</p> <p>c) HIP Basic members who do not enroll in HIP Plus at the end of their benefit period.</p>	Provider survey data	% of HIP patients for which providers report regularly collecting copayments
					Copayment collection rates
				Copayment collection policies	
				MCE incentive data	# and amount of individuals receiving incentives for healthy behaviors, by MCE and by income and by HIP Plus vs. HIP Basic plan
			Enrollment data	<p>Track HIP Plus member pro-rata share of balance</p> <p>POWER account rollover rates and the average amount by which contributions are reduced in the next benefit period for:</p> <ul style="list-style-type: none"> • Base rollovers (100% of member pro-rata share of balance); and • Preventive care rollovers (200% of member pro-rata share of balance). 	Total enrollment by HIP Plus vs. HIP Basic plan
					# enrolled in HIP Basic who enroll in HIP Plus later
					# and % transitioned from HIP Plus to HIP Basic due to non-contribution
					Total enrollment in HIP Plus, by income (above and below 100% FPL)
			Administrative data	<p>Track the average amount by which required contributions are discounted for HIP Basic members transitioning to HIP Plus at redetermination.</p>	% of POWER accounts that have a balance at the end of a benefit period
	Average POWER account balance amount at the end of the benefit period.				
	Percentage of HIP Plus members that have a POWER account balance at the end of the benefit period				
	POWER account rollover rates for HIP Plus members (100% and 200%)				
	Average amount by which HIP Plus member contributions are reduced in the next benefit period				
	Average discount for required contributions in the next benefit period				
	<p>Track the copayment collection rate for HIP Basic members.</p>				
	<p>Use univariate and bivariate analysis to describe and compare a) the number of members who make POWER account contributions, and b) the number of members who receive rollover rates.</p>				

#	Hypothesis	Research Questions	Analytic Approach	Data Source	Metric
Goal 2: Promote value-based decision making and personal health responsibility.					
		individuals paying a PAC and those who do not?	<p>Use multivariate analysis to describe and compare a) the number of members who make POWER account contributions, and b) the number of members who receive rollover rates, controlling for confounding factors.</p> <p>Use multivariate analysis to describe differences in utilization and POWER account management among members with ambulatory-sensitive conditions, controlling for confounding factors.</p> <p>Comparison Groups: Service utilization and POWER account rollover data from previous demonstration period (HIP 1.0).</p> <p>Compare HIP Plus with HIP Basic and Medically Frail participation, stratifying by income level</p>		<p><i>for HIP Basic members transitioning to HIP Plus.</i></p> <p><i># and amount of rollover for HIP Plus, HIP Basic</i></p> <p><i># and % of members making initial POWER account contribution, total and within allowed time</i></p> <p><i># and % locked out due to non-contribution of PAC</i></p> <p><i>% of individuals with rollover receiving enhanced rollover for preventive services</i></p> <p>Rate of primary care use, by income and by HIP Plus vs. HIP Basic plan</p> <p>Prior authorization requests</p> <p>Rate of specialty care use, by income and by HIP Plus vs. HIP Basic plan</p> <p>Rate of generic medicine use vs. brand name, by income and by HIP Plus vs. HIP Basic plan</p> <p>Rate of ED use, by income and by HIP Plus vs. HIP Basic plan and by number of visits</p>
2.2	HIP Plus members will exhibit more cost-conscious healthcare consumption behavior than: a) HIP Basic members; and b) traditional Hoosier Healthwise members in the areas of primary, specialty,	<ol style="list-style-type: none"> Are HIP Plus members more likely to exhibit cost-conscious consumption behavior? In what area(s)? Are HIP Plus members less likely 	<p>Track health service utilization rates for following groups, controlling for health status, age, and other relevant variables:</p> <ul style="list-style-type: none"> HIP Plus members; HIP Basic members; Section 1931 Group; Medically Frail <p>Track service utilization by income and benefit plan (HIP Plus vs. HIP Basic) for generic vs. brand name</p>	Member out-of-pocket tracking data	<i># of individuals reaching the 5% threshold on a monthly or quarterly basis, by income and by HIP Plus vs. HIP Basic plan</i>
				Administrative data	Cost of care, by disease state and by HIP Plus vs. HIP Basic plan and within transitioning Medicaid population (before and after transition to HIP)
				Encounter data	Projected copayment costs for HIP Basic members <i>ED use</i>

#	Hypothesis	Research Questions	Analytic Approach	Data Source	Metric
Goal 2: Promote value-based decision making and personal health responsibility.					
	and pharmacy service utilization without harming beneficiary health.	to reach the 5% threshold?	<p>medications, primary care vs. specialty care utilization</p> <p>Use univariate and bivariate analysis to describe and compare the utilization patterns of HIP Plus members versus HIP Basic and traditional Hoosier Healthwise members.</p> <p>Use univariate and bivariate analysis to compare the number of HIP Plus members who reach the 5% income threshold versus HIP Basic and traditional Hoosier Healthwise members.</p> <p>Use multivariate analysis to compare the utilization patterns of HIP Plus members versus HIP Basic and traditional Hoosier Healthwise members, controlling for confounding factors.</p> <p>Comparison Groups: Service utilization from previous demonstration period (HIP 1.0).</p> <p>Compare cost of care for populations making PAC to those who are not.</p> <p>Compare the cost of care for populations transitioning from traditional Medicaid to HIP, looking at costs before and after transition.</p>		<p><i>Primary care encounters vs. specialty care</i></p> <p><i>Preventive service codes</i></p> <p><i>Pharmacy (overall costs, brand vs. generic dispensing rate)</i></p> <p>% of individuals using the ED for non-emergency services, by HIP Plus vs. HIP Basic plan</p> <p>% of individuals using specialty care for chronic disease care, by HIP Plus vs. HIP Basic plan vs. medically frail</p> <p>% of individuals accessing chronic disease management services (if chronic disease present), by HIP Plus vs. HIP Basic plan</p> <p># of unique individuals accessing preventive services, by income</p> <p># of preventive care visits, total and average per person, by income</p> <p># of specialty care visits, total and average per person, by income</p> <p># of unique individuals accessing specialty care</p> <p># of visits to urgent care center, by income</p> <p>% of individuals taking brand name medications when generic medication is available, by HIP Plus vs. HIP Basic plan vs. medically frail</p>
2.3	HIP's (i) graduated copayments required for non-emergency use of the emergency department (ED), (ii)	1. What is the rate of non-emergency use of the ED among individuals in the control group vs.	Survey HIP members on whether the copayment for non-emergency use of the ED caused them to seek services with their primary care physician or in an alternative urgent care setting	Claims/encounter data	<p><i># individuals using the ED, by income level</i></p> <p><i># visits classified as emergency, by income level and HIP Plus vs. HIP Basic plan</i></p>

#	Hypothesis	Research Questions	Analytic Approach	Data Source	Metric
Goal 2: Promote value-based decision making and personal health responsibility.					
	<p>ED prior authorization process, and (iii) efforts to expand access to other urgent care settings will together effectively deter inappropriate ED utilization without harming beneficiary health (HIP 2.0 Waiver, Section 5).</p> <ul style="list-style-type: none"> The graduated copayment structure for non-emergency use of the emergency department will decrease inappropriate ED utilization without harming beneficiary health (STCs, Section XIII, Paragraph 3x). The prior authorization process for hospital emergency department use and efforts to expand access to other urgent care settings will decrease inappropriate ED utilization 	<p>the graduated copay group?</p> <p>2. What portion of individuals calling the Nurse Hotline are recommended to go to the ED and what portion of individuals use the ED in spite of the Nurse Hotline advising a different course of action?</p> <p>3. What portion of individuals are accessing urgent care settings outside of the ED?</p>	<p>Track annual rates of members seeking prior authorization through the nurses' hotline prior to seeking ED services.</p> <p>Track annual rates of members paying increased copayments based on repeated inappropriate ED utilization.</p> <p>Use univariate and bivariate analysis to describe and compare inappropriate ED utilization among members with graduated ED copayment rates versus members within the control group.</p> <p>Use univariate and bivariate analysis to describe and compare the a) number of individuals calling the Nurse Hotline who are recommended to go to the ED, and b) what portion of individuals use the ED in spite of the Nurse Hotline advising a different course of action.</p> <p>Use univariate and bivariate analysis to describe and compare the number of individuals who utilize urgent care settings outside of the ED?</p> <p>Comparison groups: Non-emergency ED utilization rates compared between HIP 1.0, HIP Plus, HIP Basic, Hoosier Healthwise (e.g. Section 1931 group), by income.</p> <p>Compare annual rates of inappropriate ED utilization between HIP populations for the years before (2008-2014) and after (2015 and beyond) for non-caretakers and caretakers.</p>	<p><i>Survey data – Member</i></p> <p><i>MCE-reported data</i></p>	<p><i># visits classified as non-emergency, by income level and HIP Plus vs. HIP Basic plan</i></p> <p><i># individuals in differing copay structures for non-emergency use of ED</i></p> <p><i># individuals calling nurse hotline and subsequently visiting ED</i></p> <p><i>Annual overall ED utilization rates (percent of members and visits/100,000 members)</i></p> <p><i>Annual non-emergency ED utilization rates (percent of members and visits/100,000 members)</i></p> <p><i>Annual rates of alternative urgent care setting utilization (percent of members and visits/100,000 members).</i></p> <p><i>Alternative urgent care locations utilized</i></p> <p><i>% of members who report the required copayment for non-emergency use of the ED caused them to seek services with their primary care physician or in an alternative urgent care setting in lieu of the ED</i></p> <p><i>Number of members that utilized ED services</i></p> <p><i>Number of members utilizing nurse's hotline for ED prior authorization</i></p> <p><i>Number of members receiving affirmative prior authorization for ED services</i></p> <p><i>Number of members that utilized inappropriate ED services:</i></p> <ul style="list-style-type: none"> <i>Only once</i>

#	Hypothesis	Research Questions	Analytic Approach	Data Source	Metric
Goal 2: Promote value-based decision making and personal health responsibility.					
	without harming beneficiary health (STCs, Section XIII, Paragraph 3xi).		Compare annual rates of alternative urgent care setting utilization (e.g. retail clinics) between HIP populations for the years before (2008-2014) and after (2015 and beyond) the HIP 2.0. Comparable populations where member contributions are not required from other states.		<ul style="list-style-type: none"> • <i>Two times</i> • <i>Three times</i> • <i>More than three times</i>
				Historical data	Rate of individuals accessing the ED for non-emergency services, by benefit plan (e.g. HIP 1.0, HHW, etc.)
				Member out-of-pocket tracking data	# individuals charged the \$8 non-emergency use of ED copay
					# individuals charged \$25 non-emergency use of ED copay

Goal 3: Promote Disease Prevention and Health Promotion to Achieve Better Health Outcomes

Disease prevention and health promotion is central to the CMS Three-Part Aim of better care, better health, and reduced costs. To identify the program’s success in achieving this aim, the State will track and compare health service utilization rates among HIP members. Specific metrics which the State will monitor include POWER account rollover and contribution discounts, preventive care utilization, and participation with chronic disease management programs offered by the health plans.

The State will be guided the following research questions in evaluating its achievement of this goal:

- How does primary care and chronic disease management utilization among HIP members compare to preventive care and chronic disease management in commercial health insurance and other Medicaid populations?
- How does primary care and chronic disease management vary by population age, gender, benefit plan, FPL, etc.?

In comparing preventive care utilization and chronic disease management between HIP members and other health insurance populations, the evaluation will track and compare health service utilization rates between HIP and traditional Medicaid members. The evaluation will also track and compare POWER account rollover and contribution discount rates for HIP Plus members, and for HIP Basic members who enroll in HIP Plus at the end of the benefit period.

In assessing the impact of disease prevention and health promotion within HIP, the State will track preventive care utilization rates and trends among different age and gender groups, in addition to tracking member participation in the health plans’ chronic disease management programs.

The following table includes a series of research questions, analytic approaches with comparison groups to assess, data sources, and metrics the evaluation will use to assess Goal 3. Cells written in italics and shaded orange are requirements from the STCs and/or HIP 2.0 waiver.

Goal 3 evaluation approach summary

#	Hypothesis	Research Questions	Analytic Approach	Data Source	Metric	
Goal 3: Promote disease prevention and health promotion to achieve better health outcomes.						
3.1	<p>HIP will effectively promote member use of preventive, primary, and chronic disease management care to achieve improved health outcomes (HIP 2.0 Waiver, Section 5 and STCs, Section XIII, Paragraph 3iii).</p>	<p>1. How does primary care and chronic disease management utilization among HIP members compare to preventive care and chronic disease management in commercial health insurance and other Medicaid populations?</p> <p>2. How does primary care and chronic disease management vary by population age, gender, benefit plan, FPL, etc.?</p>	Track and compare health service utilization rates between HIP and traditional Medicaid members.	Administrative data	# individuals with PAC requirement reductions/rollover due to preventive care	
			Examine specific disease categories and assess whether management was better by HIP Plus or Basic status.		POWER account preventive care rollover rates (200% of member pro-rata contribution amount) for HIP Plus members	
			Track medically frail status, and assess its impact upon utilization.		Average discount in required contributions for HIP Basic members who enroll in HIP Plus at the end of the benefit period	
			Identify key metrics for specific disease groups and examine utilization across the different comparison groups.	Health plan data	Track preventative care utilization by all, and across the different comparison groups.	Chronic disease management program participation numbers and rates
			Track and compare POWER account rollover and contribution discount rates for:		Selected chronic disease management aggregate program outcomes	
			<ul style="list-style-type: none"> HIP Plus members HIP Basic members who enroll in HIP Plus at the end of the benefit period 	Encounter data	Track preventive care utilization rates and trends among different age and gender groups.	Primary and preventive care utilization by specific disease category
			Track participation in health plans' chronic disease management programs.		Primary and preventive care utilization ambulatory care sensitive conditions	
			Use univariate and bivariate analysis to describe and compare primary care and chronic disease management utilization among HIP members versus members within commercial health insurance and other Medicaid populations.		HEDIS measures by specific disease category	
					HEDIS measures by ambulatory care sensitive conditions.	
					Primary care encounters	
					Specialty encounters	
					ED visits	
	Preventive care codes					
	Chronic disease management codes					

#	Hypothesis	Research Questions	Analytic Approach	Data Source	Metric
Goal 3: Promote disease prevention and health promotion to achieve better health outcomes.					
			<p>Use multivariate analysis to describe how primary care and chronic disease management vary by population age, gender, benefit plan, FPL, and other measures, controlling for confounding factors.</p> <p>Comparison Groups: Enrollment data from previous demonstration period (HIP 1.0), and comparable populations from other states.</p> <p>Indiana residents who are not enrolled in HIP (e.g., uninsured and other insurance)</p>		<p><i>Number, type, and frequency of preventive care services used</i></p> <p><i>Gender- and age-specific rates of pre-determined preventive service utilization.</i></p>

Goal 4: Promote Private Market Coverage and Family Coverage Options to Reduce Network and Provider Fragmentation within Families.

Leveraging the existing private market as a means of reducing network and provider fragmentation within families is an important goal of HIP 2.0. The State seeks to accomplish this goal through the HIP Employer Benefit Link (HIP Link) program.

HIP Link is an optional defined contribution insurance program for all HIP eligible individuals age 21 or older who have access to HIP Link qualifying employer sponsored insurance (ESI). HIP Link provides enrolled individuals with a HIP Link Personal Wellness and Responsibility (POWER) account valued at \$4,000. This Health Savings-like account holds the state's defined contribution for ESI coverage of \$4,000 and will cover the premiums and out of pocket costs associated with enrollment in ESI. In addition, the account serves as supplemental coverage for medical expenses incurred during the employer's annual coverage period. Like HIP Plus, individuals enrolled in HIP Link will be required to contribute 2 percent of their income towards the cost of their employer sponsored insurance. Premiums will be deducted from the employee's paycheck as usual, and the state will send the employee reimbursement for the difference between the premium amount and their 2 percent POWER account contribution on a monthly basis.

The individual who elects to enroll into HIP Link will receive the benefits offered by the HIP Link qualified employer health insurance instead of the HIP Plus, HIP Basic, or HIP State Plan benefits as applicable. HIP Link beneficiaries will access benefits provided through their employer sponsored insurance.

The State will evaluate two specific hypotheses:

1. HIP's defined contribution premium assistance program (HIP Link) will increase the proportion of Indiana residents under 138% FPL covered by employer-sponsored insurance (ESI) (HIP 2.0 Waiver, Section 5 and STCs, Section XIII, Paragraph 3xii); and
2. HIP's ESI premium assistance option for family coverage will increase the number of low income families in which the parents and children have access to the same provider network (HIP 2.0 Waiver, Section 5).

4.1. HIP's Defined Contribution Premium Assistance Program (HIP Link) will Increase the Proportion of Indiana Residents Under 138% FPL Covered by Employer-sponsored Insurance (ESI)

In determining the effect that HIP Link has on increasing the proportion of low-income Indiana residents covered by ESI, the State will consider the following a number of research questions, such as:

- How does the number of HIP-eligible members covered by their ESI before the implementation of HIP Link compare to the number after its implementation?
- How many members enroll in their ESI because of assistance provided by HIP Link (i.e., ESI is now affordable because of HIP Link)?
- Is a \$4,000 POWER account sufficient for HIP Link members?

Answers to these (and related) research questions will be generated through the evaluation of a series of data metrics furnished by the HIP Link program. Specifically, the State will track and compare the number of members who **a)** apply for HIP Link and **b)** qualify for HIP Link.

Of the members who do not qualify for HIP Link, the State will assess the reason (e.g., member not employed, member employed, but employer does not offer qualifying health plan; etc.).

Of the members who do qualify for HIP Link, the State will track a series of data, including (but not limited to):

- The number of members who choose to enroll in HIP Link;
- The average premium contribution reimbursed to HIP Link members;
- The average expenditures (copayments, deductibles, POWER account payments) associated with participating in HIP Link;
- Utilization rates of among HIP Link members (e.g., preventive and specialty), and how they compare to other HIP members (e.g., HIP Plus and HIP Basic members);
- The number of members who leave the HIP Link program and return to HIP; and other related data

The State will also track and compare the number of employers who **a)** apply for HIP Link and **b)** qualify for HIP Link.

Of the employers who do not qualify for HIP Link, the State will assess the reason (e.g., employer health plan does not qualify with Essential Health Benefit requirements, employer health plan determined to be unaffordable for the majority of members, etc.).

Of the employers who do qualify for HIP Link, the State will track a series of data, including (but not limited to):

- Employer industry type;
- Employer size;
- Number of employees on HIP Link;
- The number of employers who leave HIP Link; and other related data

In addition, the State will use surveys to assess both member and employer experiences within the program. In general, survey questions will aim to assess the following:

- Member and employer reasons for choosing to participate in HIP Link;
- Member and employer perceptions on how HIP Link can be improved;
- Member and employer reasons for leaving HIP Link (if applicable).

4.2. HIP's ESI Premium Assistance Option for Family Coverage will Increase the Number of Low Income Families in which the Parents and Children have Access to the Same Provider Network

The State will be guided by two fundamental research questions in assessing this hypothesis:

- How will the availability of HIP Link impact dependent coverage?
- How will the availability of HIP Link impact the number of adults enrolled in HIP?

In answering these questions, the State will track and compare the number of HIP link parents who have dependents on Medicaid. In addition, the State will also track and compare the number of HIP link parents with dependents less than 21-years old, as this represents a confounding factor, due to the fact that these dependents are eligible for HIP.

The following table includes a series of research questions, analytic approaches with comparison groups to assess, data sources, and metrics the evaluation will use to assess these two hypotheses. Cells written in italics and shaded orange are requirements from the STCs and/or HIP 2.0 waiver.

Goal 4 evaluation summary table

#	Hypothesis	Research Questions	Analytic Approach	Data Source	Metric
Goal 4: Promote private market coverage and family coverage options to reduce network and provider fragmentation within families.					
4.1	HIP's defined contribution premium assistance program (HIP Link) will increase the proportion of Indiana residents under 138% FPL covered by employer-sponsored insurance (ESI) (HIP 2.0 Waiver, Section 5 and STCs, Section XIII, Paragraph 3xii).	<ol style="list-style-type: none"> How many members who have access to HIP Link enroll in HIP Link instead of HIP? How many members move from HIP Link to HIP? How many total members and their dependents utilize HIP Link? Of the employers whose employees are enrolled in HIP: <ul style="list-style-type: none"> How many employers are enrolled in HIP Link? How many employees are enrolled in HIP versus their employers' sponsored insurance/HIP Link?? 	<p>Track Indiana residents with income under 138% FPL covered by ESI over the demonstration</p> <p>Track Indiana residents with income under 138% FPL receiving defined contribution premium assistance to purchase ESI each year of the demonstration</p> <p>Use univariate and bivariate analysis to describe and compare a) the number of members who have access to HIP Link who enroll in HIP Link instead of HIP and b) the number of members who move from HIP Link to HIP.</p> <p>Use multivariate analysis to describe how many members participate in HIP Link, controlling for confounding factors.</p> <p>Comparison Group: Enrollment data from previous demonstration period (HIP 1.0), and comparable populations from other states.</p>	Enrollment data	# of members who apply for HIP Link.
					<i>Total # qualifying for/enrolling in HIP Link</i>
					<i>#and % of HIP enrollees who receive premium assistance to purchase ESI—monthly and annually</i>
					<i># moving from HIP Link to HIP Plus, HIP Basic</i>
					# of members who call enrollment broker: <ul style="list-style-type: none"> Number who enroll in HIP Link. Number who enroll in HIP.
					# of members who were on HIP before the roll-out of HIP Link.
					# of members who transition from HIP to HIP Link.
					# of members who were on their employers ESI before applying for HIP Link.
					# of members who were on their employers ESI before qualifying/ enrolling in HIP Link.
					# of members who were uninsured before applying for HIP Link.
					# of members who were uninsured before qualifying for/enrolling in HIP Link.
					# of members who were in a non-qualifying health plan previously (i.e., number of members who changes plans within the 60 day enrollment period created by HIP Link)
					# of members who qualify for rollover (due to completion of preventive services)
					# of employers who apply for HIP Link.
					# of employers who qualify for/enroll in HIP Link.
# of employer health plans submitted for HIP Link approval.					
# of employer health plans which qualify for HIP Link.					
Employer characteristics: <ul style="list-style-type: none"> Industry Size 					

#	Hypothesis	Research Questions	Analytic Approach	Data Source	Metric
Goal 4: Promote private market coverage and family coverage options to reduce network and provider fragmentation within families.					
					# of employees: <ul style="list-style-type: none"> • Total # of employees • # of employees enrolled in HIP Link
					# of members who leave HIP Link and move to HIP due to reaching 5% income limit. <ul style="list-style-type: none"> • # of months member stayed on HIP Link.
					# of members who leave HIP Link due to pregnancy. <ul style="list-style-type: none"> • # of months member stayed on HIP Link.
					# of members who leave HIP Link due to increased salary/income. <ul style="list-style-type: none"> • # of months member stayed on HIP Link.
					# of members who leave HIP Link due to leaving their job. <ul style="list-style-type: none"> • # of months member stayed on HIP Link.
					Number of employers who leave HIP Link. <ul style="list-style-type: none"> • # of months employer stayed on HIP Link.
					# of members who leave HIP Link due to their employer leaving HIP Link.
					# of large employers and small employers registered with HIP Link
				Claims/Encounter Data	Utilization and amounts paid by HIP Link: <ul style="list-style-type: none"> • By provider type • By service type
				Member Survey	Member satisfaction with HIP Link: <ul style="list-style-type: none"> • Why staying in HIP Link? • Why leaving HIP Link?
				Employer Survey	Employer satisfaction with HIP Link: <ul style="list-style-type: none"> • Why staying in HIP Link? • Why leaving HIP Link?
				<i>Current Population Survey & American Community Survey</i>	<i>ESI coverage rate estimates, all ages.</i>
					<i>POWER account balance</i>

#	Hypothesis	Research Questions	Analytic Approach	Data Source	Metric
Goal 4: Promote private market coverage and family coverage options to reduce network and provider fragmentation within families.					
				POWER account data	POWER account expenditures: <ul style="list-style-type: none"> • HIP Link members • HIP Plus members Premium amounts paid to members. Copayment amounts paid to providers: <ul style="list-style-type: none"> • By provider type • By service type Deductible amounts paid to providers: <ul style="list-style-type: none"> • By provider type • By service type Wrap-around service payments: <ul style="list-style-type: none"> • By provider type • By service type Employer contribution (with change from beginning to end of quarter)
4.2	HIP's ESI premium assistance option for family coverage will increase the number of low income families in which the parents and children have access to the same provider network (HIP 2.0 Waiver, Section 5).	<ol style="list-style-type: none"> 1. How will the availability of HIP Link impact the number of children on Medicaid and CHIP? 2. How will the availability of HIP Link impact the number of adults enrolled in HIP? 	Track the number of parents eligible for and utilizing premium assistance for their children to enroll in the family coverage ESI plan in lieu of CHIP. Use univariate and bivariate analysis to describe and compare the number of children covered by HIP Link versus CHIP among whose parents are eligible for HIP Comparison Group: Enrollment data from previous demonstration period (HIP 1.0), and comparable populations from other states.	HIP ESI premium records and Survey data - Member	<i># and % of parents who are eligible for premium assistance for their children</i> # of parents with dependents on Medicaid # of parents of with dependents less than 21-years old <i># and % of parents who accept premium assistance to enroll in ESI family coverage.</i>

Goal 5: Provide HIP Members with Opportunities to Seek Job Training and Stable Employment to Reduce Dependence on Public Assistance

Research has demonstrated that employed individuals are both physically and mentally healthier, as well as more financially stable.^{7,8} To this end, the State will introduce the new Gateway to Work program to promote employment by integrating the State's various work training and job search programs with HIP. Through this employment initiative, all eligible HIP members will be provided with general information on the State's job search and training programs. HIP participants who are unemployed or working less than 20 hours a week will be referred to available employment, work search and job training programs that will assist them in securing gainful employment.

All non-disabled adults on the program who are unemployed or working less than 20 hours a week will be referred, as a condition of HIP 2.0 eligibility, to the State's existing workforce training programs and work search resources. Full-time students will be exempted from the referral for each year they are enrolled in a postsecondary education institution or technical school. The HIP application will screen for education and employment status and contain an acknowledgement of the referral.

All identified eligible individuals will receive information on available employment resources, including IndianaCareerConnect.com available through the Indiana Department Workforce Development (DWD). IndianaCareerConnect.com is the most comprehensive source of Indiana job openings in the state. It provides individuals access to current job openings, the ability to create and upload a resume, explore a career, and research the job market.

As research indicates that employed persons have better health outcomes as unemployed persons,⁹ HIP 2.0 seeks to leverage available State resources by referring eligible Indiana residents for workforce development.

To identify the program's success in achieving this aim, the State will track and compare the number of HIP applicants referred for job search and job training assistance. In particular, the State will track the number of HIP members who accept/participate in work search/job training programs, and compare rates of full and part-time employment among the enrolled population at application at specific intervals (e.g., after six months, one year, and two years into the program). The State will also track the number of HIP individuals who transition off of HIP due to increased income.

The State will be guided the following research questions in evaluating its achievement of this goal:

⁷ F. M. McKee-Ryan, Z. Song., C. R. Wanberg, and A. J. Kinicki. (2005). Psychological and physical well-being during unemployment: a meta-analytic study. *Journal of Applied Psychology*, 90 (1), 53-76.

⁸ K. I. Paul, E. Geithner, and K. Moser. (2009). Latent deprivation among people who are employed, unemployed, or out of the labor force. *Journal of Psychology*, 143 (5), 477-491.

⁹ Robert Wood Johnson Foundation. How Does Employment, or Unemployment, Affect Health? Available at <http://www.rwjf.org/en/library/research/2012/12/how-does-employment--or-unemployment--affect-health-.html>. Accessed 05/25/15.

1. What percent of members referred to DWD become employed (part time vs. full time)?
2. How will referrals to the DWD impact member income and eligibility for HIP?
 - a. How many stay in HIP and how many referred individuals leave HIP?
3. How will referrals to the DWD impact the number of Indiana residents enrolled in HIP Link?

In assessing the impact of providing HIP members with opportunities to seek job training with the Department of Workforce Development, the State will compare HIP eligibility and enrollment data (e.g. income level and employment status changes) to eligibility and enrollment data from previous the demonstration period (HIP 1.0), as well as other traditional Medicaid populations.

The following table includes a series of research questions, analytic approaches with comparison groups to assess, data sources, and metrics the evaluation will use to assess Goal 5. Cells written in italics and shaded orange are requirements from the STCs and/or HIP 2.0 waiver.

Goal 5 evaluation summary table

#	Hypothesis	Research Questions	Analytic Approach	Data Source	Metric
Goal 5: Provide HIP members with opportunities to seek job training and stable employment to reduce dependence on public assistance.					
5.1	Referrals to Department of Workforce Development (DWD) employment resources at the time of application will increase member employment rates over the course of the demonstration (HIP 2.0 Waiver, Section 5).	<ol style="list-style-type: none"> 1. What percent of members referred to DWD become employed (part time vs. full time)? 2. How will referrals to the DWD impact member income and eligibility for HIP? How many stay in HIP and how many referred individuals leave HIP? 3. How will referrals to the DWD impact the number of Indiana residents enrolled in HIP Link? 	Track the number of HIP applicants referred for work search and job training assistance.	Enrollment data	<i># of HIP applicants annually and monthly</i>
			Track the number of HIP members who accept/participate in work search/job training programs.		<i># of members who lose HIP eligibility due to income increase—monthly and annual.</i>
			Track the number of HIP individuals transitioning off the program due to increased income.	Member survey data	<i>% of members who report engagement in work search/job training activities after the time of HIP application—one month, six months, and one year</i>
			Use univariate and bivariate analysis to describe and compare a) the number of members referred to DWD, b) the number of members who are referred to DWD who earn employment, and c) the number of members referred to DWD who enroll in HIP Link.		<i>% of enrollees with full or part-time employment at program entry, six months, one year, and two years into the program</i>
			Use multivariate analysis to describe the number of members who are referred to DWD who earn employment, controlling for confounding factors.		
			<p><u>Comparison Group:</u></p> <p>Enrollment data from previous demonstration period (HIP 1.0).</p> <p>Compare rates of full- and part-time employment among the entire HIP-enrolled population and across the HIP-enrolled population referred to DWD at application and after six months, one year, and two years into the program.</p>		

Goal 6: Assure State Fiscal Responsibility and Efficient Management of the Program

Ensuring budget neutrality for both the State and the Federal government represents a top priority of the HIP program. In order to evaluate the fiscal responsibility and efficient management of HIP, the State will conduct a comprehensive budget neutrality analysis based on HIP financial data, in addition to documenting and describing adherence to the waiver margin.

Examples of the metrics which the State will use in its analysis include (but are not limited to):

- All expenditures related to the demonstration, including services rendered or capitation payments made;
- Expenditures for specific waiver populations, including (1) 1931 parents and low income 19-20 year old dependent expenditures, (2) New adult group, and (3) HIP Link;
- Administrative costs;
- Pharmacy rebates assigned to the demonstration, ensuring these rebates are not applicable to the HIP Link program;
- Estimate of matchable demonstration expenditures, separating expenditures (by quarter) for Medical Assistance Payments (MAP) and State and Local Administration Costs (ADM);
- Total annual expenditures for the demonstration population throughout the demonstration year
- Calculation of the waiver margin (annual and cumulative);
- Documentation of all state and federal costs; etc.

The State will use the following research questions as a guide in its evaluation of the achievement of this goal:

1. How do current HIP expenditures compare to previous HIP and Medicaid expenditures?
2. How do HIP expenditures compare to comparable expenditures among other States?

In assessing the assurance of State fiscal responsibility and efficient program management within HIP, the State will compare HIP outcomes to fiscal data from previous demonstration period (HIP 1.0), as well as comparable fiscal data from other states.

The following table includes a series of research questions, analytic approaches with comparison groups to assess, data sources, and metrics the evaluation will use to assess Goal 6. Cells written in italics and shaded orange are requirements from the STCs and/or HIP 2.0 waiver.

Goal 6 evaluation summary table

#	Hypothesis	Research Questions	Analytic Approach	Data Source	Metric
Goal 6: Assure State fiscal responsibility and efficient management of the program.					
6.1	HIP will remain budget-neutral for both the federal and state governments (HIP 2.0 Waiver, Section 5).	<p>1. How do current HIP expenditures compare to previous HIP and Medicaid expenditures?</p> <p>2. How do HIP expenditures compare to comparable expenditures among other States?</p>	<p>Conduct a budget neutrality analysis and document adherence to waiver margin, adjusting for the higher provider rates compared to Hoosier Healthwise/Medicaid. Analysis will also need to account for a recent rate increase for Medicaid beneficiaries, as this can be a confounding factor.</p> <p>Comparison Group: Fiscal data from previous demonstration period (HIP 1.0), and traditional Medicaid population transitioning to HIP 2.0 (e.g. Section 1931 group).</p> <p>Cost effectiveness between HIP Plus, HIP Basic, and HIP Link members.</p>	Internal financial data	<i>Expenditures by waiver populations, including (1) 1931 parents and low income 19-20 year old dependent expenditures, (2) New adult group, (3) HIP Link, (STCs, Section XI, Paragraph 2d) and (4) pregnant women</i>
					<i>Administrative costs (STCs, Section X, Paragraph 5b)</i>
					<i>Pharmacy rebates assigned to the demonstration, ensuring these rebates are not applicable to the HIP Link program (STCs, Section XI, Paragraph 2e)</i>
					<i>Estimate of matchable demonstration expenditures, separating expenditures (by quarter) for Medical Assistance Payments (MAP) and State and Local Administration Costs (ADM) (STCs, Section XI, Paragraph 3)</i>
					<i>Cost settlements (STCs, Section XI, Paragraph 2c)</i>
					<i>Total annual expenditures for the demonstration population throughout the demonstration year (STCs, Section X, Paragraph 5b)</i>
				Budget neutrality estimates and reports	<i>Calculation of the waiver margin (annual and cumulative) (HIP 2.0 Waiver, Section 5)</i>
					<i>Documentation of all state and federal costs(HIP 2.0 Waiver, Section 5)</i>
					<i>Demonstration of budget neutrality (HIP 2.0 Waiver, Section 5 and STCs, Section XI, Paragraph 2g and Section XII)</i>
				Internal financial data (for Retroactive coverage for Section 1931 group transition to HIP 2.0)	<i># individuals with costs paid under the retroactive coverage for Section 1931 group transition to HIP 2.0 (STCs Section IV, Paragraph 4e)</i>
					<i>Total costs paid (STCs Section IV, Paragraph 4e)</i>
					<i>Average cost per person (STCs Section IV, Paragraph 4e)</i>
					<i># and type of providers paid (STCs Section IV, Paragraph 4e)</i>
					<i>Amounts not reimbursed under retroactive coverage for Sec. 1931 group transition to HIP 2.0 (STCs Section IV, Paragraph 4e)</i>
Claims/encounter data (for Retroactive coverage for Section	<i>Type of costs incurred, including specific conditions with which they are associated (STCs Section IV, Paragraph 4e)</i>				

#	Hypothesis	Research Questions	Analytic Approach	Data Source	Metric
Goal 6: Assure State fiscal responsibility and efficient management of the program.					
				1931 group transition to HIP2.0)	
				POWER account data	<i>MCE contributions (STCs, Section XI, Paragraph 2b)</i>
					<i>State contributions to participant POWER accounts (STCs, Section XI, Paragraph 2b)</i>
					<i>Recouped State contributions to participant POWER accounts (STCs, Section XI, Paragraph 2b)</i>

The following tables include a series of research questions, analytic approaches, comparison groups, data sources, and metrics which the evaluation will use to assess the hypotheses therein. Cells written in italics and highlighted pink are requirements from the STCs and/or HIP 2.0 waiver.

Appendix A – Summary Table of Research Questions, Analytic Methods, and Data Metrics

#	Hypothesis	Research Questions	Analytic Approach	Data Source	Metric	Quarterly Report	Annual Report	Interim & Final Report	Policy-Specific Report
Goal 1: Reduce the number of uninsured low income Indiana residents and increase access to health care services.									
1.1	HIP will reduce the number of uninsured Indiana residents with income under 138% FPL over the course of the demonstration (HIP 2.0 Waiver, Section 5 and STCs, Section XIII, Paragraph 3i).	<p>4. How many Indiana residents with income under 138% FPL have insurance relative to the total Indiana resident population and how many have Medicaid/HIP coverage in this population group?</p> <p>5. Are there socio-demographic differences in the health insurance coverage/HIP coverage among Indiana residents with income under 138% (e.g., differences by age, education, income, etc.)?</p> <p>6. How many insured Indiana residents with income under 138% were previously uninsured before the implementation of HIP (i.e., newly enrolled)?</p>	<p>Track rates of uninsured Indiana residents by income:</p> <ul style="list-style-type: none"> ○ Under 138% FPL; ○ 100-138% FPL; and ○ Under 100% FPL. 	Enrollment and US Census data	<i>Total # enrolled by income level and HIP Plus vs. HIP Basic plan</i>	X	X	X	
			<ul style="list-style-type: none"> ○ Under 138% FPL; ○ 100-138% FPL; and ○ Under 100% FPL. <p>Track the number of Indiana residents served by the HIP program over the course of the demonstration.</p>		<i>Unique # of Indiana residents enrolled</i>	X	X	X	X
			Track rates of uninsured Indiana residents by county and/or region.		<i>Total # of enrollments for the demonstration year</i>		X	X	
			Use univariate and bivariate analysis to describe and compare the number of insured versus uninsured Hoosiers.		Length of time individuals enrolled in HIP 2.0	X	X	X	
			Use multivariate analysis to describe and compare insured versus uninsured Hoosiers, controlling for confounding factors.		Reason for leaving HIP 2.0	X	X	X	
			Comparison Group: Enrollment data from previous demonstration period (HIP 1.0), and		Total # enrolled who have had HIP coverage before	X	X	X	
					Total # enrolled by race and HIP Plus vs. HIP Basic plan	X	X	X	
					Total # enrolled by sex/gender and HIP Plus vs. HIP Basic plan	X	X	X	
					Total # enrolled by age and HIP Plus vs. HIP Basic plan	X	X	X	
					Total # enrolled by county and HIP Plus vs. HIP Basic plan	X	X	X	
					Estimated # eligible for HIP by county	X	X	X	
					Total # enrolled by income and HIP Plus vs. HIP Basic plan	X	X	X	

#	Hypothesis	Research Questions	Analytic Approach	Data Source	Metric	Quarterly Report	Annual Report	Interim & Final Report	Policy-Specific Report
			comparable populations from other states.		Total # enrolled by county of residence and HIP Plus vs. HIP Basic plan	X	X	X	
				Current Population Survey, American Community Survey	Health insurance coverage estimates, by age, by county, and by income	X	X	X	
					Total health insurance coverage estimates (all ages, counties, and income levels)	X	X	X	
				Survey data – Member	How individuals access coverage after leaving HIP	X	X	X	
1.2	HIP will increase access to health care services among the target population (HIP 2.0 Waiver, Section 5 and STCs, Section XIII, Paragraph 3ii).	<p>3. How do member perceptions of access to health care change before and after fully enrolling in HIP?</p> <p>4. How does perceived access to care differ between HIP members and individuals who are eligible but have not applied and/or enrolled in HIP?</p>	Track member feedback for perceived access to different types of health care services before and after enrollment in the HIP program.	Survey data - Members and Providers for Section 1931 group	Unreimbursed costs for Section 1931 group				X
			Measure geo-access standards for primary and specialty care for all health plans.	Survey data – Members and non-members	% of members who report having a usual source of care		X	X	
			Measure member health plan satisfaction indicators.		Measure of ability to obtain primary care visit		X	X	
			Use univariate and bivariate analysis to describe a) member feedback for perceived access to		Measure of ability to obtain specialty care visit		X	X	
					Utilization of primary care vs. specialty care vs. emergency department services				
					Measure of ability to obtain a prescription		X	X	

#	Hypothesis	Research Questions	Analytic Approach	Data Source	Metric	Quarterly Report	Annual Report	Interim & Final Report	Policy-Specific Report
			different types of health care services, b) geo-access standards for primary and specialty care, and c) member health plan satisfaction indicators. Comparison Group: Survey responses for HIP members and non-members	HIP health plan network and geo-access data	Proximity of primary care providers for all members		X	X	
					Proximity of specialist types for all members		X	X	
				CAHPS survey	Rating of plan overall		X	X	
					Ability to get needed care quickly		X	X	
					Provider communication		X	X	
					Coordination of care		X	X	
					Other relevant CAHPS indicators		X	X	
				Historical data and current encounter data (for PCP, OB/GYN, most commonly used adult specialty providers)	Change in # of providers available to HIP 2.0 members vs. Hoosier Healthwise (HHW) members				X
					Change in # of providers accepting new HIP 2.0 members vs. HHW				X
					Change in time to access care for HIP 2.0 members vs. HHW				X
1.3	POWER account contributions for individuals in the HIP Plus plan are affordable and do not create a barrier to health care access (STCs, Section XIII, Paragraph 3v).	7. How many members will be impacted by employers and not-for-profit organizations paying all or part of their POWER account contributions? 8. How do HIP 2.0 enrollees perceive the affordability of	Track member POWER account payment rates over the course of the demonstration. Track the impact of fast-track payments on member application start date.	POWER account data	# individuals subject to PAC (by income level)	X	X	X	
					# of individuals receiving POWER account contributions (PAC) from employers and/or not-for-profit entities (by entity type)	X	X	X	
					Average amount paid by employer and/or	X	X	X	

#	Hypothesis	Research Questions	Analytic Approach	Data Source	Metric	Quarterly Report	Annual Report	Interim & Final Report	Policy-Specific Report
	Few individuals will experience the lock-out period because the policy will deter nonpayment of POWER account contributions for HIP Plus beneficiaries (STCs, Section XIII, Paragraph 3vi).	<p>the PAC and non-payment penalties?</p> <p>9. How many individuals lost HIP Plus coverage due to non-payment of the PAC?</p> <p>10. How many individuals requested a waiver from the six month lockout?</p> <p>11. How are individuals accessing healthcare if they are locked out due to non-payment of the PAC?</p> <p>12. Was the lockout period a deterrent for individuals over 100% FPL to miss a PAC?</p>	<p>Track HIP members making initial and subsequent flat-rate POWER account contributions:</p> <ul style="list-style-type: none"> • Overall; • Above 100% FPL • Under 100% FPL. <p>Use univariate and bivariate analysis to describe and compare the number of members who do and do not experience a lock-out period for failure to make POWER account contributions.</p> <p>Use multivariate analysis to describe and compare members who experience a lock out period for failure to make POWER account contributions, controlling for confounding factors</p> <p>Comparison Group: Enrollment data from previous demonstration period (HIP 1.0), and comparable populations from other states, examined by FPL.</p> <p>Non-payment rates from HIP 1.0 and HIP 2.0</p>		<i>not-for-profit (by member income level)</i>				
# individuals in HIP Basic					X	X	X		
# individuals approved for HIP and over 100% FPL who do not pay first PAC									
# of months PAC paid, average per member					X	X	X		
Timing of eligibility change due to non-payment (transition to Basic or lockout), by # of months paid and by month in the year					X	X	X		
Rate of non-payment of PAC, by FPL					X	X	X		
# individuals with overdue PAC (less than and greater than 60 days)					X	X	X		
Administrative data					# individuals requesting waiver of lockout	X	X	X	
					# individuals granted waiver of lockout	X	X	X	
Member Eligibility data					# individuals subjected to 6 mo. lockout, by FPL	X	X	X	
					Rate of disenrollment for failure to pay PAC	X	X	X	
					# individuals exempted from PAC	X	X	X	

#	Hypothesis	Research Questions	Analytic Approach	Data Source	Metric	Quarterly Report	Annual Report	Interim & Final Report	Policy-Specific Report
			populations, examined by FPL		<i># individuals meeting qualifying event criteria</i>	X	X	X	
				Member Enrollment data, - by income level	<i># individuals disenrolled</i>				X
					<i># of individuals making fast-track payments, by FPL</i>	X	X	X	
					<i>Timing of fast-track payment submission</i>	X	X	X	
				Member and non-member survey data	<i>Reasons for non-payment of PAC</i>	X	X	X	
					<i>Perception of ability to make POWER account contribution</i>		X	X	
					<i>Member aware of non-payment penalties? (Y/N)</i>	X	X	X	
					<i>Perceived affordability of the PAC, by income level</i>				X
					<i>Reasons individual did not make contribution, by income level</i>				X
					<i>Individual health care needs during lockout period, by income level</i>				X
					<i>How health care needs addressed during lockout period, by income level</i>				X
1.4	Presumptive eligibility (PE) and fast-track prepayments will provide the necessary coverage so as not to have gaps in health care	4. How does the waiver of retroactive coverage impact uncompensated care costs?	Track presumptive eligibility and fast-track prepayments over the course of the demonstration. Use univariate and bivariate analysis to describe and	Eligibility data	<i>Average # of days between submission of app and eligibility determination</i>	X	X	X	
					<i>Average # of days between eligibility determination and HIP</i>	X	X	X	

#	Hypothesis	Research Questions	Analytic Approach	Data Source	Metric	Quarterly Report	Annual Report	Interim & Final Report	Policy-Specific Report
	coverage (STCs, Section XIII, Paragraph 3vii).	5. What is the number of PE applications vs. traditional applications? 6. How many PE members go to HIP vs. HIP Plus?	compare the number of members who experience a coverage gap. Comparison Group: Members who do not obtain PE and who do not make fast-track payments.		<i>2.0 plan enrollment, by payment of PAC or 60-day default into HIP Basic for members under 100% FPL</i>				
<i># of individuals determined eligible using ex parte</i>								X	
<i># of individuals receiving prepopulated renewal form</i>								X	
<i># of individuals responding to prepopulated renewal form</i>								X	
<i># of responders determined eligible</i>								X	
<i># of individuals who reapply within (a) 90 days or less, (b) 6 months, (c) 1 year, following a termination for failure to respond</i>								X	
<i>% of all applications coming through PE</i>								X	
<i>% of eligibility determinations following PE period vs. determinations on all applications</i>								X	
Administrative data					# of PE individuals making fast-track payments		X	X	
Enrollment data				# entities participating in PE (by type, # of PE applications filed, # full	X	X	X		

#	Hypothesis	Research Questions	Analytic Approach	Data Source	Metric	Quarterly Report	Annual Report	Interim & Final Report	Policy-Specific Report
					<i>apps filed, # determined eligible, by entity)</i>				
					<i>% of potentially qualifying entities trained and participating in HIP 2.0 PE assessment (not counting entities that have refused or not responded to opportunities to participate)</i>				X
					Re-enrollment rates		X	X	
					Length of PE period before making PAC, by FPL		X	X	
					# of PE-eligible individuals enrolling in HIP Plus vs. HIP Basic, by income		X	X	
				Survey data - PE providers	<i>Perceptions of the effectiveness of the PE process</i>		X	X	
				Claims/Enrollment data	Service utilization during PE period (primary care vs. specialty care vs. emergency care), by income		X	X	
				Survey data - Providers	<i>Cost of uncompensated care for individuals who would have been eligible for retroactive coverage</i>		X	X	
					Level of uncompensated care		X	X	

#	Hypothesis	Research Questions	Analytic Approach	Data Source	Metric	Quarterly Report	Annual Report	Interim & Final Report	Policy-Specific Report
					Copayment policies and collection rates		X	X	
1.5	Waiver of non-emergency transportation to the non-pregnant and non-medically frail population does not pose a barrier to accessing care (STCs, Section XIII, Paragraph 3ix).	<p>4. What is the effect of the NEMT waiver of coverage on missed appointments by income level for individuals who are neither pregnant nor medically frail? Are there parts of the state that are more affected by no access to NEMT?</p> <p>5. How does not having access to NEMT affect preventive care and overall health outcomes?</p> <p>6. What is the impact of no access to NEMT as viewed by the providers and beneficiaries?</p>	Track member perception over the course of the demonstration.	Survey data – Providers and Members, using questions from HIP 1.0 survey	Perceptions about impact of access to NEMT		X	X	
			Use univariate and bivariate analysis to describe and compare the number of missed appointments with current Indiana utilization trends.		% of respondents reporting challenges in keeping appointments due to lack of transportation, by income level and by county		X	X	
			<p>Comparison Group: Compare populations in HIP receiving State Plan Benefits to HIP recipient receiving HIP Plus/HIP Basic benefits that do not include NEMT..</p> <p>Compare survey results between HIP 1.0 and HIP 2.0.</p>	Survey data – Member	Estimated# of missed appointments, by income level and with NEMT vs. without NEMT		X	X	
Goal 2: Promote value-based decision making and personal health responsibility									
2.1	HIP policies will encourage member compliance with required contributions and provide incentives to actively manage POWER account funds (HIP 2.0 waiver, Section 5).	3. What are the differences in utilization behaviors for individuals that make PAC contributions and those that do not (difference between HIP Plus/HIP Basic) or those that receiving rollover vs. those who do not? How are these variables impacted by member income level?	Track initial HIP Plus vs. HIP Basic enrollment by FPL.	Survey data – Member	Reported health status, by eligibility for POWER account rollover		X	X	
			Track and compare average remaining POWER account balances at the end of a benefit period between: a) HIP Plus members;	Survey data – Provider	% of HIP patients for which providers report regularly collecting copayments		X	X	

#	Hypothesis	Research Questions	Analytic Approach	Data Source	Metric	Quarterly Report	Annual Report	Interim & Final Report	Policy-Specific Report
	HIP policies surrounding rollover and preventive care will encourage beneficiaries' compliance with required contributions and provide incentives to actively manage POWER account funds (STCs, Section XIII, Paragraph 3viii).	<p>4. Are there differences in utilization and POWER account management among members related to health status, (e.g., diabetes, or other chronic diseases)?</p> <p>2. Are there differences in utilization and POWER account management between individuals paying a PAC and those who do not?</p>	<p>b) HIP Basic members who enroll in HIP Plus at the end of their benefit period; and</p> <p>c) HIP Basic members who do not enroll in HIP Plus at the end of their benefit period.</p> <p>Track HIP Plus member pro-rata share of balance</p> <p>POWER account rollover rates and the average amount by which contributions are reduced in the next benefit period for:</p> <ul style="list-style-type: none"> • Base rollovers (100% of member pro-rata share of balance); and • Preventive care rollovers (200% of member pro-rata share of balance). <p>Track the average amount by which required contributions are discounted for HIP Basic members transitioning to HIP Plus at redetermination.</p> <p>Track the copayment collection rate for HIP Basic members.</p>		Copayment collection rates		X	X	
					Copayment collection policies		X	X	
				MCE incentive data	# and amount of individuals receiving incentives for healthy behaviors, by MCE and by income and by HIP Plus vs. HIP Basic plan		X	X	
					<i>Total enrollment by HIP Plus vs. HIP Basic plan</i>		X	X	
				Enrollment data	<i># enrolled in HIP Basic who enroll in HIP Plus later</i>		X	X	
					<i># and % transitioned from HIP Plus to HIP Basic due to non-contribution</i>		X	X	
					<i>Total enrollment in HIP Plus, by income (above and below 100% FPL)</i>		X	X	
				Administrative data	<i>% of POWER accounts that have a balance at the end of a benefit period</i>		X	X	
					<i>Average POWER account balance amount at the end of the benefit period.</i>		X	X	
					<i>Percentage of HIP Plus members that have a POWER account balance at the end of the benefit period</i>		X	X	

#	Hypothesis	Research Questions	Analytic Approach	Data Source	Metric	Quarterly Report	Annual Report	Interim & Final Report	Policy-Specific Report
			Use univariate and bivariate analysis to describe and compare a) the number of members who make POWER account contributions, and b) the number of members who receive rollover rates.		<i>POWER account rollover rates for HIP Plus members (100% and 200%)</i>		X	X	
			Use multivariate analysis to describe and compare a) the number of members who make POWER account contributions, and b) the number of members who receive rollover rates, controlling for confounding factors.		<i>Average amount by which HIP Plus member contributions are reduced in the next benefit period</i>		X	X	
			Use multivariate analysis to describe differences in utilization and POWER account management among members with ambulatory-sensitive conditions, controlling for confounding factors.		<i>Average discount for required contributions in the next benefit period for HIP Basic members transitioning to HIP Plus.</i>		X	X	
			Comparison Groups: Service utilization and POWER account rollover data from previous demonstration period (HIP 1.0).		<i># and amount of rollover for HIP Plus, HIP Basic</i>	X	X	X	
			Compare HIP Plus with HIP Basic and Medically Frail		<i># and % of members making initial POWER account contribution, total and within allowed time</i>		X	X	
					<i># and % locked out due to non-contribution of PAC</i>		X	X	
					<i>% of individuals with rollover receiving enhanced rollover for preventive services</i>		X	X	
				Claims/Encounter data	Rate of primary care use, by income and by HIP Plus vs. HIP Basic plan		X	X	
					Prior authorization requests		X	X	

#	Hypothesis	Research Questions	Analytic Approach	Data Source	Metric	Quarterly Report	Annual Report	Interim & Final Report	Policy-Specific Report
			participation, stratifying by income level		Rate of specialty care use, by income and by HIP Plus vs. HIP Basic plan		X	X	
					Rate of generic medicine use vs. brand name, by income and by HIP Plus vs. HIP Basic plan		X	X	
					Rate of ED use, by income and by HIP Plus vs. HIP Basic plan and by number of visits		X	X	
2.2	<p>HIP Plus members will exhibit more cost-conscious healthcare consumption behavior than: a) HIP Basic members; and b) traditional Hoosier Healthwise members in the areas of primary, specialty, and pharmacy service utilization without harming beneficiary health.</p>	<p>3. Are HIP Plus members more likely to exhibit cost-conscious consumption behavior? In what area(s)?</p> <p>4. Are HIP Plus members less likely to reach the 5% threshold?</p>	<p>Track health service utilization rates for following groups, controlling for health status, age, and other relevant variables:</p> <ul style="list-style-type: none"> • HIP Plus members; • HIP Basic members; • Section 1931 Group; • Medically Frail <p>Track service utilization by income and benefit plan (HIP Plus vs. HIP Basic) for generic vs. brand name medications, primary care vs. specialty care utilization</p> <p>Use univariate and bivariate analysis to describe and compare the</p>	Member out-of-pocket tracking data	<i># of individuals reaching the 5% threshold on a monthly or quarterly basis, by income and by HIP Plus vs. HIP Basic plan</i>	X	X	X	
				Administrative data	Cost of care, by disease state and by HIP Plus vs. HIP Basic plan and within transitioning Medicaid population (before and after transition to HIP)				
					Projected copayment costs for HIP Basic members		X	X	
				Encounter data	<i>ED use</i>		X	X	
					<i>Primary care encounters vs. specialty care</i>		X	X	
					<i>Preventive service codes</i>		X	X	

#	Hypothesis	Research Questions	Analytic Approach	Data Source	Metric	Quarterly Report	Annual Report	Interim & Final Report	Policy-Specific Report
			utilization patterns of HIP Plus members versus HIP Basic and traditional Hoosier Healthwise members.		<i>Pharmacy (overall costs, brand vs. generic dispensing rate)</i>		X	X	
			Use univariate and bivariate analysis to compare the number of HIP Plus members who reach the 5% income threshold versus HIP Basic and traditional Hoosier Healthwise members.		% of individuals using the ED for non-emergency services, by HIP Plus vs. HIP Basic plan		X	X	
			Use multivariate analysis to compare the utilization patterns of HIP Plus members versus HIP Basic and traditional Hoosier Healthwise members.		% of individuals using specialty care for chronic disease care, by HIP Plus vs. HIP Basic plan vs. medically frail		X	X	
			Use multivariate analysis to compare the utilization patterns of HIP Plus members versus HIP Basic and traditional Hoosier Healthwise members, controlling for confounding factors.		% of individuals accessing chronic disease management services (if chronic disease present), by HIP Plus vs. HIP Basic plan		X	X	
			Comparison Groups: Service utilization from previous demonstration period (HIP 1.0).		# of unique individuals accessing preventive services, by income		X	X	
			Compare cost of care for populations making PAC to those who are not.		# of preventive care visits, total and average per person, by income		X	X	
			Compare the cost of care for populations transitioning from traditional Medicaid to HIP, looking at costs before and after transition.		# of specialty care visits, total and average per person, by income		X	X	
					# of unique individuals accessing specialty care		X	X	
					# of visits to urgent care center, by income		X	X	
					% of individuals taking brand name		X	X	

#	Hypothesis	Research Questions	Analytic Approach	Data Source	Metric	Quarterly Report	Annual Report	Interim & Final Report	Policy-Specific Report
					medications when generic medication is available, by HIP Plus vs. HIP Basic plan vs. medically frail				
2.3	<p>HIP's (i) graduated copayments required for non-emergency use of the emergency department (ED), (ii) ED prior authorization process, and (iii) efforts to expand access to other urgent care settings will together effectively deter inappropriate ED utilization without harming beneficiary health (HIP 2.0 Waiver, Section 5).</p> <ul style="list-style-type: none"> The graduated copayment structure for non-emergency use of the emergency department will decrease inappropriate ED utilization without harming beneficiary health (STCs, Section XIII, Paragraph 3x). The prior authorization process for hospital emergency department use and 	<p>4. What is the rate of non-emergency use of the ED among individuals in the control group vs. the graduated copay group?</p> <p>5. What portion of individuals calling the Nurse Hotline are recommended to go to the ED and what portion of individuals use the ED in spite of the Nurse Hotline advising a different course of action?</p> <p>6. What portion of individuals are accessing urgent care settings outside of the ED?</p>	<p>Survey HIP members on whether the copayment for non-emergency use of the ED caused them to seek services with their primary care physician or in an alternative urgent care setting</p> <p>Track annual rates of members seeking prior authorization through the nurses' hotline prior to seeking ED services.</p> <p>Track annual rates of members paying increased copayments based on repeated inappropriate ED utilization.</p> <p>Use univariate and bivariate analysis to describe and compare inappropriate ED utilization among members with graduated ED copayment rates versus members within the control group.</p>	Claims/encounter data	# individuals using the ED, by income level	X	X	X	
					# visits classified as emergency, by income level and HIP Plus vs. HIP Basic plan	X	X	X	
					# visits classified as non-emergency, by income level and HIP Plus vs. HIP Basic plan	X	X	X	
					# individuals in differing copay structures for non-emergency use of ED	X	X	X	
					# individuals calling nurse hotline and subsequently visiting ED	X	X	X	
					Annual overall ED utilization rates (percent of members and visits/100,000 members)		X	X	
					Annual non-emergency ED utilization rates (percent of members and visits/100,000 members)		X	X	
					Annual rates of alternative urgent care setting utilization		X	X	

#	Hypothesis	Research Questions	Analytic Approach	Data Source	Metric	Quarterly Report	Annual Report	Interim & Final Report	Policy-Specific Report	
	efforts to expand access to other urgent care settings will decrease inappropriate ED utilization without harming beneficiary health (STCs, Section XIII, Paragraph 3xi).		Use univariate and bivariate analysis to describe and compare the a) number of individuals calling the Nurse Hotline who are recommended to go to the ED, and b) what portion of individuals use the ED in spite of the Nurse Hotline advising a different course of action.		<i>(percent of members and visits/100,000 members).</i>					
				Alternative urgent care locations utilized		X	X			
			Survey data – Member	% of members who report the required copayment for non-emergency use of the ED caused them to seek services with their primary care physician or in an alternative urgent care setting in lieu of the ED			X	X		
			Use univariate and bivariate analysis to describe and compare the number of individuals who utilize urgent care settings outside of the ED?	Number of members that utilized ED services		X	X			
			Comparison groups:	Number of members utilizing nurse’s hotline for ED prior authorization	X	X	X			
			Non-emergency ED utilization rates compared between HIP 1.0, HIP Plus, HIP Basic, Hoosier Healthwise (e.g. Section 1931 group), by income.	Number of members receiving affirmative prior authorization for ED services		X	X			
			Compare annual rates of inappropriate ED utilization between HIP populations for the years before (2008-2014) and after (2015 and beyond) for non-caretakers and caretakers.	Number of members that utilized inappropriate ED services:			X	X		
				<ul style="list-style-type: none"> • Only once • Two times • Three times • More than three times 						

#	Hypothesis	Research Questions	Analytic Approach	Data Source	Metric	Quarterly Report	Annual Report	Interim & Final Report	Policy-Specific Report
			Compare annual rates of alternative urgent care setting utilization (e.g. retail clinics) between HIP populations for the years before (2008-2014) and after (2015 and beyond) the HIP 2.0.	Historical data	Rate of individuals accessing the ED for non-emergency services, by benefit plan (e.g. HIP 1.0, HHW, etc.)		X	X	
			Comparable populations where member contributions are not required from other states.	Member out-of-pocket tracking data	# individuals charged the \$8 non-emergency use of ED copay	X	X	X	
					# individuals charged \$25 non-emergency use of ED copay	X	X	X	
Goal 3: Promote disease prevention and health promotion to achieve better health outcomes.									
3.1	HIP will effectively promote member use of preventive, primary, and chronic disease management care to achieve improved health outcomes (HIP 2.0 Waiver, Section 5 and STCs, Section XIII, Paragraph 3iii).	3. How does primary care and chronic disease management utilization among HIP members compare to preventive care and chronic disease management in commercial health insurance and other Medicaid populations? 4. How does primary care and chronic disease management vary by population age, gender, benefit plan, FPL, etc.?	Track and compare health service utilization rates between HIP and traditional Medicaid members.	Administrative data	# individuals with PAC requirement reductions/rollover due to preventive care	X	X	X	
			Examine specific disease categories and assess whether management was better by HIP Plus or Basic status.		POWER account preventive care rollover rates (200% of member pro-rata contribution amount) for HIP Plus members		X	X	
			Track medically frail status, and assess its impact upon utilization.		Average discount in required contributions for HIP Basic members who enroll in HIP Plus at the end of the benefit period		X	X	
			Identify key metrics for specific disease groups and examine utilization across	Health plan data	Chronic disease management program		X	X	

#	Hypothesis	Research Questions	Analytic Approach	Data Source	Metric	Quarterly Report	Annual Report	Interim & Final Report	Policy-Specific Report
			the different comparison groups.		<i>participation numbers and rates</i>				
			Track preventative care utilization by all, and across the different comparison groups.		<i>Selected chronic disease management aggregate program outcomes</i>		X	X	
			Track and compare POWER account rollover and contribution discount rates for:		Primary and preventive care utilization by specific disease category		X	X	
			<ul style="list-style-type: none"> HIP Plus members HIP Basic members who enroll in HIP Plus at the end of the benefit period 		Primary and preventive care utilization ambulatory care sensitive conditions		X	X	
			Track preventive care utilization rates and trends among different age and gender groups.		HEDIS measures by specific disease category		X	X	
			Track participation in health plans' chronic disease management programs.		HEDIS measures by ambulatory care sensitive conditions.		X	X	
			Use univariate and bivariate analysis to describe and compare primary care and chronic disease management utilization among HIP members versus members within commercial health	<i>Encounter data</i>	<i>Primary care encounters</i>		X	X	
					<i>Specialty encounters</i>		X	X	
					<i>ED visits</i>		X	X	
					<i>Preventive care codes</i>		X	X	
					Chronic disease management codes		X	X	
					<i>Number, type, and frequency of preventive care services used</i>		X	X	
					<i>Gender- and age-specific rates of pre-determined preventive service utilization.</i>		X	X	

#	Hypothesis	Research Questions	Analytic Approach	Data Source	Metric	Quarterly Report	Annual Report	Interim & Final Report	Policy-Specific Report
			<p>insurance and other Medicaid populations.</p> <p>Use multivariate analysis to describe how primary care and chronic disease management vary by population age, gender, benefit plan, FPL, and other measures, controlling for confounding factors.</p> <p>Comparison Groups: Enrollment data from previous demonstration period (HIP 1.0), and comparable populations from other states.</p> <p>Indiana residents who are not enrolled in HIP (e.g., uninsured and other insurance</p>						
Goal 4: Promote private market coverage and family coverage options to reduce network and provider fragmentation within families.									
4.1	HIP's defined contribution premium assistance program (HIP Link) will increase the proportion of Indiana residents under 138% FPL covered by employer-sponsored insurance (ESI) (HIP 2.0 Waiver, Section 5 and	<p>5. How many members who have access to HIP Link enroll in HIP Link instead of HIP?</p> <p>6. How many members move from HIP Link to HIP?</p> <p>7. How many total members and their dependents utilize HIP Link?</p> <p>8. Of the employers whose employees are enrolled in HIP:</p>	<p>Track Indiana residents with income under 138% FPL covered by ESI over the demonstration</p> <p>Track Indiana residents with income under 138% FPL receiving defined contribution premium assistance to purchase ESI</p>	Enrollment data	# of members who apply for HIP Link.	X	X	X	
					Total # qualifying for/enrolling in HIP Link	X	X	X	
					#and % of HIP enrollees who receive premium assistance to purchase ESI—monthly and annually		X	X	
					# moving from HIP Link to HIP Plus, HIP Basic	X	X	X	

#	Hypothesis	Research Questions	Analytic Approach	Data Source	Metric	Quarterly Report	Annual Report	Interim & Final Report	Policy-Specific Report
	STCs, Section XIII, Paragraph 3xii).	How many employers are enrolled in HIP Link? How many employees are enrolled in HIP versus their employers' sponsored insurance/HIP Link??	each year of the demonstration Use univariate and bivariate analysis to describe and compare a) the number of members who have access to HIP Link who enroll in HIP Link instead of HIP and b) the number of members who move from HIP Link to HIP. Use multivariate analysis to describe how many members participate in HIP Link, controlling for confounding factors. Comparison Group: Enrollment data from previous demonstration period (HIP 1.0), and comparable populations from other states.		# of members who call enrollment broker: <ul style="list-style-type: none"> Number who enroll in HIP Link. Number who enroll in HIP. 		X	X	
					# of members who were on HIP before the roll-out of HIP Link.		X	X	
					# of members who transition from HIP to HIP Link.		X	X	
					# of members who were on their employers ESI before applying for HIP Link.		X	X	
					# of members who were on their employers ESI before qualifying/ enrolling in HIP Link.		X	X	
					# of members who were uninsured before applying for HIP Link.		X	X	
					# of members who were uninsured before qualifying for/enrolling in HIP Link.		X	X	
					# of members who were in a non-qualifying health plan previously (i.e., number of members who changes plans within the 60 day enrollment period created by HIP Link)		X	X	
					# of members who qualify for rollover		X	X	

#	Hypothesis	Research Questions	Analytic Approach	Data Source	Metric	Quarterly Report	Annual Report	Interim & Final Report	Policy-Specific Report
					(due to completion of preventive services)				
					# of employers who apply for HIP Link.		X	X	
					# of employers who qualify for/enroll in HIP Link.		X	X	
					# of employer health plans submitted for HIP Link approval.		X	X	
					# of employer health plans which qualify for HIP Link.		X	X	
					Employer characteristics: <ul style="list-style-type: none"> • Industry • Size 		X	X	
					# of employees: <ul style="list-style-type: none"> • Total # of employees • # of employees enrolled in HIP Link 		X	X	
					# of members who leave HIP Link and move to HIP due to reaching 5% income limit. <ul style="list-style-type: none"> • # of months member stayed on HIP Link. 		X	X	
					# of members who leave HIP Link due to pregnancy. <ul style="list-style-type: none"> • # of months member stayed on HIP Link. 		X	X	

#	Hypothesis	Research Questions	Analytic Approach	Data Source	Metric	Quarterly Report	Annual Report	Interim & Final Report	Policy-Specific Report
					# of members who leave HIP Link due to increased salary/income. • # of months member stayed on HIP Link.		X	X	
					# of members who leave HIP Link due to leaving their job. • # of months member stayed on HIP Link.	X	X	X	
					Number of employers who leave HIP Link. • # of months employer stayed on HIP Link.	X	X	X	
					# of members who leave HIP Link due to their employer leaving HIP Link.		X	X	
					# of large employers and small employers registered with HIP Link	X	X	X	
				Claims/Encounter Data	Utilization and amounts paid by HIP Link: • By provider type • By service type		X	X	
				Member Survey	Member satisfaction with HIP Link: • Why staying in HIP Link? • Why leaving HIP Link?		X	X	
				Employer Survey	Employer satisfaction with HIP Link: • Why staying in HIP Link?		X	X	

#	Hypothesis	Research Questions	Analytic Approach	Data Source	Metric	Quarterly Report	Annual Report	Interim & Final Report	Policy-Specific Report
					<ul style="list-style-type: none"> Why leaving in HIP Link? 				
				<i>Current Population Survey & American Community Survey</i>	<i>ESI coverage rate estimates, all ages.</i>				
				POWER account data	<i>POWER account balance</i>	X	X	X	
					POWER account expenditures: <ul style="list-style-type: none"> HIP Link members HIP Plus members 		X	X	
					Premium amounts paid to members.		X	X	
					Copayment amounts paid to providers: <ul style="list-style-type: none"> By provider type By service type 		X	X	
					Deductible amounts paid to providers: <ul style="list-style-type: none"> By provider type By service type 		X	X	
					Wrap-around service payments: <ul style="list-style-type: none"> By provider type By service type 		X	X	
					<i>Employer contribution (with change from beginning to end of quarter)</i>	X	X	X	
4.2	HIP's ESI premium assistance option for family coverage will increase the number of low income families in which the parents and	3. How will the availability of HIP Link impact the number of children on Medicaid and CHIP?	Track the number of parents eligible for and utilizing premium assistance for their children to enroll in the family coverage ESI plan in lieu of CHIP.		<i>HIP ESI premium records and Survey data - Member</i>	<i># and % of parents who are eligible for premium assistance for their children</i>		X	X
					<i># of parents with dependents on Medicaid</i>		X	X	

#	Hypothesis	Research Questions	Analytic Approach	Data Source	Metric	Quarterly Report	Annual Report	Interim & Final Report	Policy-Specific Report
	children have access to the same provider network (HIP 2.0 Waiver, Section 5).	4. How will the availability of HIP Link impact the number of adults enrolled in HIP?	Use univariate and bivariate analysis to describe and compare the number of children covered by HIP Link versus CHIP among whose parents are eligible for HIP Comparison Group: Enrollment data from previous demonstration period (HIP 1.0), and comparable populations from other states.		# of parents of with dependents less than 21-years old		X	X	
# and % of parents who accept premium assistance to enroll in ESI family coverage.						X	X		
Goal 5: Provide HIP members with opportunities to seek job training and stable employment to reduce dependence on public assistance.									
5.1	Referrals to Department of Workforce Development (DWD) employment resources at the time of application will increase member employment rates over the course of the demonstration (HIP 2.0 Waiver, Section 5).	4. What percent of members referred to DWD become employed (part time vs. full time)? 5. How will referrals to the DWD impact member income and eligibility for HIP? How many stay in HIP and how many referred individuals leave HIP? 6. How will referrals to the DWD impact the number of Indiana residents enrolled in HIP Link?	Track the number of HIP applicants referred for work search and job training assistance.	Enrollment data	<i>Number of HIP applicants annually and monthly</i>		X	X	
			Track the number of HIP members who accept/participate in work search/job training programs.		<i>Number of members who lose HIP eligibility due to income increase—monthly and annual.</i>		X	X	
			Track the number of HIP individuals transitioning off the program due to increased income.	Survey data - Member	<i>Percentage of members who report engagement in work search/job training activities after the time of HIP application—one month, six months, and one year</i>		X	X	
			Use univariate and bivariate analysis to describe and compare a) the number of members referred to DWD, b) the number of members		<i>Percentage of enrollees with full or part-time employment at program entry, six months, one year, and</i>		X	X	

#	Hypothesis	Research Questions	Analytic Approach	Data Source	Metric	Quarterly Report	Annual Report	Interim & Final Report	Policy-Specific Report
			<p>who are referred to DWD who earn employment, and c) the number of members referred to DWD who enroll in HIP Link.</p> <p>Use multivariate analysis to describe the number of members who are referred to DWD who earn employment, controlling for confounding factors.</p> <p>Comparison Group: Enrollment data from previous demonstration period (HIP 1.0).</p> <p>Compare rates of full- and part-time employment among the entire HIP-enrolled population and across the HIP-enrolled population referred to DWD at application and after six months, one year, and two years into the program.</p>		<i>two years into the program</i>				
Goal 6: Assure State fiscal responsibility and efficient management of the program.									

#	Hypothesis	Research Questions	Analytic Approach	Data Source	Metric	Quarterly Report	Annual Report	Interim & Final Report	Policy-Specific Report
6.1	HIP will remain budget-neutral for both the federal and state governments (HIP 2.0 Waiver, Section 5).	<p>3. How do current HIP expenditures compare to previous HIP and Medicaid expenditures?</p> <p>4. How do HIP expenditures compare to comparable expenditures among other States?</p>	<p>Conduct a budget neutrality analysis and document adherence to waiver margin, adjusting for the higher provider rates compared to Hoosier Healthwise/Medicaid. Analysis will also need to account for a recent rate increase for Medicaid beneficiaries, as this can be a confounding factor.</p> <p>Comparison Group: Fiscal data from previous demonstration period (HIP 1.0), and traditional Medicaid population transitioning to HIP 2.0 (e.g. Section 1931 group).</p> <p>Cost effectiveness between HIP Plus, HIP Basic, and HIP Link members.</p>	Internal financial data	<p><i>Expenditures by waiver populations, including (1) 1931 parents and low income 19-20 year old dependent expenditures, (2) New adult group, (3) HIP Link, (STCs, Section XI, Paragraph 2d) and (4) pregnant women</i></p>	X	X	X	
					<p><i>Administrative costs (STCs, Section X, Paragraph 5b)</i></p>		X	X	
					<p><i>Pharmacy rebates assigned to the demonstration, ensuring these rebates are not applicable to the HIP Link program (STCs, Section XI, Paragraph 2e)</i></p>	X	X	X	
					<p><i>Estimate of matchable demonstration expenditures, separating expenditures (by quarter) for Medical Assistance Payments (MAP) and State and Local Administration</i></p>	X	X	X	

#	Hypothesis	Research Questions	Analytic Approach	Data Source	Metric	Quarterly Report	Annual Report	Interim & Final Report	Policy-Specific Report
					<i>Costs (ADM) (STCs, Section XI, Paragraph 3)</i>				
					<i>Cost settlements (STCs, Section XI, Paragraph 2c)</i>	X	X	X	
					<i>Total annual expenditures for the demonstration population throughout the demonstration year (STCs, Section X, Paragraph 5b)</i>		X		
				Budget neutrality estimates and reports	<i>Calculation of the waiver margin (annual and cumulative) (HIP 2.0 Waiver, Section 5)</i>		X	X	
					<i>Documentation of all state and federal costs (HIP 2.0 Waiver, Section 5)</i>			X	
					<i>Demonstration of budget neutrality (HIP 2.0 Waiver, Section 5 and STCs, Section XI, Paragraph 2g and Section XII)</i>			X	
				Internal financial data (for Retroactive coverage for Section 1931 group transition to HIP 2.0)	<i># individuals with costs paid under the retroactive coverage for Section 1931 group transition to HIP 2.0 (STCs Section IV, Paragraph 4e)</i>				X

#	Hypothesis	Research Questions	Analytic Approach	Data Source	Metric	Quarterly Report	Annual Report	Interim & Final Report	Policy-Specific Report
					<i>Total costs paid (STCs Section IV, Paragraph 4e)</i>				X
					<i>Average cost per person (STCs Section IV, Paragraph 4e)</i>				X
					<i># and type of providers paid (STCs Section IV, Paragraph 4e)</i>				X
					<i>Amounts not reimbursed under retroactive coverage for Sec. 1931 group transition to HIP 2.0 (STCs Section IV, Paragraph 4e)</i>				X
				Claims/encounter data (for Retroactive coverage for Section 1931 group transition to HIP2.0)	<i>Type of costs incurred, including specific conditions with which they are associated (STCs Section IV, Paragraph 4e)</i>				X
				POWER account data	<i>MCE contributions (STCs, Section XI, Paragraph 2b)</i>	X	X	X	
			<i>State contributions to participant POWER accounts (STCs, Section XI, Paragraph 2b)</i>		X	X	X		
			<i>Recouped State contributions to participant POWER accounts (STCs, Section XI, Paragraph 2b)</i>		X	X	X		

Appendix B – HIP Enrollee Survey

Survey of Current Enrollees in the Healthy Indiana Plan (HIP)

INTERVIEWER INITIALS:				MPR ID:									
--------------------------	--	--	--	---------	--	--	--	--	--	--	--	--	--

CONFIRM ENROLLMENT IN HIP

Q1. The State of Indiana runs an insurance program called the Healthy Indiana Plan (or HIP) for Hoosiers age 19 to 64. Are you enrolled in the “Healthy Indiana Plan” or “HIP” at this time?

YES → CONTINUE WITH THE SURVEY, GO TO Q2

NO

Q1a. Have you ever been enrolled in HIP?

YES

NO

DON'T KNOW

REFUSED

→ GO TO CLOSE1

Q1b. Why did you leave HIP? INTERVIEWER: PROBE FOR PROGRAM COSTS AS REASON FOR LEAVING.

MARK ALL THAT APPLY THEN GO TO CLOSE 1.

1 COULDN'T AFFORD IT ANYMORE

2 DIDN'T NEED IT ANYMORE

3 FORGOT TO RE-ENROLL

4 GOT INSURANCE THROUGH MY SPOUSE

5 GOT INSURANCE THROUGH AN EMPLOYER

6 GOT MEDICARE

7 GOT MEDICAID

8 NOT ABLE TO SEE DOCTOR OF MY CHOICE

9 NOT SATISFIED WITH PLAN

10 TRIED TO RE-ENROLL - STAFF COULDN'T HELP ME/SYSTEM FAILED/IT DIDN'T WORK OUT

11 TRIED TO RE-ENROLL BUT THEY DIDN'T GET MY PAPERWORK DONE IN TIME

12 TOO COMPLICATED

13 TOO MUCH PAPERWORK

14 MOVED / NO LONGER LIVING IN INDIANA

15 NO LONGER ON HIP PER ADMIN DATA

16 INCARCERATED

17 PREGNANT

18 OTHER REASON (*Specify*) _____

19 **NO LONGER INCOME ELIGIBLE**

d DON'T KNOW

r REFUSED

CLOSE1 Thank you for answering these questions. This survey is meant to be completed by people who are currently enrolled in HIP. If you have any questions about the plan, please call 1-877-438-4479. Thank you and have a good (day/night).

INTERVIEWER: HANG UP. CODE CASE AS INELIGIBLE – DOES NOT MEET SURVEY CRITERIA IN CATI. THEN PLACE THIS COMPLETED SCREENER WITH CASES FOR ENTRY.

Q2. Which Healthy Indiana health plan are you enrolled with? Is it:

- 1 Anthem
- 2 MDwise
- 3 MHS – Managed Health Services
- 4 The Enhanced Services Plan, or
- 5 Some other plan
- d DON'T KNOW
- r REFUSED

MONTHLY CONTRIBUTIONS

Q3. Some people make a monthly contribution to be in HIP. Have you ever paid anything to be in HIP?

IF NEEDED, PROBE: Do you pay something each month to be in HIP? Some call this a monthly contribution and others call it a monthly bill.

- 1 YES → **GO TO Q4**
 - 0 NO
 - d DON'T KNOW
 - r REFUSED
- **GO TO Q9**

Q3a. If HIP required you to pay \$10 each month to be enrolled, would you continue to stay enrolled in HIP?

- 1 YES
- 0 NO
- d DON'T KNOW
- r REFUSED

Q3b. What about \$5? Would you continue to stay enrolled if HIP required you to pay \$5 each month?

- 1 YES
 - 0 NO
 - d DON'T KNOW
 - r REFUSED
- **GO TO Q9**

Q4. How much money do you contribute each month to be in HIP?

\$, .

- d DON'T KNOW
- r REFUSED

Q5. Would you say the amount you contribute each month is:

- 1 Way too much
- 2 A little too much
- 3 The right amount
- 4 Below the right amount, or
- 5 Way below the right amount
- d DON'T KNOW
- r REFUSED

Q6. If HIP required you to pay \$10 more each month, would you continue to stay enrolled?

- 1 YES
- 0 NO
- d DON'T KNOW
- r REFUSED

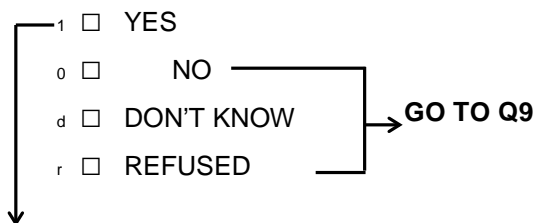
Q6a. What about \$5 more? Would you continue to stay enrolled if HIP required you to pay \$5 each month?

- 1 YES
- 0 NO
- d DON'T KNOW
- r REFUSED

Q7. In the past 12 months, how often were you worried about having enough money to pay your monthly contribution?

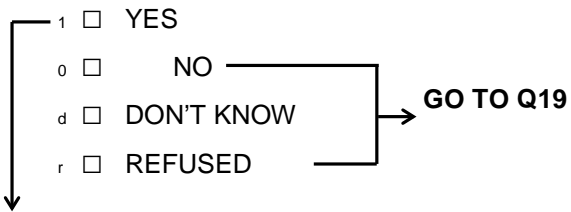
- 1 Always
- 2 Usually
- 3 Sometimes
- 4 Rarely
- 5 Never
- d DON'T KNOW
- r REFUSED

Q8. Has your monthly contribution amount for HIP ever gone down?

- 1 YES
 - 0 NO
 - d DON'T KNOW
 - r REFUSED
- GO TO Q9
- 

POWER ACCOUNTS

Q11. Have you heard of the Healthy Indiana Plan POWER account, which stands for Personal Wellness and Responsibility Account?

- YES
 NO
 DON'T KNOW
 REFUSED
- GO TO Q19
- 

Q12. How did you hear or learn about the POWER account? (MARK ALL THAT APPLY)

- Member handbook
 Someone from the plan called and explained it to you
 HIP website
 Your health plan
 Your doctor or health care professional
 Family/friends
 NONE OF THESE
 DON'T KNOW
 REFUSED

Q13. How often do you check the balance in your POWER account? Would you say ...

- Weekly
 A few times a month
 Monthly
 A few times a year but not every month
 Once a year
 Never
 DON'T KNOW
 REFUSED

Q14. What is the balance in your POWER account at this time? Your best estimate is fine.

\$ |_|, |_|_|_|. |_|_|

- DON'T KNOW
 REFUSED

Q15. If you were to get preventive services such as annual exams, do you think the cost would be deducted from your POWER account, if you have enough money available in the account?

- 1 YES
- 0 NO
- d DON'T KNOW
- r REFUSED

Q16. If you were to get preventive services, such as a cancer screening, do you think the cost would be deducted from your POWER account, if you have enough money available in the account?

- 1 YES
- 0 NO
- d DON'T KNOW
- r REFUSED

Q17. When you last renewed your HIP coverage, did you have any funds left in your POWER account?

- 1 YES
- 0 NO
- d DON'T KNOW
- r REFUSED

Q18. Have you ever had any of your POWER account funds roll over to the next year?

- 1 YES
 - 0 NO → GO TO Q18d
 - d DON'T KNOW → GO TO Q19
 - r REFUSED → GO TO Q19
-

Q18a. Did this rollover affect the size of your monthly contributions afterwards?

- 1 YES
 - 0 NO → GO TO Q18c
 - d DON'T KNOW → GO TO Q18c
 - r REFUSED → GO TO Q18c
-

Q18b. Did your monthly contributions ...

- 1 Go down
- 2 go up
- 3 did you not have to pay any monthly contributions
- d DON'T KNOW
- r REFUSED

Q18c. Did this rollover make you more or less likely to get preventive care like a routine checkup or physical exam?

- 1 MORE LIKELY
 - 2 LESS LIKELY
 - 3 NO IMPACT
 - d DON'T KNOW
 - r REFUSED
- GO TO Q19

Q18d. When you did not get a rollover, were you more likely or less likely to get preventive care like a routine checkup or physical exam?

- 1 MORE LIKELY TO GET PREVENTATIVE CARE
- 2 LESS LIKELY TO GET PREVENTATIVE CARE
- 3 NO IMPACT
- d DON'T KNOW
- r REFUSED

Q19. Has your health plan given you a HIP membership card?

IF NEEDED: This is a card that can be used to card to access the funds in your POWER account.

- 1 YES
 - 0 NO
 - d DON'T KNOW
 - r REFUSED
- GO TO Q20

Q19a. Have you ever used the card to access the funds in your POWER account?

- 1 YES
- 0 NO
- d DON'T KNOW
- r REFUSED

Q19b. How often do you present the card to a health care provider? Is it...

- 1 Every time you get care, _____
 - 2 Some of the time, _____
 - 3 Only for specific services, or
 - 4 Never?
 - d DON'T KNOW
 - r REFUSED
- GO TO Q20
- GO TO Q20

Q19c. For what kinds of services do you present the card to a health care provider?

MARK ALL THAT APPLY

- 1 TO SEE A DOCTOR
- 2 TO USE A CLINIC
- 3 FOR PRESCRIPTION DRUGS
- 4 TO GO TO THE HOSPITAL OR ER
- 5 FOR MENTAL HEALTH CARE / TO SEE A THERAPIST OR COUNSELOR
- 6 OTHER REASON - (Specify) _____
- 7 TO SEE A NEW DOCTOR
- 8 TO SEE A SPECIALIST
- 9 FOR TESTS OR LAB WORK
- d DON'T KNOW
- r REFUSED

Q20. In general, would you say that your health now is:

- 1 Excellent,
- 2 Very good,
- 3 Good,
- 4 Fair, or
- 5 Poor?
- d DON'T KNOW
- r REFUSED

Q21. In general, would you say that your mental health now is:

- 1 Excellent,
- 2 Very good,
- 3 Good,
- 4 Fair, or
- 5 Poor?
- d DON'T KNOW
- r REFUSED

Q22. About how long has it been since you last visited a doctor for a routine check up? A routine checkup is a general physical exam, not an exam for a specific injury, illness, or condition. Was it...

- 1 Within the past 3 months, →GO TO Q23
- 2 Within the past year, →GO TO Q23
- 3 Within the past 2 years,
- 4 Within the past 5 years
- 5 5 or more years ago
- d DON'T KNOW →GO TO Q23
- r REFUSED →GO TO Q23

Q22a. Why haven't you visited a doctor for a routine check up in the last 12 months?

MARK ALL THAT APPLY

- 1 COST TOO MUCH
- 2 COULDN'T GET CHILDCARE
- 3 COULDN'T GET TIME OFF FROM WORK
- 4 COULDN'T GET THROUGH ON THE PHONE
- 5 COULDN'T SCHEDULE APPOINTMENT SOON ENOUGH
- 6 DIDN'T GET APPROVAL FROM PLAN
- 7 DIDN'T HAVE TIME
- 8 DIDN'T WANT TO GO
- 9 HOURS OF OPERATION WERE NOT CONVENIENT FOR ME
- 10 NO INSURANCE
- 11 PLACE DID NOT ACCEPT THE INSURANCE COVERAGE
- 12 TAKES TOO LONG TO GET THERE/ TRANSPORTATION PROBLEM
- 13 TOO SICK TO GO
- 14 OTHER REASON, NOT LISTED ABOVE
(Specify) _____
- 15 FELT IT WAS UNNECESSARY
- 16 GET REGULAR TREATMENT FOR OTHER MEDICAL CONDITION(S)
- 17 HAVE AN UPCOMING APPOINTMENT
- 18 COULD NOT FIND A DOCTOR I LIKED/LOOKING FOR NEW DOCTOR
- d DON'T KNOW
- r REFUSED

Q23. Are there any health-related preventative care services your health plan wants you to get?

- 1 YES
 - 0 NO
 - d DON'T KNOW
 - r REFUSED
- GO TO Q23f

Q23a. Which preventative care services do they want you to get?

MARK ALL THAT APPLY

- 1 Blood Glucose Screen
- 2 Cholesterol Screen
- 3 Flu Shot
- 4 Mammogram
- 5 Pap Test / PAP Smear
- 6 Physical Exam / Routine Check-up
- 7 Sigmoidoscopy and Colonoscopy
- 8 Tetnus shot
- 9 Test for Chlamydia
- 10 OTHER SERVICE - NOT LISTED ABOVE (*Specify*) _____
- 11 VISION CARE, EYE EXAM, OR VISION-RELATED SERVICES
- d DON'T KNOW
- r REFUSED

Q23b. Has your health plan contacted you to encourage you to get these services? This includes any personalized contact such as a letter, phone call, or email.

- 1 YES
- 0 NO
- d DON'T KNOW
- r REFUSED

Q23c. Have you gotten any of these services since the last time you renewed your eligibility for HIP?

- 1 YES → GO TO Q24
 - 0 NO
 - d DON'T KNOW
 - r REFUSED
- GO TO Q24

Q23d. Do you plan to get these services before you renew your eligibility for HIP?

- 1 YES → GO TO Q24
 - 0 NO
 - d DON'T KNOW
 - r REFUSED
- GO TO Q24

Q23e. Why not? (MARK ALL THAT APPLY)

- 1 COST TOO MUCH
 - 2 CHILDCARE ISSUES
 - 3 CAN'T GET TIME OFF FROM WORK
 - 4 DON'T HAVE TIME
 - 5 DON'T WANT TO GO
 - 6 NO INSURANCE
 - 7 PLACE I WANT TO GO WILL NOT ACCEPT THE INSURANCE COVERAGE
 - 8 TAKES TOO LONG TO GET THERE OR TRANSPORTATION PROBLEM
 - 9 TOO SICK TO GO
 - 10 OTHER REASON, NOT LISTED ABOVE -(SPECIFY)
 - 11 FELT IT WAS UNNECESSARY
 - 12 COULD NOT FIND A DOCTOR I LIKED
 - d DON'T KNOW
 - r REFUSED
- GO TO Q24

Q23f. Has your health plan contacted you to encourage you to get any services? This includes any personalized contact such as a letter, phone call, or email.

- 1 YES
 - 0 NO
 - d DON'T KNOW
 - r REFUSED
- GO TO Q24

Q23g. Which services does your health plan want you to get? (MARK ALL THAT APPLY)

- 1 Blood Glucose Screen
 - 2 Cholesterol Screen
 - 3 Flu Shot
 - 4 Mammogram
 - 5 Pap Test / Pap Smear
 - 6 Physical Exam / Routine Check-up
 - 7 Sigmoidoscopy and Colonoscopy
 - 8 Tetnus Shot
 - 9 Test for Chlamydia
 - 10 OTHER SERVICE - NOT LISTED ABOVE (*Specify*) _____
 - 11 **VISION CARE OR VISION-RELATED SERVICES**
 - d DON'T KNOW
 - r REFUSED
- GO TO Q24**

Q23h. Have you gotten these services since the last time you renewed your eligibility for HIP?

- 1 YES → **GO TO Q24**
 - 0 NO
 - d DON'T KNOW
 - r REFUSED
- ↓

Q23i. Do you plan to get these services before you need to renew your eligibility for HIP?

- 1 YES → **GO TO Q24**
 - 0 NO
 - d DON'T KNOW
 - r REFUSED
- GO TO Q24**
- ↓

Q23j. Why not? (MARK ALL THAT APPLY)

- 1 COST TOO MUCH
- 2 CHILDCARE ISSUES
- 3 CAN'T GET TIME OFF FROM WORK
- 4 DON'T HAVE TIME
- 5 DON'T WANT TO GO
- 6 NO INSURANCE
- 7 PLACE I WANT TO GO WILL NOT ACCEPT THE INSURANCE COVERAGE
- 8 TAKES TOO LONG TO GET THERE OR TRANSPORTATION PROBLEM
- 9 TOO SICK TO GO
- 10 OTHER REASON, NOT LISTED ABOVE -(SPECIFY) _____
- 11 FELT IT WAS UNNECESSARY
- 12 COULD NOT FIND A DOCTOR I LIKED
- d DON'T KNOW
- r REFUSED

Q24. Thinking about the services we just discussed, how will getting these services affect your POWER account rollover, if you have money to rollover to the next year?

Which of the following statements best describes your answer?

- 1 If I get these services, I'll be eligible for a rollover - the funds in my POWER account will rollover to the next year
- 2 I am not sure how they affect my POWER account rollover
- 3 I don't think getting these services affects my POWER account rollover
- 4 I DON'T HAVE A POWER ACCOUNT / HAVE NEVER HEARD OF A POWER ACCOUNT
- d DON'T KNOW
- r REFUSED

Q25. During the past six months, was there any time that you needed to see a doctor or other health care professional for care but did not go?

- 1 YES
 - 0 NO
 - d DON'T KNOW
 - r REFUSED
- GO TO Q26
-

Q25a. What was the main reason you did not see a doctor or other health care professional during the past six months? MARK ONLY ONE

- 1 COST TOO MUCH
- 2 COULDN'T GET CHILDCARE OR TIME OFF FROM WORK
- 3 COULDN'T GET THROUGH ON THE PHONE
- 4 COULDN'T SCHEDULE APPOINTMENT SOON ENOUGH
- 5 DIDN'T GET APPROVAL FROM MY HEALTH PLAN
- 6 DIDN'T HAVE TIME; DIDN'T WANT TO GO
- 7 HOURS OF OPERATION WERE NOT CONVENIENT FOR ME
- 8 PLACE DID NOT ACCEPT THE INSURANCE COVERAGE
- 9 TAKES TOO LONG TO GET THERE OR HAD A TRANSPORTATION PROBLEM
- 10 OTHER REASON, NOT LISTED ABOVE
- d DON'T KNOW
- r REFUSED

Next we'll talk about use of emergency room services.

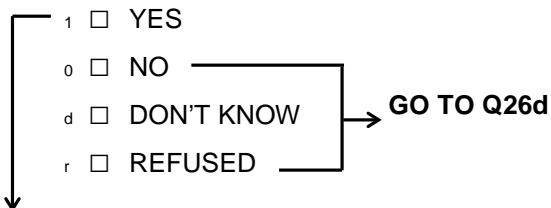
Q26. The Healthy Indiana Plan has a copayment for emergency room visits that do not result in an admission to the hospital. This copayment ranges from \$3 to \$6 to \$25 depending on your circumstances. Has your health plan told you about this copayment?

- 1 YES
- 0 NO
- d DON'T KNOW
- r REFUSED

Q26a. Has the emergency room copayment ever caused you to wait to get care from a doctor's office or clinic instead of going to the emergency room?

- 1 YES
- 0 NO
- d DON'T KNOW
- r REFUSED

Q26b. Has the emergency room visit copayment ever caused you to decide not to go to the emergency room?

- 1 YES
 - 0 NO
 - d DON'T KNOW
 - r REFUSED
- GO TO Q26d
- 

Q26c. Did you get care someplace else or did you not get care?

- 1 GOT CARE SOMEPLACE ELSE
- 0 DID NOT GET CARE
- d DON'T KNOW
- r REFUSED

Q26d. What do you think of a \$25 copayment for an emergency room visit? Would it be ...

- 1 Way too much
- 2 A little too much
- 3 The right amount
- 4 Below the right amount
- 5 Way below the right amount
- d DON'T KNOW
- r REFUSED

Q27. In the past six months, about how many trips did you make to an emergency room for your own care? Do not include any trips for other members of your household.

|_|_| TRIPS

- d DON'T KNOW
 - r REFUSED
- GO TO Q28

IF ER TRIPS WERE TAKEN, GO TO Q27a. IF NO TRIPS TAKEN, GO TO Q28

Q27a. In the past six months, was there any time when you contacted a doctor's office or clinic, but couldn't get an appointment soon enough so you went to the emergency room instead?

- 1 YES
- 0 NO
- d DON'T KNOW
- r REFUSED

Q27b. In the past 6 months, how many times were you admitted to the hospital after going to the emergency room?

|_|_| ADMISSIONS

- d DON'T KNOW
- r REFUSED

Q27c. Of the times you went to the emergency room and were not admitted to the hospital, were you asked to pay a copayment for the emergency room visit?

- 1 YES – WAS ASKED TO PAY A COPAYMENT EVERY TIME
- 2 YES – WAS SOMETIMES ASKED TO PAY A COPAYMENT
- 3 I WAS ADMITTED TO THE HOSPITAL EVERY TIME I WENT TO THE ER → **GO TO Q28**
- 4 NO - NEVER ASKED TO PAY A COPAYMENT → **GO TO Q28**
- d DON'T KNOW → **GO TO Q28**
- r REFUSED → **GO TO Q28**

Q27d. Were you able to pay it?

- 1 YES
- 0 NO
- d DON'T KNOW
- r REFUSED

SATISFACTION WITH HIP

The next set of questions will ask about your satisfaction with the Healthy Indiana Plan.

Q28. Thinking about your overall experience with the Healthy Indiana Plan so far, would you say you are:

- 1 Very satisfied,
- 2 Somewhat satisfied,
- 3 Neither satisfied nor dissatisfied,
- 4 Somewhat dissatisfied, or
- 5 Very dissatisfied?
- d DON'T KNOW → **GO TO Q29**
- r REFUSED → **GO TO Q29**

Q28a. Why are you dissatisfied? MARK ALL THAT APPLY

- 1 CAN'T SEE MY DOCTOR WITH HIP
- 2 DISSATISFACTION WITH CHOICE OF DOCTOR'S IN HIP
- 3 HIP DOES NOT COVER DENTAL
- 4 HIP DOES NOT COVER VISION/OPTICAL
- 5 HIP DOES NOT COVER PROCEDURE/ MEDICATION
- 6 MANY DOCTORS DO NOT ACCEPT HIP
- 7 DISSATISFIED WITH ADMINISTRATIVE ISSUE(S) OR PROCESS
- 8 DISSATISFACTION WITH A PAYMENT RELATED ISSUE
- 9 OTHER REASON NOT LISTED ABOVE: (*SPECIFY*)

-
- d DON'T KNOW

r REFUSED

Q29. If you ever left HIP, would you try to reenroll if you became eligible for the program again?

1 YES

0 NO

d DON'T KNOW

r REFUSED

DEMOGRAPHICS

The last few questions are about you and your household in general.

IF NEEDED: This information will help us compare the opinions and experiences of different groups of people who take part in this survey.

Q30. What is the highest grade or year of school you have completed?

1 NO FORMAL EDUCATION

2 GRADES 1-8 (ELEMENTARY)

3 GRADES 9-11 (SOME HIGH SCHOOL)

4 GRADE 12 OR GED (HIGH SCHOOL GRADUATE)

5 COLLEGE 1-3 YEARS (SOME COLLEGE)

6 COLLEGE 4 YEARS OR MORE (COLLEGE GRADUATE)

d DON'T KNOW

r REFUSED

Q31. Are you Hispanic or Latino?

1 YES

0 NO

d DON'T KNOW

r REFUSED

Q32. Which one or more of the following would you say is your race?

MARK ALL THAT APPLY

1 American Indian or Alaska Native

2 Asian

3 Black or African American

4 Native Hawaiian or

Other Pacific Islander

5 White

d DON'T KNOW

r REFUSED

Q33. Are you currently:

MARK ALL THAT APPLY

- 1 Employed for wages
- 2 Self-employed
- 3 Out of work more than 1 year
- 4 Out of work less than 1 year
- 5 A homemaker
- 6 Taking care of an elderly parent or a family member with a disability → **GO TO Q35**
- 7 A student
- 8 Retired
- 9 Unable to work because of a physical or mental health condition
- d DON'T KNOW
- r REFUSED

Q34. Were you aware that employers are allowed to help pay your monthly contribution to HIP?

- 1 YES
- 0 NO
- d DON'T KNOW → **GO TO Q35**
- r REFUSED

Q34a. Have you asked your employer to help pay part of your monthly contribution?

- 1 YES
- 0 NO → **GO TO Q34b**
- d DON'T KNOW → **GO TO Q35**
- r REFUSED → **GO TO Q35**

Q34a1. What was your employer's response?

- 1 EMPLOYER AGREED TO PAY ALL OF IT
- 2 EMPLOYER AGREED TO PAY PART OF IT
- 3 EMPLOYER DID NOT AGREE TO CONTRIBUTE → **GO TO Q35**
- 4 EMPLOYER STILL DECIDING
- 5 OTHER RESPONSE - (SPECIFY): _____ → **GO TO Q35**
- d DON'T KNOW → **GO TO Q35**
- r REFUSED → **GO TO Q35**

Q34b. Why have you not asked your employer to help pay the monthly HIP contribution?

MARK ALL THAT APPLY

- 1 DIDN'T KNOW WHO TO ASK
 - 2 AFRAID OF LOSING MY JOB / ASKING MAY JEOPARDIZE MY JOB
 - 3 CONFIDENT MY EMPLOYER WOULD SAY NO
 - 4 DIDN'T WANT EMPLOYER TO KNOW I AM ON HIP
 - 5 FELT LIKE I WAS ASKING FOR A FAVOR
 - 6 OTHER REASON, NOT LISTED ABOVE: (SPECIFY)
-
- 7 DIDN'T THINK TO ASK EMPLOYER
 - 8 DO NOT NEED/WANT EMPLOYER'S HELP WITH MONTHLY CONTRIBUTION
 - 9 CONCERNS OVER FINANCIAL STABILITY OF EMPLOYER / BURDEN CONTRIBUTION WOULD POSE TO EMPLOYER
 - d DON'T KNOW
 - r REFUSED

Q35. Are you limited in the type or amount of work you can do because of a physical or mental health condition?

- 1 YES
- 0 NO
- d DON'T KNOW
- r REFUSED

Q36. Have you applied for either SSI (otherwise known as Supplemental Security Income) or SSDI (otherwise known as Social Security Disability Insurance) benefits within the past 12 months?

- 1 YES
- 0 NO
- d DON'T KNOW
- r REFUSED

Q37. Are you currently receiving SSI, otherwise known as Supplemental Security Income?

- 1 YES
- 0 NO
- d DON'T KNOW
- r REFUSED

Q38. Are you currently receiving SSDI, otherwise known as Social Security Disability Insurance?

- 1 YES
- 0 NO
- d DON'T KNOW
- r REFUSED

Q39. What is your marital status? Are you currently ...

- 1 Married,
- 2 Divorced,
- 3 Widowed,
- 4 Separated, or have you
- 5 Never married?
- d DON'T KNOW
- r REFUSED

Q40. Do you have a spouse or partner living with you?

- 1 YES
 - 0 NO
 - d DON'T KNOW
 - r REFUSED
- GO TO Q41

Q40a. Is your spouse or partner:

MARK ALL THAT APPLY

- 1 Employed for wages
- 2 Self-employed
- 3 Out of work more than 1 year
- 4 Out of work less than 1 year
- 5 A homemaker
- 6 Taking care of an elderly parent or a family member with a disability
- 7 A student
- 8 Retired
- 9 Unable to work because of a physical or mental health condition
- d DON'T KNOW
- r REFUSED

Q41. About how long have you lived in Indiana?

IF MOVED BACK AND FORTH, PROBE:

Please think about the most recent time you returned to Indiana.

|__|__| YEARS OR # |__|__| MONTHS

d DON'T KNOW

r REFUSED

Those are all the questions in the survey. I'd like to confirm the spelling of your name and your mailing address so we can send you your payment to thank you for taking part in this survey.

**INTERVIEWER:
CONFIRM/UPDATE DATA.**

Thank you for completing this survey. We appreciate your time and your help in better understanding the experiences of people across Indiana. You should receive your check within four to six weeks.

If you have any questions about the Healthy Indiana Plan, please call 1-877-GET-HIP9. Thank you and have a good (day/night).