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To: Joseph Moser, Medicaid Director
Indiana Family and Social Services Administration

From: David Hanig, Project Director
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Subject: Response to Recent Communications from CMS (10/29/15) and Mathematica Policy Research (10/27/15)

The Lewin Group is a premier national health and human services consulting firm with 45 years of experience delivering objective analyses and strategic counsel to state and federal agencies, non-profit organizations, and private companies across the United States. Among other research areas, evaluations are an area of expertise for the Lewin Group; we pride ourselves on having a refined evaluation approach, which takes into consideration flexibility, participation, diversity, timeliness/relevance and capacity building. Lewin has supported both state and federal agencies in evaluating innovative health care programs and we are pleased to be working with the State of Indiana on the Indiana HIP 2.0 evaluation.

We are delighted to bring a very strong team to this effort, including several of Lewin's experts on quantitative and qualitative research. We are working closely with Brian Simonson, MS, our lead statistician, and Cindy Gruman, PhD and Jessica Steier, DrPH, both experts in survey research and other qualitative methods. They have been integral in establishing our survey approach and survey tools and in reviewing and responding to subsequent feedback from the Centers for Medicare and Medicaid Services (CMS) and their partner for this engagement, Mathematica Policy Research (MPR).

Lewin has prepared this memorandum in response to recent feedback from MPR and CMS, received on October 29, 2015. In addition to responding to this feedback, we have outlined how this feedback, and the time we are using to respond to it, is impacting Indiana's self-evaluation more generally. We hope that the information we have provided below will illustrate our concerns. If you have any additional questions, please do not hesitate to get in touch.

Revisions and Impacts

The State first submitted the draft surveys for the HIP 2.0 evaluation to CMS on September 1, 2015. Since that time, CMS has provided ongoing recommendations for changes to the HIP 2.0 surveys, in addition to the evaluation plan, through both conference calls and written communications.

Lewin has worked with Indiana to incorporate this feedback into their self-evaluation, while simultaneously working to stay on track with other requirements outlined in the Standard

Terms and Conditions (STC). As it relates to changes to the surveys, the State has agreed to make a total of 74 changes to the wording, format and answers choices within of the surveys, and has added a total of 43 new questions to surveys, including separating the member survey into two separate surveys for members enrolled in HIP Plus and HIP Basic. The following table details the number of changes made in each survey.

Table 1. Number of Changes Made to HIP 2.0 Surveys, in Response to Recommendations from CMS

Survey Type	Number of Changes Requested by CMS	Number of Changes Made by State	Percent of Changes Made by State
Provider	14	13	93%
Member	26	22	85%
Previous Member	23	21	91%
Non-Member	19	18	95%
Total	**82**	**74**	**90%**

In addition to separating the member survey into two separate surveys for HIP Plus and HIP Basic members, the State also agreed to divide the non-member survey into two separate surveys, including one survey for Presumptive Eligibility (PE) members who did not complete a full application, and one survey for members with household income over 100% FPL who did not make an initial POWER Account Contribution (PAC).

Due to this ongoing work, CMS extended the due date of the report on Non-Emergency Medical Transportation (NEMT) from November 1, 2015 to January 1, 2016. This extension of the NEMT report does not account for the fact that, as of the date of this memo, the surveys are not yet approved. Furthermore, the extension fails to address broader implications from failing to start in September as planned. More specifically, the call-center with which Lewin is subcontracting has remained "on hold" and ready to start the surveys as soon as they are approved; however, with the holiday season approaching, serious complications arise. First, the call-center will lose at least two weeks of time to conduct surveys surrounding the Thanksgiving and Christmas holidays. Second, because telephone surveys are rarely conducted between Thanksgiving and the end of the calendar year, many call center staff will be unavailable (due to annual planned vacations), so the call center will have fewer staff to conduct the surveys, which will extend the amount of time required to complete them.

Given these factors, the report cannot be delivered by January 1, 2016. Lewin estimates that it can deliver the NEMT report to Indiana by February 3, 2016, in preparation for delivery to CMS by February 29, 2016. The timeline for the submission of the NEMT report to CMS is detailed in Table 2.

Table 2. Timeline for Submission of NEMT Report to CMS.

Estimated Date	Task	Days to Complete
11/15/15	Surveys Approved	N/A
11/20/15	Lewin Reprograms Survey	5 days
11/21/15	Call Center Conducts Surveys	45 days
1/6/15	Lewin Conducts Survey Analysis	15 days
1/20/16	Lewin Drafts NEMT Report	15 days
2/3/16	The State Works with Lewin to Finalize NEMT Report	27 days
02/29/16	The State Submits NEMT Report to CMS	N/A

In the remainder of this memo, we provide responses to the most recent feedback from CMS and MPR received by Indiana. Below, please find:

1. Technical Response to MPR Memorandum, dated 10/27/15
2. Response to Recommendations from CMS (10/29/15) and MPR (10/27/15)

I. Technical Response to MPR Memorandum, dated 10/27/15

Two basic themes emerge from the comments that ultimately rely on some level of subjective value judgement. First, MPR recommends a level of detectible difference that is beyond what is policy relevant and, more importantly, not cost-effective. That is, the improved detectable differences are marginal considering the large increase in required sample sizes for MPR recommendations. Second, although a greater number of responses always allows for greater ability to stratify results into smaller cells, this is only needed to the degree that stratification can help to address relevant policy questions. The combination of additional stratification and detectible difference leads to large sample size requirements. Third, many comments presume one will compare populations with and without access to NEMT. These two populations are by definition different and a comparison, even with robust statistical adjustment, is fundamentally "apples to oranges" and not recommended or contained in our Survey Analysis Plan.

Section A: Sample Sizes and Power Calculations

1. Power calculation for descriptive statistics analyzing difference in two means

A key discussion point for this and other issues is whether the comparison between the NEMT and non-NEMT group is a comparison of interest. As described previously in a memorandum to CMS dated October 6, 2015, the NEMT waiver for non-emergency medical transportation does not apply to certain populations, including low-income parents and caretakers, Transitional Medical Assistance, persons who are medically frail, and pregnant women, all of whom historically have more complex needs – due to poorer health status and lower income – than the general HIP 2.0 population.[1] These populations are very different in nature than other HIP-eligible populations; and policy-driven questions for this study do not naturally lead to comparing across these two sub-groups.

However, if the study were to analyze the NEMT and non-NEMT sub-groups within the HIP Member group, then Lewin agrees in principle with the sample sizes set forth in in Table 1 of MPR's response (excerpted below). Lewin presented similar sample sizes, which are shown in Table 2 below. It is noteworthy to observe the sample sizes in Table 2, where the assumed rate is 50%. When there is little prior knowledge of the observed proportion, researchers might utilize this null proportion because it requires the greatest possible sample size for a given detectable difference. However, Lewin has strongly advocated that an assumed proportion of .10 is more appropriate given the context of this study.

Table 1 From MPR Memorandum on 10/27/15

Table 1: Sample sizes needed for an unadjusted comparison between groups with and without NEMT

Mean of indicator, respondents with NEMT benefit	Mean of indicator, respondents in NEMT waiver group	Estimated sample size needed to detect this difference
0.05	0.08	1,700
0.05	0.10	600
0.05	0.12	310
0.10	0.13	3,200
0.10	0.15	1,150
0.10	0.17	575

Note: Calculations assume a 95% confidence interval and 80% power to detect differences between two groups. These estimates also assume that respondents in each group have an equal probability of being sampled. However, the sampling frame is not equally balanced; 54 percent do not have the NEMT benefit and 46 percent do have the NEMT benefit.

Table 2. Required Sample Sizes (Treatment and Control) by Observed Treatment Group Rates and Detectable Differences[2]

	Detectable Difference			
Null Proportion (Treatment Group)	**0.03**	**0.05**	**0.1**	**0.15**
0.9	3,009	866	70	N/A
0.6	10,067	3,555	835	340
0.5	10,703	3,833	935	398
0.4	10,479	3,802	958	422
0.1	4,658	1,855	564	289

As discussed above, creating sample sizes tailored to evaluating an observed proportion of .10 is much more practical than proportions of .5. Under this assumption, Table 1 suggests the current design is constructed to evaluate a detectable difference of 7 percentage points. We believe that measuring a detectable difference less than this is not meaningful from a policy perspective. Hence, we believe a 7 percentage point detectable difference is an appropriate specification. The importance of this issue is best described through an example:

> **Example:** 10% of the member group reports having trouble accessing care, while 13% of the never member group reports trouble accessing care. Lewin agrees that the proposed design cannot conclude this difference is real. However, is the difference between not accessing care 10% or 13% an important finding? Are there policy ramifications for such a slight difference in

[2] Assumptions for sample size calculations: Type I error .05 (one tail), Type II error of .20 (power=.80), treatment group is larger group with the observed null proportion; the control group observes a higher proportion; and an allocation ratio of 4 to 1 for treatment to control responses.

barriers to care? We contend the value of such findings are minimal, especially in light of the MPR calculations that the sample size must increase over 550%, from 575 to 3,200 responses.

Hence, if costs were not an issue, more narrow detectable differences would always be preferred. The key issue is determining the marginal improvement gained through increased sample sizes. Table 1 from MPR's response illustrates that decreasing the detectable difference by 2 percentage points would require a 100 percent increase in the sample size. This does not appear beneficial from a cost-benefit perspective.

In this section, we have focused on the more rational assumption that the observed proportion would be .10. However, in discussions with MPR, their initial work was focused on the worst case scenario of an observed proportion of .5. We believe it is important to understand the ramifications if such a high rate were observed. Note our analysis focuses on the comparison of the member and never member groups, as opposed to NEMT versus non-NEMT. With sample sizes of 550 and 137 for the member and never member group, respectively, the detectable difference would be 11.6 percentage points.[3] While we would concur that, given the strictest set of assumptions used by MPR, the recommended sample sizes would not attain detectable differences of 10 percentage points, we don't believe that an 11.6 percentage point detectable difference falls far from this this standard.

In fact, in order to meet the 10 percentage point precision requirement suggested by MPR, the total sample size would need to be 937 responses (750 members, 187 never members), or a 36% increase in the overall sample size of the study. Increasing the sample size almost 36% so as to reduce the detectable difference from 11.6 to 10.0 percentage points would not be efficient from a cost-benefit perspective. We assume in these calculations an allocation ratio of 4:1.[4]

This discussion provides a basis theme Lewin utilizes for sampling design. While obtaining detectable differences of 3 percentage points when observing a .10 proportion would be preferable if sampling were relatively free, the cost of obtaining these detectable differences compared to a policy driven detectable difference of, say 7 percentage points, seems excessive. Similarly, when assuming a .5 proportion, Lewin's design would obtain 11.6 percentage point detectable differences between the member and never member groups, and would require a 36% increase in sample size. In both

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[3] Note the sample of 137 in the never group is greater than the 125 listed in the statistical analysis plan. This is due to using a 4 to 1 allocation ratio of treatment group to never group responses. The allocation ratio is the ratio of treatment group responses over control group responses. For purposes of discussing differences of other major parameters affecting sample size estimation, we have set the allocation ratio equal to 4, as Lewin believes this to be the ratio utilized by MPR. MPR sample size recommendations are anchored from the treatment group size of 750; hence all of Lewin's comparisons follow the same method. Note if we assume a slightly higher response rate for the never group, then the reported detectable differences would be realized.

[4] Note that sample sizes are highly sensitive to the specification of the allocation ratio. The ratio of members to the never sample was determined to be 4.4 in the statistical analysis plan. This slight difference would, for example, increase MPR's recommended sample size from 937 to 991, assuming a .10 detectable difference. Similarly, precision for Lewin's proposed sampling design would widen the detectable difference to 12%. The net effect would be a 50% increase in the sample size in order to narrow the detectable differences by 2 percentage points. Given the elastic nature of allocation ratio on sample size requirements, we recommend considering the impact of observing a ratio closer to those outlined in the statistical analysis plan.

situations, the required increase in sample sizes provides relatively marginal improvements in detectable differences.

2. Power calculation for hypothesis testing in a regression framework

Lewin does not contend with MPR's computed sample size. Lewin again would stress that (1) MPR focus on NEMT/non-NEMT analysis which, as described in Section A1 above, Lewin does not consider comparable, and (2) MPR's choice of .03 or .05 detectable differences would not yield more meaningful conclusions from a policy standpoint than Lewin's proposed sample sizes.

Section B: HIP 2.0 Analysis Plans

1. Hypothesis 1. HIP will reduce the number of uninsured Indiana residents with income under 138% FPL over the course of the demonstration

Comments in this section center around further need for greater sample sizes for the leaver sample in order to measure effects for different reasons for entering the leaver group. If so, then clearly sample sizes would need to be increased to levels to identify such effects. However, any analysis of the subpopulation of the leaver group was not intended to allow for such detailed statistical precision. While the ability to drill down a sample is always preferred, the costs of such design must be weighed with the benefits of the reporting outcomes. Lewin did not believe the focus of the study was on these specific sub-populations, and hence did not recommend expending resources in this area.

2. Hypotheses 2 and 3. HIP will increase access to health care services among the target population and the POWER account contributions do not create a barrier to health care access

Comments in this section are concerned with the use of a simple random sample, which, if sample sizes are too small, would allow for a distribution that is skewed in key dimensions compared to the universe. However, the first sample of the member survey is a sample of 11,000 cases, and hence the distribution of NEMT/non-NEMT and HIP Basic/HIP plus will certainly mimic universe proportions reasonably well. An area of concern might arise during the phase of obtaining responses from this 11,000 sample. If certain subgroups were to respond at much higher rates than others (e.g. HIP Plus versus HIP Basic), then indeed the final sample would be skewed. Therefore, the process constructed will ensure that combinations of HIP Plus/HIP Basic and NEMT/non-NEMT will be filled so that they correctly represent the universe of the HIP population. Hence, in most forms, this sample is stratified in the sense the study enters into the sampling phase with a predetermined number of responses for each "bucket" of HIP and NEMT classification.

Further Issues for Discussion

Differences between the member group and another group (e.g. the "never member" group) are not required for all major hypotheses.

It is worth noting that many hypotheses in the survey analysis plan do not entail comparison of the member group to another group. For example, as described previously in a memo to CMS dated October 6, 2015, we do not plan to compare members to non-members to address Hypothesis 5: Waiver of non-emergency transportation to the non-pregnant and non-medically frail population does not pose a barrier to accessing care. Instead, we will use a series of descriptive analyses and logistic regressions to analyze the survey data and examine differences in members reporting challenges keeping appointments by characteristics such as region and income level. Therefore, the use of the term

"detectable difference," which often denotes the difference between two groups, does not always apply to our survey analysis.

However, even though many research analyses do not have a comparison group, detectable differences are more generally considered the detection of an estimate being different than an alternative hypothesis. That is, all hypothesis tests have an inherent power, or conversely a probability of incorrectly concluding the true effect lies within a stated confidence interval when, in fact, it does not. This is also referred to as a type II error. While Lewin did not state the detectable differences explicitly in the survey analysis plan, its specification is simple enough. Lewin stated that for 125 cases, assuming the observed proportion of .1, then 95% confidence levels would lead to precision of approximately 5 percentage points. The detectable difference for this estimate, assuming .80 power, would be 7.5 percentage points. For policy related effects, this level of detectable difference appears quite reasonable. Effects smaller than 7.5 percentage points could be considered clinically insignificant. For example, even if the study were designed to have detectable difference of 3 percentage points, such a small difference is not considered a large effect in terms of policy ramifications. Further, this raises a cost benefit issue.

Summary of Sampling Design Expected Sample Sizes

Table 3. Summary of Member, Never Member and Leaver Sample Sizes from Survey Analysis Plan[5]

Survey	Detail		Total Number of Members	Members Selected into Sample	Target Completed Responses
Member	Includes all HIP Basic and HIP Plus enrollees. Also encompasses two large sub-populations: i) ~145,000 persons who do not have NEMT coverage ii) ~8,000 persons below 100% FPL who moved to HIP Basic	**Plan Selection - Total**	**266,435**	**11,000**	**550**
		HIP Plus	185,184	7,637	385
		HIP Basic	81,251	3,363	165
		Transportation Coverage - Total	**266,435**	**11,000**	**550**
		Non-Emergency Medical Transportation (NEMT)	124,083	5,192	260
		No NEMT	142,352	5,808	290
Never Member	Includes persons who were: 1) conditionally approved, but did not make PAC in the first month, or 2) presumptively eligible, but did not submit the full application		5,311	2,500	125
Leaver	Includes all persons who exited HIP, by eligibility group (e.g., Basic vs. Plus)		8,754	2,500	125
	Persons >100% FPL who went into lock-out		899	899	125

[5] Note: Due to a change in the meaning of an indicator used to generate these counts, some of these numbers may not sum correctly. We generated the master sample using random sampling methods, so members will be represented in the sample based on the distribution described here.

Table 4. Summary of Provider Sample Sizes from Survey Analysis Plan[6]

Survey	Detail	Universe Size	Sample Size	Target Completed Responses
Provider	FQHCs	42	42	40
	Hospitals requested to be sampled	3	3	3
	Random Sample	48,361	1,705	1,619

[6] Lewin achieved a 97% response rate for the provider survey administered as part of the Maine SIM evaluation. While the actual response rate will depend on the level of engagement of Indiana providers and the vigor of outreach efforts, we are assuming a 95% response rate for this evaluation.

II. Responses to Recommendations in Letter from CMS (10/29/15) and Memorandum from Mathematica Policy Research (10/27/15)

Table 1. Recommendations from Letter from CMS and Responses from Indiana

Reference	CMS Recommendation	Indiana's Response
Letter from CMS (10/29/15)		
Paragraph 2, Bullet 1	**Identify** and/or clarify the key research questions under each hypothesis to assure that the research questions and the selected metrics address the hypothesized outcomes.	**Confirmed.** Key research questions under each hypothesis are provided in the existing Evaluation Design plan. To help clarify the research questions, the State agreed to outline metrics according to "process" measures and "outcomes" measures in the revised Evaluation Design plan. The State also agreed to revise certain outcome metrics, including outcome metrics concerning presumptive eligibility and fast track payments, to align more closely with the hypotheses.
Paragraph 2, Bullet 1	For each metric the state should provide the following; • A proposed baseline/comparison group, where applicable. If randomization is not used, methods to adjust for non-equivalence of the control and comparison must be proposed; • Data sources, collection frequency, and process for demonstrating accuracy and completeness of the data; • Sampling methodology for selecting the population being included in your analysis; and • Analysis plan that describes the statistical methods that will be employed, and demonstrate how the state will analyze the data.	• The evaluation design does not provide for control groups (this was also the case for the HIP 1.0 evaluation performed by Mathematica) but does make some between group comparisons as appropriate. See the Technical Response, earlier in the document, for details. • Members are randomly selected into the survey sample. Regression is used to account for covariates; but again, there is no control group. • Sources of data will be provided in our analysis. ;Accuracy and completeness of survey responses is under the purview of the professional survey subcontractors conducting the surveys and will be provided. • We have validated the administrative data with FSSA. • *Sampling methodology, statistical methods, and data analysis goals are included in the previously submitted analysis plan.*
Paragraph 2, Bullet 2	Identify which questions and metrics are the key questions needed to assess whether a goal has been achieved.	**Confirmed.** The State has agreed to incorporate this into the revised Evaluation Design plan.

Reference	CMS Recommendation	Indiana's Response
Letter from CMS (10/29/15)		
Paragraph 2, Bullet 3	Consider using a tool such as a logic model or driver diagram to develop a clear understanding of how HIP 2.0 policies are expected to affect program outcomes and help focus the research questions, analytic approaches, and metrics.	**Confirmed.** The report will describe how policies are expected to impact program outcomes and logic and driver diagrams are not needed and are not expected to add value to the analysis, as the program policies were drafted in the HIP 2.0 waiver and are reflected in the STCs. Furthermore, it would require additional resources.
Paragraph 2, Bullet 4	Ensure that the sample size that receives the survey is sufficient enough to gather significant results.	A detailed description of the State's sampling methodology is included in the Technical Response, above.
Paragraph 2, Bullet 5	Include outcome measures and data that would capture unintended, but potential harms to beneficiaries, particularly on services that the state is not required to provide, such as non-emergency medical transportation (NEMT)	Lewin will report rates of adherence to national preventative care measures and ambulatory care sensitive conditions. We do not intend to compare rates between populations because these measures often exhibit unexpected relationships with respect to population acuity and social determinants of health. Risk adjustment of quality measures is beyond the scope of this evaluation. We also do not intend to measure harm, which is typically measured by patient safety measures.
Paragraph 2, Bullet 6	Revise the survey so it can be used to explore key research questions about beneficiary understanding of the program incentives and whether they are engaging in cost-conscious purchasing behaviors or using disease prevention and health promotion services.	**Confirmed.** The State agreed to develop a new set of questions to assess member understanding of program incentives. These questions were included in revised surveys.

Table 2. Recommendations from Memorandum from Mathematica Policy Research (MPR) and Responses from Indiana

Reference	MPR Recommendation	Indiana's Response
Memorandum from Mathematica Policy Research (10/27/15)		
Section A (Page 1)	We developed two different sets of power calculations for the analyses Indiana plans for the survey data. One set is for descriptive statistics when the objective is to conduct a simple comparison of two means that are unadjusted. In this case, a t-	A full description can be found in the Technical Response included at the beginning of this document. In summary, we believe a difference of less than 7 percentage points is not meaningful from a policy perspective and that the 7 percentage

Reference	MPR Recommendation	Indiana's Response
Memorandum from Mathematica Policy Research (10/27/15)		
	test is used to determine whether the two means are statistically significantly different from one another. The second set of power calculations applies when the objective is to test whether the program affected an outcome of interest. In this case, a regression framework is used to control for a range of characteristics that might influence the outcome of interest. Both sets of power calculations suggest that the sample sizes Indiana has proposed (550 for the member survey) will not be adequate to detect differences between groups with statistical significance if the differences are smaller than 7 percentage points.	point difference is an appropriate specification. In addition, to meet the criteria suggested by MPR, we would need to greatly increase the sample size at additional cost, for limited benefit.
Section B-1 (Page 4)	The analysis plan proposes to use only survey data from leavers to determine what type of insurance coverage a former HIP member has at the time of the interview. It appears that the evaluator is proposing a sample of 250 respondents, including 125 who left the program because they failed to make their monthly contributions and became ineligible for the next 6 months and 125 who left the program for other reasons. The plan suggests the evaluator will conduct a descriptive analysis of factors associated with the type of insurance coverage someone has after leaving the program and it does not appear the evaluator is planning to estimate a program effect or impact. The plan notes that most of the analytical work for this hypothesis will rely on data from the American Community Survey. We think this analysis of leavers could be strengthened if the focus was on determining whether those who failed to make their monthly contributions and were ineligible for HIP for 6 months were more likely to be uninsured at the time of the interview compared to those who left the program for other reasons. This approach would assess the effect of a program feature (6-month lockout) and would require the sample sizes presented in Table 2.	Comments in this section center around further need for greater sample sizes for the leaver sample in order to measure effects for different reasons for entering the leaver group. If this were to be the goal of the study, then sample sizes would need to be increased to levels to identify such effects. For more detail, please see the Technical Response included at the beginning of this document.

Reference	MPR Recommendation	Indiana's Response
Memorandum from Mathematica Policy Research (10/27/15)		
	In aiming to complete an equal number of survey responses from each group, the evaluator will need to oversample those subject to the 6-month lockout. Oversampling specific groups means the evaluator will need to develop sampling weights that account for the probability of selection into the sample. These weights should be subsequently used in the analysis so that the overall results of their work can be generalized to the entire population of leavers.	
Section B-2 (Page 4)	The analysis plan indicates the test of this hypothesis will include non-members. It is not clear from the description whether the non-member group will include both leavers and never members.	The non-member population will include both leavers and never members.
Section B-2 (Page 4)	We would recommend including both types of non-members to increase the sample size, but this type of design then also requires that the leaver and never member surveys include the same access to care information as collected by the member surveys.	Never and leaver groups are each evaluated with regard to POWER accounts being a barrier to access.
Section B-2 (Page 4-5)	There is no indication that the sampling plan for the member survey will ensure adequate numbers of HIP Plus and HIP Basic respondents. For example, if there are far fewer HIP Basic members compared to HIP Plus, the simple random sample of all members may produce an extremely small number of HIP Basic members, making it difficult to compare HIP Plus to HIP Basic or the influence of copayment policies. We recommend the evaluator design a stratified random sample to oversample the smaller benefit group because access may differ between HIP Plus and HIP Basic, and it would be important to understand those differences given the different cost sharing requirements and incentives for each group.	This sample is stratified as the study enters into the sampling phase with a predetermined number of responses for each of the buckets of HIP plan participation (i.e., Plus, Basic). For more detail, please see the Technical Response included prior to this table.
Section B-2 (Page 5)	In addition, the health status of the two benefit groups may differ in important ways, particularly if members tend to sort into HIP Plus or HIP Basic by health status. For example, people who have lower levels of health and need to visit health care providers on a frequent basis may find HIP Plus to be more appealing if they	We concur that health status is a useful factor to consider in evaluating the differences between those in HIP Basic vs. Plus. For this reason, we are using the Medically Frail indicator as a proxy for that status. Because it is verified and documented in the administrative records, we believe it would be more robust than

Reference	MPR Recommendation	Indiana's Response
Memorandum from Mathematica Policy Research (10/27/15)		
	understand or believe that paying a monthly contribution will be less costly than paying co-payments each time they visit a provider. Regardless, health status will likely be an important covariate when testing program effects on access to care and we recommend the member and non-member surveys include self-reported health status question at a minimum.	a self-report of health status. For example, a report of poor health status may reflect a temporary or acute condition.
Section B-3 (Page 5)	To test this hypothesis adequately, the sample plan should ensure sample sizes like those presented in Table 2 above, as well as sufficient numbers of members who do and do not have an NEMT benefit.	A comparison between the NEMT and non-NEMT group is not an appropriate comparison. The populations have different characteristics; policy driven questions for this study do not naturally lead to comparing across these two sub-groups.
Section B-3 (Page 5)	Because the analysis plan indicates HIP membership is relatively balanced between those who do and do not have access to NEMT, we are not particularly concerned about this issue. Nevertheless, to ensure the expected balance of surveys from those with and without NEMT benefits, the evaluator should monitor on a daily basis the number of completed interviews by category while the member surveys are in the field. The evaluator will then know to increase sample recruitment efforts if one group (for example, those who lack NEMT benefits) has a lower response rate that may jeopardize the size of the sample for that group.	The survey collection process will ensure that the combinations of HIP Plus/HIP Basic and NEMT/non-NEMT will be filled such that is correctly represents the universe. This will include frequent monitoring of survey collections.
Section B-3 (Page 5)	Regarding the survey questions themselves, in the following section, we also recommend that Indiana and its evaluator seriously consider using the access to care questions from the 2010 survey of members instead of the missed appointment question currently proposed.	Please see response to recommendations from Section C-1 (Page 9) regarding survey questions **Q17 (Plus)/Q8 (Basic)** in the Member surveys.
Section B-3 (Page 5)	If this change is not feasible, then the missed appointment question and other survey questions needed to assess the effect of the NEMT waiver (any transportation related questions) should be included in the leaver and never member surveys so that these	The purpose of the evaluation is to measure the impact of the NEMT waiver on existing HIP members, per the STCs, and whether it has affected the number of missed appointments. Adding these questions to the Leaver and Never Member surveys

Reference	MPR Recommendation	Indiana's Response
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	other samples could be included in the analysis, in part to help increase the power of the estimate of the NEMT waiver effect.	is outside the scope of evaluation, and would lengthen surveys of a population that is already hard to reach.
Section C (Page 6),	We recommend the non-member surveys include a question about the person's county of residence so that respondents to the non-member surveys can be pooled with respondents to the member surveys in some of the analyses relating to access.	**Confirmed.** We can add a question for the non-member surveys regarding county of residence, understanding that administrative data is less complete than for current members.
Section C-1, Bullet 1 (Page 6)	**Q14-16a (Plus) and Q5-7a (Basic).** The access questions are very close to what is included in CAHPS instruments, but the wording is not exact. In the CAHPS instruments, they first ask about the need for care, such as "In the last 6 months, did you have an illness, injury, or condition that needed care right away in a clinic, emergency room, or doctor's office?" and response options are yes or no. If yes, the respondent is then asked "In the last 6 months, when you needed care right away, how often did you get care as soon as you needed?" with response options of "Never," "Sometimes," "Usually," and "Always." We recommend the HIP member surveys adhere to this well-tested approach and set of response options. It helps with the interpretation of the "Never" response to the frequency question and allows the data to be compared to other CAHPS data. This recommendation means adding in the screening question about the need for each type of service and also expanding the response option "Usually" to the question about the frequency of getting care when needed (the current member surveys only have three response options of "Never," "Sometimes," and "Always"). If Indiana has concerns about lengthening the survey, then we would recommend dropping the questions about prescription medications or limiting the access to care questions to only the one about getting care for illness, injury, or a condition that need care right away.	**Confirmed.** We will update the surveys to mirror CAHPS questions.

Reference	MPR Recommendation	Indiana's Response
Memorandum from Mathematica Policy Research (10/27/15)		
Section C-1, Bullet 2 (Page 6)	**Q17 (Plus) and Q8 (Basic).** We recommend Indiana consider replacing the questions about missed appointments with the access to care questions used in the 2010 member survey. "During the past six months, was there any time that you needed to see a doctor or other health care professional because of an illness, accident, or injury but did not go?" That survey also included similar questions for preventive care and specialty care (see the bottom of page 2 and page 3 of this memorandum). We think these more general questions, particularly the one about illness or injury, get at broader access issues including whether people may avoid seeking care because of the known cost (either in travel costs or co-payments).	The 2010 HIP 1.0 questions are more general than what is needed to accurately measure the number of missed appointments, per the STCs. The 2010 questions could be answered by people who did not make an appointment even though they needed one **and** by people who made appointments but did not keep them. The current questions specifically ask about missed appointments, in accordance with the STCs (Sec. XIII, Paragraph 4a). **For reference:** ***<u>Current Questions in HIP Plus (Q17) and HIP Basic (Q8):</u>*** *"In the past six months, have you missed any healthcare appointments, such as doctor's appointments?"* ***<u>HIP 1.0 Questions (included in pages 2-3 of MPR memo):</u>*** *C14) During the past six months, was there any time that you needed to see a doctor or other health care professional for preventive care such as a checkup or physical examination but did not go?* *C15b) During the past six months, was there any time that you needed to see a doctor or other health care professional because of an illness, accident, or injury but did not go?* *C17) During the past six months, was there any time when you needed to see a specialist but did not go?*
Section C-1, Bullet 3 (Page 7)	**Q17a (Plus) and Q8a (Basic).** We recommend the list of reasons for missing (or not going to) an appointment be read in its entirety to respondents. If the respondent picks multiple options, we recommend a follow-up question be asked about which reason is the most common reason they miss an appointment to help judge the relative importance of all the options.	This question is formatted to be consistent with the approach of the HIP 1.0 Survey for comparison purposes. ***For reference:*** *Q17a (Plus), Q8a (Basic)* *What are the reasons you missed an appointment? (ALLOW MULTIPLE RESPONSE OPTIONS)* ☐ *COST TOO MUCH* ☐ *COULDN'T GET CHILDCARE* ☐ *COULDN'T GET TIME OFF FROM WORK*

Reference	MPR Recommendation	Indiana's Response
Memorandum from Mathematica Policy Research (10/27/15)		
		☐ *COULDN'T GET THROUGH ON THE PHONE* ☐ *COULDN'T SCHEDULE APPOINTMENT SOON ENOUGH* ☐ *DIDN'T GET APPROVAL FROM PLAN* ☐ *DIDN'T HAVE TIME* ☐ *DIDN'T WANT TO GO* ☐ *HOURS OF OPERATION WERE NOT CONVENIENT FOR ME* ☐ *NO INSURANCE* ☐ *PLACE DID NOT ACCEPT THE INSURANCE COVERAGE* ☐ *TAKES TOO LONG TO GET THERE* ☐ *TRANSPORTATION PROBLEM* ☐ *TOO SICK TO GO* ☐ *OTHER REASON, NOT LISTED ABOVE: (SPECIFY)* __________
Section C-1, Bullet 4 (Page 7)	**Q18 (Plus) and Q9 (Basic).** As noted on the previous draft of the survey, for this question to provide the information needed to assess whether primary care services are accessible, the survey also needs to collect information about whether the respondent used the ER at all during the last six months. With that piece of information, evaluators can more accurately interpret the "No" answers to the existing question. If respondents did not use the ER, then a "No" means they did not need to go to the ER. Conversely, if they used the ER during the six months, then a "No" would suggest they used the ER for a true emergency.	We will use claims data to determine whether the respondent used the ER in the last 6 months. ***For reference:*** *Q18 (Plus), Q9 (Basic):* *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?* *YES* *NO* *DON'T KNOW* *REFUSED*
Section C-1, Bullet 5 (Page 7)	**Q23 (Plus) and Q14 (Basic).** As we noted on the previous draft, the state may want to restrict the question to only those respondents who report having a POWER account. Without this restriction, some respondents will be irritated because they'll think/say "but I just told you that I don't have a POWER account."	All members are assigned both a POWER account and a POWER Account Debit Card. This question measures the respondent's understanding of the program; even if the respondent is not aware of having a POWER account, the respondent may know whether or not he or she has a POWER Account Debit Card. ***For reference:*** ***Q23 (Plus), Q14 (Basic).***

Reference	MPR Recommendation	Indiana's Response
Memorandum from Mathematica Policy Research (10/27/15)		
		Has your health plan given you a HIP POWER account debit card? (IF NEEDED: This is a card that can be used to access the funds in your POWER account.) *YES* *NO* *DON'T KNOW* *REFUSED* *Q23a. How often do you present the card to a health care provider? Is it…* *EVERY TIME YOU GET CARE* *SOME OF THE TIME* *ONLY FOR SPECIFIC SERVICES* *NEVER* *DON'T KNOW* *REFUSED*
Section C-1, Bullet 6 (Page 7)	**Q24-25 (Plus) and Q15-16 (Basic).** The wording of these questions is improved over the previous versions in that there is less potential for respondents to answer incorrectly because they do not want to admit to ignorance. However, the first question asks about two policies together and both questions together ask essentially the same thing but flip the scenario. This duplication may confuse respondents or lead them to start guessing, potentially introducing biased responses that are inconsistent with one another. We recommend striking the second sentence in the first question ("Also, this could result in lower payments in the next year") so that it only tests the respondent's knowledge of the rollover. The second question would then focus on how the rollover might lower the monthly payments in the next year. The next question could then read "If you get preventive services suggested by your plan and have money left over in your POWER account, this could result in lower	**Confirmed.** We will make the suggested changes.

Reference	MPR Recommendation	Indiana's Response
Memorandum from Mathematica Policy Research (10/27/15)		
	payments in the next year." That way, respondents would have a true/false test on two questions that are both stated in the positive but get at different elements of the POWER account policy.	
Section C-1 , Bullet 7, Sub-bullet 1 (Page 7)	As mentioned above, health status is an important control variable. These surveys should include some type of question on health status or the evaluator needs to get information on the number or types of chronic conditions from encounter claims records. The proposed approach to measuring this characteristic should be explicit in the analysis plan.	Please see response to recommendations from Section B-2 (Page 5).
Section C-1, Bullet 7, Sub-bullet 2 (Page 7-8)	The member surveys do not ask for information on age, gender, location of residence (urban/rural or county code), income, and household size. Indiana may be planning to get this information from administrative data, but this should be discussed explicitly with the state.	The evaluation design considers demographic differences derived from administrative data.
Section C-1, Bullet 7, Sub-bullet 3 (Page 8)	We do not see member questions sufficient to address Hypothesis 7 (graduated co-pays). The single question about emergency rooms is unrelated to graduated co-pays or prior authorization.	The draft Evaluation Plan refers to graduated copayments only in the context of inappropriate use of the Emergency Department. Indiana submitted the Emergency Department Use Protocol to CMS on May 1, 2015 and has not yet received approval. Because the protocol has not been implemented, we cannot include questions about it in the survey.
Section C-2, Bullet 1 (Page 8)	**Q1-1b (Plus).** The skip pattern is unclear—are respondents answering any of the first three answer choices for Q1a sent to Q2?	We will clarify the skip pattern. Please note that this will be a CATI survey and all skip patterns will be checked and tested by the programmer.
Section C-2, Bullet 2 (Page 8)	**Q21 (Plus).** The skip pattern here is unclear – looks like a possible formatting error.	We will clarify the skip pattern. Please note that this will be a CATI survey and all skip patterns will be checked and tested by the programmer.
Section C-2, Bullet 3 (Page 8)	**Q26-27 (Plus).** These are helpful additions, but we recommend making the wording more neutral than asking "are you aware," which could bias responses toward the positive because respondents may not want to admit to ignorance. One possibility	We feel it is preferable to avoid true/false questions so that the survey does not feel like an exam.

Reference	MPR Recommendation	Indiana's Response
Memorandum from Mathematica Policy Research (10/27/15)		
	would be to state the policy and then ask the respondent to indicate whether the policy is true or false.	
Section C-3, Bullet 1 (Page 8)	**Q27/28 (Basic).** We recommend more neutral wording because asking "did you know" could bias responses toward the positive. One possibility would be to state the policy and then ask the respondent to indicate whether the policy is true or false.	We feel it is preferable to avoid true/false questions so that the survey does not feel like an exam.
Section C-3, Bullet 2 (Page 8)	**Q29 (Basic).** This question seems misplaced in the Basic survey.	We include this question in the HIP Basic Member survey because it measures the respondent's understanding of the program. ***For reference:*** ***Q29 (Basic):*** *Did you know that, if you do not make your monthly or annual POWER account contribution, you will be moved from HIP Plus to HIP Basic?* ☐ *YES* ☐ *NO* ☐ *DON'T KNOW* ☐ *REFUSED*
Section C-3, Bullet 3 (Page 8)	**Q32 (Basic).** This question is leading and we recommend it be dropped from the survey. We believe that the evaluation can get the same information with the more neutrally worded Q25 and Q18.	We will reword question to state: "Would you rather remain in HIP Basic or move to HIP Plus, knowing that they are different?" ***For reference:*** *Q32 (Basic)* *"Now that you understand how HIP Plus is different from HIP Basic, if you have an opportunity to move to HIP Plus, would you rather remain in HIP Basic or move to HIP Plus?"*
Section C-3, Bullet 4 (Page 8)	**Q33-34 (Basic).** The wording for these questions is confusing. HIP Basic members do not make monthly payments. We suggest striking "more" so that these read "pay $5 each month" and "What about $10 each month."	**Confirmed.** We will remove the word "more." ***For reference:*** *Q33. If HIP required you to pay $5 more each month, would you continue to stay enrolled?*

Reference	MPR Recommendation	Indiana's Response
Memorandum from Mathematica Policy Research (10/27/15)		
		YES GO TO Q34 *NO GO TO Q35* *DON'T KNOW GO TO Q34* *REFUSED GO TO Q35* *Q34. What about $10 more? Would you continue to stay enrolled if HIP required you to pay $10 each month?* *YES* *NO* *DON'T KNOW* *REFUSED*
Section C-4, Bullet 1 (Page 8)	**Q5 and 7 (Leaver).** It's not clear why Q7 would be asked of people who answer Q5 by saying "Did not make a monthly or annual payment." Should the skip pattern for Q5 read "Go to Q8"?	We will clarify the skip pattern. Please note that this will be a CATI survey and all skip patterns will be checked and tested by the programmer.
Section C-4, Bullet 2 (Page 8)	**Q13 (Leaver).** The instructions here seem to conflict. We recommend allowing multiple responses because people can have Medicare and Medicaid together, as well as other combinations of coverage. We suggest deleting the instruction "Stop me when I read the source for your insurance coverage."	**Confirmed.** We will remove conflicting text from the instructions: "Stop me when I read the source for your insurance coverage."
Section C-4, Bullet 3 (Page 8)	**Q13-14 (Leaver).** As noted on the previous draft, we recommend including respondents in Q14 who answer "a spouse" for Q13 because the spouse's insurance may be employer-sponsored.	We will clarify the skip pattern. Please note that this will be a CATI survey and all skip patterns will be checked and tested by the programmer.
Section C-4, Bullet 4 (Page 8-9)	**Q21-22 (Leaver).** For Q22, the response option "never" does not make sense if only those who answered "yes" to the previous question are asked Q22. We suggest changing the previous question, Q21, to "Since you left HIP, have you been given prescriptions for any medicines by your doctor?"	We will reword the first question to state "Since you left HIP, did you need any new prescriptions…" ***For reference:*** *Q21. Since you left HIP, did you get any new prescription medicines or refill a prescription?* □ *YES → GO TO Q22* □ *NO → GO TO Q23 [Q23 is the next section of the survey, which includes questions about education level and employment status]*

Reference	MPR Recommendation	Indiana's Response
Memorandum from Mathematica Policy Research (10/27/15)		
		Q22. Since you left HIP, how often did you get the prescription medicine you needed? □ *NEVER* □ *SOMETIMES* □ *ALWAYS*
Section C-4, Bullet 5, Sub-bullet 1 (Page 9)	We recommend the access to care section be the same as the access to care section in the member surveys so that leavers can be included in analyses of access to care. For this survey, this recommendation means adding in the transportation question.	This is beyond the scope of the evaluation, which seeks to understand barriers to care for the current HIP members.
Section C-4, Bullet 5, Sub-bullet 2 (Page 9)	The analysis plan indicates the leaver survey would be used to assess access to insurance (hypothesis 1) and this particular analysis would use income as a covariate. However, income is not included in the survey instrument and the analysis plan should be explicit on what type of data source will be used to determine a respondent's income.	Income level for the Leaver population also comes from historical Medicaid administrative data.
Section C-5 (Page 9)	The survey methodology suggests that a target number of 125 completed surveys for the combined population of those who (1) were conditionally approved, but did not make the first POWER account contribution, and (2) were presumptively eligible, but did not submit the full application. These two groups of never-members have different surveys with somewhat different questions, and there is no indication of how the 125 target number will be balanced across the two never-member groups. We suggest that each population be treated as a separate subgroup, with its own sample size target.	For the Never Member sample populations, the underlying universe for "no PAC" is only 121 so the likely number of potential completed surveys will be extremely small if we were to stratify. Additionally, there is no analysis that requires the separation of "no PAC" from "PE". We do not believe stratification is an appropriate approach here.
Section C-5, Bullet 1 (Page 9)	**Q6a (Never, No PAC):** This new question asks about the reasons why someone did not make the first POWER account contribution. One response option for this question is "don't understand the program/differences." This wording is confusing - is this in reference to the Basic/Plus distinction? We recommend	This is an open ended question. Responses will not be read, but are included to inform coding. ***For reference:***

Reference	MPR Recommendation	Indiana's Response
Memorandum from Mathematica Policy Research (10/27/15)		
	adding a response choice of "Did not know contributions were required" since this is the main subject of Q5, and respondents who note confusion in Q5 still go on to answer Q6a.	*Q6a. What is the main reason you did not make your first payment?* *CAN'T AFFORD/FEES TOO HIGH* *CHANGED MY MIND ABOUT WANTING HIP COVERAGE* *GOT OTHER INSURANCE* *DON'T NEED ADDITIONAL SERVICES* *DON'T KNOW HOW TO START PAYING ON A MONTHLY BASIS* *DO NOT WANT HIP PLUS OR ADDED BENEFITS* *DON'T PLAN TO BE IN THE PROGRAM VERY LONG* *NOT OFFERED THE OPTION TO PAY ON A MONTHLY BASIS* *DON'T UNDERSTAND THE PROGRAM/DIFFERENCES* *NOT REQUIRED TO PAY THE CONTRIBUTION* *FORGOT* *OTHER REASON NOT LISTED ABOVE: (SPECIFY)* ___________ *DON'T KNOW* *REFUSED*
Section C-5, Bullet 2 (Page 9)	**Q11-15 (Never, No PAC) and Q14-18 (Never, PE):** We recommend asking these questions of all survey respondents – whether they do or do not report having insurance. By doing so and having the same access questions on this survey as on the member surveys (including the missed appointments and transportation questions), then the access of never members could be compared to HIP members.	**Confirmed.** We will ask questions of all respondents, regardless of their reported insurance status.
Section C-5 (Page 10)	Health status. If the never members are ever included in any analyses that compares them to HIP members, then the analysis should control for health status. The current draft does not include any type of question that assesses health status and we recommend inclusion of self-reported health status and possibly one or two other questions that would gather the same type of health status information as the evaluator will have for HIP members.	Please see response to recommendations from Section B-2 (Page 5).

Reference	MPR Recommendation	Indiana's Response
Memorandum from Mathematica Policy Research (10/27/15)		
Section C-6 (Page 10)	The provider survey takes a one-size-fits-all approach. The analysis plan states that the survey will be administered to 3 large primary hospitals, all 42 FQHCs, and 1,700 other providers of varying sizes (from solo practitioners to other hospitals), drawn from a pool of about 48,000. We recommend stratifying the random sample of 1,700 to ensure responses from a number of differently sized practices and specialties.	Stratification of provider sample was informed by discussions with program and policy staff in Indiana, leading to a focus on providers serving the HIP 2.0 population, by certain provider types (primary care vs. specialty, FQHC status and large hospital systems).
Section C-6 (Page 10	To the extent that some policies, like presumptive eligibility, are relevant only for a subset of providers, we recommend ensuring sufficient survey responses from providers that experience different policy contexts.	The provider survey asks about PE participation and will be analyzed accordingly.
Section C-6 (Page 10)	The state does not indicate a target number of completed surveys for the provider survey; we recommend setting a target that collects sufficient responses from each relevant subgroup of providers.	Our target is a 95% response rate for the provider survey. Additional details are included in our Technical Response.
Section C-6, Bullet 1 (Page 10)	**Q6a and Q7 (Provider).** We continue to advise that these questions are phrased in a way that will elicit biased responses from providers. We suggest rephrasing Q6a to read "How does the reimbursement for this program compare to the traditional Medicaid program?" with response choices of (a) reimburses at the same rate, (b) reimburses at a higher rate, (c) reimburses at a lower rate, (d) don't know, (e) refused. This same comment applies to Question 7. We also note that the reference program has been revised for Question 6a – it previously asked for awareness of the HIP reimbursement rate relative to the Medicare program reimbursement rate. We suggest that the survey designers consider which referent will produce the most valid responses for this question. If the traditional Medicaid program reimbursement rates have also increased – as indicated by question 7 – providers may be confused by which reference	**Confirmed.** We will reword questions to state "How does the program reimburse compared to the traditional Medicaid program?" and "Does the reimbursement rate influence your decision to participate in the program?" We will include the "same" response option. ***For reference:*** *Q6a. Does the program reimburse at a higher rate than the traditional Medicaid program?* □*REIMBURSES AT HIGHER RATE → GO TO 6B* □*REIMBURSES AT LOWER RATE* □*DON'T KNOW* □*REFUSED*

Reference	MPR Recommendation	Indiana's Response
Memorandum from Mathematica Policy Research (10/27/15)		
	price is implied. Medicare may be a more reliable point of reference for interpreting provider responses.	*Q6b. Did the higher reimbursement rate influence your decision to participate in the new HIP program? (ASK ONLY IF RESPONDENT ANSWERS "REIMBURSE AT HIGHER RATE" TO PREVIOUS QUESTION)* □*YES* □*NO* □*DON'T KNOW* □*REFUSED*
Section C-6, Bullet 2 (Page 10)	**Q11 (Provider).** The survey continues to ask providers why they think patients most likely miss appointments. We would caution against over-interpreting this survey question when considering the NEMT waiver; providers may believe that transportation is more/less important than it actually is from the beneficiary perspective.	This question addresses a specific STC requirement (XII.4.d) regarding provider perception on the impact of transportation on missed appointments. ***For reference:*** *Q11. If a member misses an appointment, what is the most likely reason that the member missed it, in your opinion?* *CHOOSE ALL THAT APPLY* □*COSTS TOO MUCH* □*COULDN'T GET CHILDCARE* □*COULDN'T GET TIME OFF FROM WORK* □*COULDN'T GET THROUGH ON THE PHONE* □*DIDN'T GET APPROVAL FROM HEALTH PLAN* □*DIDN'T HAVE TIME*
Section C-6, Bullet 3 (Page 10)	**Q12-13 (Provider).** In response to a recommendation on the first survey drafts, the designers have added a response option of "sometimes" to the question about whether missed appointments affect receipt of preventive services (Q12), but have not added this response option to the question about quality of care (Q13). We suggest using a parallel set of response options for these two questions.	**Confirmed.** We will add "sometimes" as a response option. ***For reference:*** *Q12. When members missed appointments, do you feel that it had an impact on members' receiving preventive care?* □*YES* □*NO* □*SOMETIMES* □*DON'T KNOW* □*REFUSED*

Reference	MPR Recommendation	Indiana's Response
Memorandum from Mathematica Policy Research (10/27/15)		
		Q13. When members missed appointments, do you feel that it had an impact on members' overall quality of care? □*YES* □*NO* □*DON'T KNOW* □*REFUSED* *Q14. How has it impacted members' quality of care? [Free response]*
Section C-6, Bullet 4 (Page 10)	**Q15 and 18 (Provider).** The skip pattern in Q15 indicates that providers who said that they are not presumptive eligibility providers, or don't know whether they are presumptive eligibility providers will still be asked questions on presumptive eligibility. We recommend that subsequent questions on presumptive eligibility not be asked of these providers.	We will clarify the skip pattern. Please note that this will be a CATI survey and all skip patterns will be checked and tested by the programmer.

Michael R. Pence, Governor
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November 6, 2015

Ms. Andrea Casart
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Dear Ms. Casart:

Thank you for your preliminary review of our draft evaluation plan and surveys for the Healthy Indiana Plan 2.0 (HIP 2.0) section 1115 waiver demonstration. We appreciate your commitment to working with us to ensure that our evaluation is suitable to complete the reporting requirements set forth in the HIP 2.0 Special Terms and Conditions (STCs).

We appreciate the number of calls and correspondence that we have had with CMS on the HIP 2.0 evaluation. My team has carefully considered CMS's input and have made significant effort to accommodate your concerns. The attached memo prepared by Indiana's HIP 2.0 evaluator, the Lewin Group, details our response to each of your suggestions. CMS has made 82 suggested modifications and we have agreed to 74, or 90% of these changes. However, your recent letter dated October 29, 2015, raises some issues in which we have strong concerns.

As you know, the State was prepared to start the HIP 2.0 surveys during the first week of September of this year in order to meet the November 1, 2015 deadline for the evaluation of non-emergency medical transportation (NEMT), as required by Section XIII.4 of the HIP 2.0 Special Terms and Conditions (STCs). The state agreed to delay the surveys to allow CMS more time to review the surveys. Your letter dated October 29, 2015, indicates that CMS expects the NEMT evaluation by January 1, 2016. Unfortunately, we cannot agree to this date, as our vendors have raised valid concerns about the feasibility of completing the surveys in this time frame, in addition to the fact that CMS's review of the surveys is still ongoing. These concerns are detailed in the attached memo.

CMS's suggestion to virtually double the number of surveys will significantly increase the cost of conducting the surveys without providing any sufficient benefit or improvement upon the integrity of the results. Indiana is committed to using taxpayer dollars prudently, and we cannot justify these costs. Our survey evaluator, the Lewin Group, has provided extensive justification for the limited statistical value that is gained by increasing the sample size for the surveys, and their rationale is detailed in the attached memo.

We look forward to discussing and resolving these concerns with you.

Sincerely,

Joseph Moser

Joseph Moser
Medicaid Director