STATE OF INDIANA
OFFICE OF THE GOVERNOR
State House, Second Floor
Indianapolis, Indiana 46204

Eric J. Holcomb
Governor

January 31, 2020

The Honorable Alex Azar
Secretary U.S. Department of Health and Human Services
200 Independence Avenue S.W.
Washington, D.C. 20201

Re: Healthy Indiana Plan §1115 Demonstration Extension Request (Project No. 11-W-00296/5)

Dear Secretary Azar,

I am pleased to submit Indiana's application to extend the Healthy Indiana Plan (HIP) Section 1115 demonstration waiver.

A fixture of Indiana's health care system since 2008, today HIP provides coverage to more than 400,000 Hoosiers each year. This waiver extension preserves HIP as a core component of health care in Indiana by seeking continued authority to operate the program for a 10-year period through December 31, 2030.

In addition to authorizing HIP, the existing waiver includes authority to operate a Substance Use Disorder (SUD) demonstration to provide greater access to SUD services for all Hoosiers that receive coverage through Indiana Medicaid. Through this demonstration, over 65,000 members have been able to receive needed SUD treatment, and I am dedicated to working with you to continue support of those overcoming addiction.

This extension requests to continue to operate the SUD demonstration and incorporate the recently approved Serious Mental Illness waiver amendment for a 5-year period through December 31, 2025. The extension also incorporates the pending HIP Workforce Bridge waiver amendment for operation through the waiver's next 10-year period, to support members transitioning to commercial coverage.

I look forward to continued collaboration to ensure access to quality healthcare for Hoosiers. Thank you for your consideration of this proposal.

Sincerely,

[redacted]

Eric J. Holcomb
Governor of Indiana

Indiana Family and Social Services Administration

Renewal Request for the
Healthy Indiana Plan (HIP)
Section 1115 Waiver
(Project Number 11-W-00296/5)

Contents

Section 1: Summary of HIP Renewal Request

The Healthy Indiana Plan (HIP) has been a feature of Indiana's Medicaid program since 2008. The current approval to operate HIP expires December 31st, 2020. This document requests to renew the HIP program with no substantive changes. Based on the long-tenure and demonstrated success of HIP, the State requests renewal for a ten-year period through December 2030.[1]

This 1115 waiver renewal requests authority to continue to operate HIP, as approved and operating in Indiana today, and to incorporate the HIP Workforce Bridge amendment into the renewed program.

Today, HIP provides coverage each year to approximately 570,000 non-disabled Hoosier adults age 19 to 64 who have income at or below 133 percent of the federal poverty level.[2] HIP enrollees have access to different benefits and cost-sharing based on factors such as income, health status, and eligibility as a low-income parent and caretaker, as described below:[3]

- Every HIP enrollee has a $2,500 **POWER Account** to fund the $2,500 deductible. Members and the State contribute to this account.
- **HIP Plus** offers a commercial coverage package including vision, dental and chiropractic services. To receive HIP Plus benefits, HIP members make contributions to their POWER Account. Member contributions to the POWER Account are refunded if a member leaves the program without spending the funds on health care services. HIP Plus is an option for coverage for all HIP enrollees. For members who have income over the poverty level, HIP Plus is the only benefit option. Members can lose coverage for HIP Plus if they fail to pay, and those with income over the poverty level are subject to a 6-month coverage exclusion for non-payment. HIP Plus also incorporates a surcharge for members who continue to use tobacco following a year of cessation opportunities.
- **HIP Basic** members have copayments instead of POWER Account contributions. HIP Basic offers a commercial coverage package that includes all of the essential health benefits but does not include vision, dental, or chiropractic services. Additionally, there are some service limits that are lower than those available under HIP Plus. Members with income at or below the poverty level who do not contribute to their POWER Accounts receive HIP Basic benefits.
- **HIP State Plan** benefits are available to members who are (1) pregnant, (2) medically frail, or (3) low-income parents and caretakers. Pregnant members have no cost sharing. Medically frail and low-income parents and caretakers receive the full Medicaid benefit

[1] The renewal incorporates the inclusion of the HIP Workforce Bridge Amendment as proposed to be effective in the final year of the demonstration.
[2] $17,422 per year for an individual, or $35,860 for a family of four in 2019, inclusive of the 5% of income disregard.
[3] All HIP benefits are approved Alternative Benefit Plans (ABPs) in the Medicaid State Plan. HIP Basic copayments are within the federally allowable limits. All HIP cost-sharing is subject to a maximum 5% of income quarterly limit.

package but may choose to make contributions to the POWER Account or have HIP Basic copayments.[4]

- **Gateway to Work** started in 2015 as a voluntary referral of HIP members to employment services. In 2019, the program expanded with the goal of increasing community engagement and connecting members to gainful employment. The program is designed to improve physical and mental health, and overall enrollee financial stability and well-being.
- **HIP Workforce Bridge** will support individuals who transition off HIP coverage to enroll in and maintain commercial coverage. If approved as requested in the amendment, beginning in 2020, qualified individuals will access the HIP Workforce Bridge Account. This account leverages unspent POWER Account dollars to fund up to $1,000 of health care costs following disenrollment from HIP and helps ensure individuals disenrolling from HIP have sufficient time to enroll into other coverage.

This renewal requests to continue the existing HIP program with the incorporation of the HIP Workforce Bridge amendment, without substantial changes to policy. The primary modification requested is the extended renewal period of ten years. The State is committed to scientific and evidence-based approaches to program oversight, monitoring and evaluation, and to continued involvement and meaningful consultation with stakeholders on program policy and operations. The ongoing cycle of three-year renewals creates unnecessary administrative burdens for the State and federal government, and does not meaningfully enhance the oversight or transparency of the demonstration. The STCs allow for withdrawal of waiver authority at any time that it is determined that the approved waiver or portions of the waiver are not meeting the objectives of the Medicaid program. In addition, the State solicits public comment prior to submitting any proposed amendment for any needed change, meaning that frequent renewal requirements do not provide an enhancement to federal authority over the demonstration.[5]

With this request to renew HIP, Indiana continues its commitment to providing innovations in the provision of public health care coverage. A ten-year renewal will give HIP members confidence that HIP will continue to be a resource for accessing quality health care, and will also allow state and federal staff to dedicate resources to continually improving HIP and ensuring the program meets its ongoing goals.

Section 2: Historical Narrative

HIP first passed the Indiana General Assembly in 2007 with bipartisan support. Indiana pioneered the concept of medical savings accounts in the commercial market and became the first state to apply the consumer-driven model to a Medicaid population. Provided by private health insurance carriers, HIP offers its members a high-deductible health plan paired with the POWER Account, which operates similarly to a health savings account. Following CMS approval, HIP began enrolling working-age, uninsured adults in coverage on January 1, 2008.

[4] As discussed in the HIP program components section, a minority of medically frail individuals that have income over the poverty level may have copayments and required contributions.
[5] Healthy Indian Plan Special Terms and Conditions, III -12.

In 2011, with the passage of the Patient Protection and Affordable Care Act (ACA), the Indiana General Assembly reinforced its support for the program by calling for HIP to be the coverage vehicle for Medicaid expansion in the State. The legislature passed Senate Enrolled Act 461 (codified at Indiana Code §12-15-44.2), to codify this requirement as well as to make several conforming changes to the HIP program related to the ACA.

In 2014, following several one-year extensions of the original HIP waiver, Governor Mike Pence opted to seek expansion of Indiana's successful HIP program to cover individuals in the new adult group. Following a historic agreement with the Indiana hospitals that secured funding for the costs of expansion beyond the existing cigarette tax revenue, the State submitted a fiscally sustainable waiver to expand its existing HIP demonstration waiver. The HIP 2.0 waiver built on the early HIP experiences and outcomes to improve the program and strengthen the core values of personal responsibility and consumer driven healthcare. In January 2015, CMS approved the HIP 2.0 program through a three-year waiver expiring in January 2018. Following implementation of HIP 2.0 on February 1, 2015, the Indiana General Assembly codified HIP 2.0 at Indiana Code §12-15-44.5. Through the 2016 codification efforts, the state legislature once again reinforced its support of HIP by expressly prohibiting the continuation of Medicaid expansion in the State except through HIP, operated in a manner consistent with the statutory provisions.

Immediately upon receiving a three-year approval for HIP on January 27, 2015, the State began accepting applications for the program. Services began just days later, as the enhanced HIP program launched on February 1, 2015. In addition to processing new program applications, the launch of HIP 2.0 included the conversion of members previously enrolled in the original HIP program as well as all non-pregnant adults enrolled in Hoosier Healthwise—Indiana's traditional Medicaid managed care program. Over 222,000 individuals were enrolled in HIP by the end of the first quarter of operations. Program enrollment stabilized with approximately 400,000 enrollees in the program on a month-to-month basis.

HIP 2.0 enhancements included the fast track prepayment option, which allows individuals to pre-pay their POWER Account contribution either by credit card on their application or an invoice received during application processing. The State also rolled out enhancements to presumptive eligibility for HIP, adding new providers that can make presumptive eligibility determinations, including county health departments, federally qualified health centers, rural health centers, and community mental health centers. In addition, at the direction of the Indiana General Assembly, the State implemented a program to provide presumptive eligibility to prison inmates who are being treated in inpatient settings while incarcerated. The State has leveraged this program to ensure that HIP applications are filed for inmates prior to release in order to improve continuity of care and continued access to prescriptions in order to reduce recidivism. A program called HIP Link, which helped individuals connect with and enroll in their employer insurance, was also established during the initial three-year approval period.

In January 2017, after two-years of program operations and 12-months prior to the expiration of the initial three-year approval, Indiana submitted the required request to renew the HIP program. This request was to renew the existing program, incorporate additional, eligible populations, and

implement new policies. Specifically, under the request, pregnant women were proposed to be included in HIP to prevent confusing coverage transitions during pregnancy. Additionally, a tobacco surcharge was proposed to support the State's initiatives around decreasing tobacco use, and the State proposed to reestablish the non-eligibility period for failure to renew coverage. The renewal request also documented State policy initiatives around encouraging MCEs to develop member incentive and engagement programs, enhancing HIP Plus benefits with chiropractic services, and technical changes requested to the STCs. In addition, the renewal included the request to add a substance use disorder (SUD) component, to ensure access to comprehensive SUD services for all Indiana Medicaid enrollees.

Prior to the renewal request being approved, in July 2017, an amendment was submitted to the original renewal application. This amendment requested additional changes to the preceding renewal request. First, the State requested to change the HIP Plus contribution schedule from two percent of income each month, to one of five set amounts which are approximately two percent of household income. This change allowed for more consistent POWER Account contribution amounts for individuals with variable income. Second, the State requested to enhance the existing voluntary Gateway to Work initiative to include a requirement that individuals who do not have an exemption, already work at least 20 hours per week, are enrolled as a full-time student, or participate in Gateway to Work for eight out of 12 months of the calendar year. The amendment to the pending renewal request also included technical corrections and the request to phase out the HIP Link program due to low enrollment.

HIP was authorized for an additional, three-year approval period on February 1, 2018. The authorization included approval for ongoing program operations and provided authority to implement the requested program changes. The change to the tiered POWER Account contribution was implemented in January 2018, following written guidance from CMS. The remaining waiver changes were implemented over the course of 2018, with Gateway to Work and the tobacco surcharge first taking effect in January 2019. Gateway to Work operates on a calendar-year basis. The program has member community engagement hours that gradually increase over the first 18-months post-implementation; the requirement will be fully phased in at the 20-hour per week level in July 2020. Effective October 2019, the enrollment penalty for not complying with Gateway to Work was temporarily suspended pending results of a lawsuit filed in federal court.

In May 2019, the state posted for public comment the HIP Workforce Bridge Amendment. This amendment proposes to add in the final year of the demonstration program components to help individuals who are no longer eligible for HIP due to increasing income successfully transition to commercial market coverage. The HIP Workforce Bridge Amendment includes a $1,000 account, funded with remaining POWER Account dollars, that helps support the cost of commercial coverage following HIP disenrollment and modifications to Gateway to Work exemptions. Following public comment, this request was submitted to CMS in July 2019.

This renewal request is to continue the HIP program as established, with the incorporation of HIP Bridge Amendment.

2.1 Historical and Current and Program Objectives

Since the initial approval in 2008, HIP has included three different sets of program objectives. The program objectives from 2008 to 2018 were relatively consistent, and progress towards these objectives has been summarized in prior waiver submissions, monitoring, and evaluation reports (see Figure 1). The objectives stipulated by the approval for the current program include a focus around (1) determining the impact of changes to the HIP Plus contribution amounts from a two percent of income amount for each individual to one of five set amounts based on income; (2) the impact of implementing a community engagement initiative; and (3) the impact of implementing the tobacco surcharge. In addition, the evaluation plan for the current demonstration period includes alignment where possible with the CMS 1115 evaluation guidance and includes three additional objectives. First, to improve health care access, appropriate utilization, and health outcomes among HIP members; and second, to evaluate member experience with the program and ensure that HIP policies approximately align with commercial market policies and promote a positive member experience; and finally, to assess the costs of implementing and operating the HIP demonstration aligned the CMS guidance around evaluating program sustainability.[6]

Figure 1: Objectives of the HIP program, 2008 to 2020

HIP (Jan. 2008 – Jan. 2015)	HIP 2.0 (Feb. 2015 to Jan. 2018)	HIP STCs (Feb. 2018 to Dec. 2020)
1. Reduce the number of uninsured low-income Hoosiers	**1. Reduce the number of uninsured low income Indiana residents and increase access to healthcare services**	The State did not request change to goals from HIP 2.0. The new HIP STCs include the following new goals:
2. Improve Statewide Access to Health Care Services for Low-Income Hoosiers	**2. Promote value-based decision making and personal health responsibility**	1. Moving the monthly payment obligation to a tiered structure will result in more efficient use of health care services, be easier for beneficiaries to understand, and increase compliance with payments
3. Promote value-based decision making and personal health responsibility by participants in the HIP Program	**3. Promote disease prevention and health promotion to achieve better health**	2. Implementing a community engagement requirement will lead to sustainable employment and improved health outcomes among HIP beneficiaries
4. Promote primary prevention for HIP Participants	4. Promote private market coverage and family coverage options to reduce network and provider fragmentation within families	3. Charging beneficiaries an increased monthly contribution for tobacco use will discourage tobacco use and increase the utilization of tobacco cessation benefits.
5. Prevent Chronic Disease Progression with Secondary Prevention	5. Provide HIP members with opportunities to seek job training and stable employment to reduce dependence on public assistance	
6. Provide Appropriate Quality-Based Health Care Services	**6. Assure State fiscal responsibility and efficient management of the program**	
7. Assure State Fiscal Responsibility and Management of the Program		

[6] HIP Evaluation goals for 2018 to 2020 include: (1) Improve health care access, appropriate utilization, and health outcomes among HIP members; (2) Increase community engagement leading to sustainable employment and improved health outcomes among HIP members; (3) Discourage tobacco use among HIP members through a premium surcharge and the utilization of tobacco cessation benefits; (4) Promote member understanding and increase compliance with payment requirements by changing the monthly POWER account payment requirement to a tiered structure; (5) Ensure HIP program policies align with commercial policies, encourage members understanding, and promote positive member experience; and (6) Assess the costs to implement and operate HIP and other non-cost outcomes of the demonstration.

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2.1.1 Tiered POWER Account Contributions

Effective January 1, 2018, member POWER Account contribution amounts changed from a two percent of income amount to one of five tiered amounts. The current tiered amounts are seen in Table 1.

Table 1: POWER Account Tiers Effective 1-1-2018

FPL	Monthly POWER Account Contribution: Single Individual	Monthly POWER Account Contribution: Spouses
<22%	$1.00	$1.00
23-50%	$5.00	$2.50
51-75%	$10.00	$5.00
75%-100%	$15	$7.50
101-133%*	$20.00	$10.00

**With 5% of income disregard*

This change is expected to have reduced the number of times a member's payment amount might change during the year and increase compliance with payments. Preliminary data for 2018 shows that this may be the case. In December 2017, 66 percent of individuals made contributions for HIP Plus coverage, and by December 2018, this had increased to 75 percent.[7] This increase may be due to the change in the contribution policy; however, other factors such as members taking advantage of rollover incentives could also be a factor. Analysis of this objective is a focus of the independent interim evaluation report, included with this renewal request.

2.1.2 Community Engagement

The 2018 HIP renewal provided authority to enhance the existing Gateway to Work program, which provided referrals to employment and job training opportunities. The changes require up to 80 hours of work or community engagement activities per month for non-exempt individuals. The Gateway to Work program rolled out in January 2019 and will be fully phased in July 2020 in alignment with the schedule seen in Table 2.

Table 2: Gateway to Work Phase In Schedule

Date Range	Required Hours
January 1, 2019 – June 30, 2019	0 hours per month (0 hours per week)
July 1, 2019 – September 30, 2019	20 hours per month (5 hours per week)
October 1, 2019 – December 31, 2019	40 hours per month (10 hours per week)
January 1, 2020 – June 30, 2020	60 hours per month (15 hours per week)
July 1, 2020 – Ongoing	80 hours per month (20 hours per week)

The program is implemented on a calendar-year basis, with the requirement applying to individuals for eight out of 12 months of the calendar year. Processes to act on non-compliant individuals were temporarily suspended in October 2019 pending results of a

[7] FSSA HIP dashboard, December 2017 & 2018 HIP Plus enrollment percentages. Accessed 2-21-2019

lawsuit filed in federal court. Due to the recent program implementation, preliminary data is available on Gateway to Work as reported in the independent interim evaluation posted and submitted concurrently with this request.

2.1.3 Tobacco Surcharge

The tobacco surcharge was authorized in 2018 and was implemented through a phased-in approach. Starting in 2019, individuals that had reported smoking and continued to smoke after 12 months were subject to an increased HIP Plus contribution amount.

The independent interim evaluation provides an overview of use of tobacco and use of cessation services in HIP and a preliminary look at individuals assessed a tobacco surcharge in 2019.

2.2 Independent Interim Program Evaluation

In addition to the three goals above, the interim program evaluation analyzes member service utilization, access to services, and health outcomes in addition to preliminary analysis on member's experiences and satisfaction with HIP. The interim evaluation also incorporates CMS evaluation guidance around assessing enrollment impacts and costs of operating the demonstration. This evaluation report is available concurrent with this renewal request. The final evaluation for the current three-year renewal period (through December 2020) will be submitted in July 2022 as required in the current program STCs.

2.3 Renewal Program Goals

Under this renewal request, HIP will continue to operate under goals that are in alignment with the prior goals of the demonstration. These goals are targeted to the following realms: Health Care, Economic and Social, Public Health, and improved Policy and Process.

Table 3: Renewal Program Goals

Realm	Factor	Policy	Program Goal
Health Care	Access	HIP members are able to see a doctor in a timely manner without traveling too far to seek care. HIP members get the care they need from the most appropriate setting. Access and appropriate utilization support positive health outcomes. HIP members are able to control chronic conditions, receive needed care, and have an overall increase in health and wellbeing.	Provide timely and geographically appropriate access to healthcare services. Promote appropriate utilization of healthcare by maintaining low inappropriate use of the emergency department and supporting utilization of needed services from qualified non-emergency providers. Promote control of chronic conditions, delivery of needed care, and increase in member health and wellbeing.
	Utilization		
	Outcomes		
Economic and Social	Work and community engagement	Through increased educational attainment, connection with community resources, and promotion of sustainable employment community engagement will increase income and self-sufficiency of HIP members.	Increase community engagement leading to increased educational attainment, sustainable employment and member self-sufficiency.

	Insurance rates; Coverage gaps	HIP members may have gaps in coverage when they leave HIP for having income over the HIP limit. HIP promotes increased uptake of commercial insurance when HIP coverage is lost and support individuals in their ability to maintain HIP coverage while they remain eligible.	Reduce the number of uninsured Hoosiers, decrease gaps in coverage, and promote uptake of commercial insurance when leaving HIP.
Public Health	Tobacco use	HIP should encourage access of tobacco cessation services and decrease member tobacco use.	Meaningfully increase use of tobacco cessation services and meaningfully decrease tobacco use status for HIP members.
	Prevention and wellness	HIP members should use preventive services and adopt healthy behaviors.	Encourage healthy behaviors and appropriate care, including early intervention, prevention, and wellness
Policy and Process	HIP Policy	HIP policies ensure continuous coverage and promote health care access, utilization, and improved health outcomes.	HIP policies support the goals of HIP by promoting continuous coverage and improved health outcomes.
	Social determinants of health	Barriers prevent HIP members from achieving health and financial stability. To support ongoing innovation in HIP, member barriers and needs will be identified.	Generate actionable information on social determinants of health needs.

Section 3: HIP Eligibility, Benefits, and Cost Sharing

HIP coverage is targeted to non-disabled adults between 19 and 64 years of age and encompasses the following eligibility groups: (1) the adult group, (2) low-income parents and caretakers, (3) transitional medical assistance, (4) pregnant women with income that would otherwise make them eligible for HIP, and (5) for limited benefit HIP Bridge coverage starting in 2020, specified former HIP enrollees that lost coverage due to increases in income over the HIP income limit.

Table 4: HIP Eligibility

#	Eligibility Group	Social Security Act and CFR Citations	Income Level	Waiver Criteria
1	Adult group	1902(a)(10)(A)(i)(VIII) and 42 CFR 435.119 including individuals who meet the definition of medically frail consistent with 42 CFR Section 440.315(f).	133 percent of the FPL including a 5 percent of income disregard	Non-medically frail individuals over 100% FPL are eligible for HIP Plus enrollment only
2	Parents & caretaker relatives	42 CFR 435.110	Parents and caretakers with income under the State's AFDC payment standard in effect as of July 16, 1996 (section 1931 parents and caretaker relatives), converted to a MAGI-equivalent amount by household	
3	Adult Transitional Medical Assistance beneficiaries	1902(a)(52) and 1925 of the Act including individuals who are medically frail	No income limit for first 6 months of eligibility. 185% FPL for the second 6 months of eligibility	Individuals with household income over the adult group income level are designated as TMA
4	Pregnant women, age 19 and older	42 CFR 435.116	133 percent of FPL	Waiver of retroactive coverage does not apply.

5	Individuals with MAGI-based income above 133 percent FPL	1902(a)(10)(A)(ii)(XX) 42 CFR 435.218	None	Limited to those that have lost HIP coverage due to increase in income. Coverage begins in 2020 following approval of the HIP Workforce Bridge.

Enrolled HIP members qualify for one of three cost-sharing models based on eligibility factors and whether they buy into the HIP Plus package. These cost sharing packages are as follows:

1. HIP Plus cost-sharing which allows individuals to make a monthly contribution to their POWER Account. For those who make a monthly contribution, there are no copayments, with the exception of non-emergency use of the emergency room. A waiver to offer the contribution option for HIP-enrolled individuals is provided; the copayment for non-emergency use of the emergency room is within Medicaid allowable limits. Monthly contributions are a set amount for specified income levels, and with the exception of some individuals with a tobacco surcharge, the amounts are below two percent of enrollee income on average, with a minimum amount of $1 per month.
2. HIP Basic cost sharing which assesses copayments on most services within the Medicaid allowable limits. The copayment model only applies to eligible individuals who do not contribute to their POWER Account.
3. For pregnant HIP members, all cost sharing is suspended.

In addition to the three cost-sharing models in HIP, there are four separate benefit options. HIP Plus, HIP Basic, the HIP State Plan benefits, and the limited HIP Workforce Bridge benefit that will begin in 2020 based on authorization of the HIP Workforce Bridge amendment. All individuals who are medically frail or low-income parents and caretakers receive the HIP State Plan benefits. HIP Plus and HIP Basic benefits are available to newly eligible adults, and individuals eligible for Transitional Medical Assistance. HIP Plus and HIP Basic are based on commercial market benefit packages and are approved Alternative Benefit Plans in the Medicaid State Plan and both offer all of the essential health benefits. Aligned with commercial market benefits, neither HIP Plus nor HIP Basic offer coverage for non-emergency medical transportation. HIP Plus has additional enhanced services such as vision, dental, and chiropractic services. Individuals receive HIP Plus and HIP Basic benefits based on income and payment of monthly POWER Account contributions.

Table 5: HIP Benefit and Cost Sharing Options

	Benefits	Cost Sharing	HIP Eligible Member Characteristics	Members Enrolled Jul 2019[8]
Healthy Indiana Plan – Cost Sharing and Benefit Options by HIP Member Characteristics	Medicaid State Plan Benefits	No cost sharing	Pregnant	18,283
		Monthly Contributions	Low-income parents and caretakers, the medically frail, and individuals eligible for Transitional Medical Assistance	123,578
		Copayments	Low-income parents and caretakers and the medically frail at or below the poverty level who do not make monthly contributions	42,456
		Contributions and Copayments	The medically frail with income over the poverty level who are 60 days past-due on their monthly contribution	315
	HIP Plus-ABP	Monthly Contributions Copayment for non-emergency ED use	Able-bodied adults	153,118
	HIP Basic-ABP	Copayments	Able-bodied adults with income at or below the poverty level	48,490
	HIP Bridge-Limited $1,000 Benefit	Contribution deducted from premium reimbursement	Previously enrolled in HIP, but disenrolled due to over income.	N/A – 2020 Implementation
Total fully eligible HIP members				386,240

Every enrolled HIP member has a $2,500 POWER Account which is used to cover the $2,500 deductible that applies to all HIP enrollees. For all plans, maternity services and preventive services, such as annual examinations, smoking cessation programs, and mammograms, are covered without charge to the members and are not included in the deductible amount of $2,500. After the plan deductible is met and covered by the $2,500 POWER Account, all benefits in the applicable benefit package continue to be covered for HIP members.

[8] FSSA HIP dashboard, July 2019 Monthly enrollment. Accessed 9-30-2019.

Section 4: HIP Components and Operations

HIP is composed of distinct program elements that integrate to achieve the program goals. Many of these elements were established in the initial HIP implementation in 2008 or incorporated when HIP expanded coverage in 2015 to all non-disabled adults with income below 133 percent of the poverty level. The HIP program continues to innovate and since 2018 has designed, developed and implemented changes such as a calendar year period for MCE enrollment, deductibles, and POWER Accounts, a tobacco surcharge, and the Gateway to Work community engagement initiative. The HIP Workforce Bridge initiative incorporated in the waiver amendment request is the most recent example of the evolution in ongoing program innovation.

4.1 POWER Accounts

HIP leverages innovations from the commercial market. Unlike traditional Medicaid, HIP coverage is based on a high-deductible model. HIP enrollees by definition are low-income, and this high-deductible plan pairs with a unique health savings-like account, the POWER Account, to fund the cost of the deductible. The POWER Account has been the central component of the HIP design since program initiation in 2008. In current operations, the POWER Account operates in alignment with original design, and provides a health-savings 'like' account that funds member deductibles. The POWER Account provides funding for the first $2,500 in health care services and holds both state and member contributions. The State contributes all dollars that are beyond the member contribution amount, up to the full $2,500, to the account.

The POWER Account promotes transparency around the costs of care and provides members incentives to engage with the health care system to help to control health care costs. As an incentive to receive preventive care, the cost of preventive services is fully covered outside of the POWER Account. Members receive monthly account statements showing account debits and credits, and members who do not use their entire account during the year may earn rollover incentives that reduce the costs of future enrollment. Receipt of preventive services can increase the member's rollover incentive.

Over 10 years of member experience with POWER Accounts has been documented by quarterly and annual reporting, independent evaluations, and required additional POWER Account reports.

The first HIP member survey, conducted in 2010, found that 95 percent of members were satisfied with the program, 97 percent of members knew their monthly contribution amount; over half (63 percent) of members knew their POWER Account balance; and nearly half (44 percent) of members checked their POWER Account balances at least once a month.[9]

The most recent HIP member survey, conducted in 2016, found that 86 percent of contributing members were satisfied with the program, with 95 percent reporting that they would re-enroll in HIP if they left and became eligible again, and 42 percent reporting that

[9] 2010 Mathematica Survey of HIP members

they are checking their POWER Account balances at least once a month.[10] FSSA internal monitoring has found that high member satisfaction with HIP continues through the current demonstration year.

The most recent POWER Account data indicate that 65 percent of members used less than half of their POWER Account balances while 44 percent of members qualified for rollover. Of the members who qualified for the State discount percent (HIP Basic members eligible for HIP Plus), the vast majority (79 percent) qualified for the maximum rollover discount rate of 50 percent.[11]

There is no specific waiver granted to operate the POWER Account under the HIP approval, and reporting on accounts is incorporated into the required CMS-64 reporting in alignment with the current HIP approval. This HIP renewal does not request any changes to the POWER Account, and solely seeks authorization to continue POWER Account operations for the requested renewal period through 2030.

4.2 Member Contributions

Members make monthly payment deposits to the POWER Account. When service costs are deducted from the POWER Account, the payment is deducted proportionally from the state and member funds in the account. In this way, for all services that are applied to the deductible, HIP member contributions are paying a portion of the cost. Members who do not spend their full account on health care during the year get to keep contributions as a rollover towards the next year of enrollment. For members who leave the program, their remaining contributions can be refunded. This design, where all services applied to the deductible are paid with member and state contributions, and where members can count on their contributions rolling over or being returned to them, gives members "skin in the game." Members engage as consumers with financial incentives to avoid unnecessary care and make value-based healthcare choices.

In the initial HIP program, the contribution was up to 4.5 percent of member annual income. The 2015 approval set contributions at two percent of income with a minimum contribution of one dollar. Starting in 2018, member contributions changed from a certain percent of income to one of five set amounts. The change to the set amount reduces the changes in contribution amounts that a member might experience during the benefit year if they have slight changes in income. Contribution amounts established for the current program are displayed in Table 6.

[10] 2016 Lewin Survey of HIP members
[11] 2018 FSSA Member Data

Table 6: HIP Member Contributions 2018 to 2020

FPL	2019 Monthly Income: Individual Estimates	2019 monthly Income: Family of Four Estimates	Monthly Power Account Contributions: Single Individual	Monthly Power Account Contributions: Spouses
<22%	<$229	<$472	$1.00	$1.00
23-50%	$229-$520	$472-$1,073	$5.00	$2.50
50-75%	$521-$780	$1,074-$1,609	$10.00	$5.00
75%-100%	$781-$1,041	$1,610-$2,146	$15.00	$7.50
100-133%* FPL	$1,042-$1,453	$2,147-$2,996	$20.00	$10.00

**With 5% of income disregard*

Since 2008, initial enrollment in the program has been contingent on making a payment. In the 2015 approval, this requirement continued with HIP Plus enrollment requiring an individual to make an initial contribution, and then an ongoing monthly contribution to maintain enrollment. Individuals have 60 days to make their initial and ongoing monthly payments.

Following application, the start date for coverage is the first of the month in which a member makes their initial contribution to their POWER Account.

Members may make an initial contribution, or fast track pre-payment, towards HIP Plus when they file their application or during application processing. If the member completes the eligibility process and is found eligible, the fast track payment is put towards the required contribution amount. When applicants are found ineligible, the fast track contribution is refunded.

In HIP, the majority of enrollees, across all income levels, have made their required contributions; since the first quarter following the expansion of HIP in 2015, 65 to75 percent of members have enrolled in HIP Plus in any given month, meaning these members are making regular contributions. The first HIP member survey, conducted in 2010, found 75% of members indicating that POWER Account contributions were affordable; this was when contributions were up to 4.5 percent of income.[12] In the most recent HIP member survey, conducted in 2016, 80% of members indicated that they would pay more to stay in the program.[13]

In this renewal, no substantial changes are requested to the member contribution component of the HIP program. To allow flexibility to adjust contributions, Indiana requests that a ceiling based on three percent of household income be established for POWER Account contribution amounts, and that any variation from the current amounts but below this threshold require member and CMS notice, but no formal waiver amendment. This

[12] 2010 Mathematica Survey of HIP members
[13] 2016 Lewin Survey of HIP members

flexibility would allow for adjustments to the contribution tier amounts without requiring an amendment submission and approval process with CMS.

4.2.1 Tobacco Surcharge

The 2018 approval incorporated a tobacco surcharge component where members who report tobacco use and continue to use after a full year of enrollment are assessed a surcharge. The tobacco surcharge increases the member POWER account contribution amount by 50 percent.

In this renewal, no changes are requested to the tobacco surcharge.

4.3 HIP Plus and HIP Basic

Members who make an initial POWER Account contribution enroll into HIP Plus with coverage effective the first day of the month in which their contribution is made. Other than the monthly contribution, the members in HIP Plus have no additional cost sharing responsibility except for a copayment for non-emergency use of the emergency room. The copayment for non-emergency use of the emergency room is within the Medicaid allowable limits and is currently set at $8.00. Members who pay their contribution receive the full Medicaid benefit package if they qualify as a Section 1931 low-income parent and caretaker, or if they are medically frail. They receive the HIP Plus alternative benefit plan, which includes all the essential health benefits and adds vision, dental and chiropractic coverage.

In the initial HIP program established in 2008, individuals that did not make their required contribution were not enrolled. Beginning in 2015, the HIP Basic plan was implemented for individuals with income below the poverty level who do not make their required contribution. Like HIP Plus, HIP Basic is both a benefit package and a cost-sharing schedule. The HIP Basic benefit package is an approved, alternative benefit plan that includes all of the essential health benefits but does not have coverage for vision, dental, or chiropractic services. HIP Basic benefits are available to adults with income under the poverty level who do not complete enrollment into HIP Plus and are not otherwise qualified for the Medicaid State Plan benefits. The HIP Basic cost-sharing schedule includes copays within the Medicaid allowable limits for most services as outlined in Table 7. All HIP-enrolled individuals who do not complete enrollment into HIP Plus and who are not otherwise exempt from cost sharing pay the HIP Basic copayment amounts when accessing care.

Table 7: HIP Plus and HIP Basic Contribution and Copayment Amounts

Category	HIP Plus	HIP Basic
Monthly Contribution	$1-$20	$0
Copayment- Outpatient services - including office visits	$0	$4
Copayment- Inpatient services - including hospital stays	$0	$75
Copayment- Preferred drugs	$0	$4
Copayment- Non-preferred drugs	$0	$8
Copayment- Non-emergency ER visit	$8	$8

Members enroll into HIP Basic when they do not pay for HIP Plus within 60 days and the member income is under the poverty level. At initial application, members' enrollment into HIP Basic is effective the first of the month in which their 60 days to pay for HIP Plus expire. For members enrolled in HIP Plus who stop making monthly payments for 60 days, HIP Basic enrollment starts the month following the end of the 60-day payment period following notification to the member of the change from HIP Plus to HIP Basic.

Regardless of income level, all members enrolled in other Medicaid categories who transfer to HIP, including those moving from presumptive eligibility, enroll directly into HIP Basic. This ensures that members who currently have Medicaid coverage do not experience coverage gaps while waiting to enroll in HIP Plus. For these initial enrollments in HIP Basic, members have a 60-day payment period while in HIP Basic to make a payment and move to HIP Plus. For members who make a payment, HIP Plus coverage begins the first of the month in which the payment is made.

Members who have income over the poverty level are not eligible for ongoing HIP Basic coverage. A member with income over the poverty level may be enrolled in HIP Basic when (1) the member transitions from another Medicaid category as noted in Table 8, or (2) the member had income at or below the poverty level and enrolled in HIP Basic, and income then increased over the poverty level. Members with income over the poverty level enrolled in HIP Basic have a 60-day period to transition to HIP Plus. Following this 60-day period, these members are disenrolled from HIP if they have not made a payment for HIP Plus since HIP Basic is not available as an ongoing coverage option for individuals with income over the poverty level.

On an annual basis, all ongoing HIP Basic enrollees receive an opportunity to move to HIP Plus by making their required contribution. This occurs following the individual's annual renewal of HIP coverage. HIP Basic members that receive preventive services and have a balance remaining in their POWER Account receive an additional opportunity to transfer to HIP Plus by a rollover incentive which provides a discount off the member's required HIP Plus contribution. Members enrolled in HIP Plus always have any of their remaining member contributions rollover, and these contributions are matched by the state when the member received preventive care. Since 2015, approximately 40 to 45 percent of HIP members who complete a full benefit period have qualified for a rollover incentive to reduce the ongoing cost of HIP Plus coverage, and in 2018 the average amount rolled over was approximately $50.

In this renewal, no substantial changes are requested to HIP Basic or HIP Plus or the rollover incentive. In the waiver approval, Indiana requests flexibility to vary HIP Basic copayment amounts within the Medicaid limits with proper notification to CMS, members and stakeholders, but without requiring a waiver amendment.

4.4 Non-Payment

Not paying monthly contributions within 60 days results either in enrollment in HIP Basic, disenrollment from HIP Plus, or failure to complete enrollment into HIP Plus. Members who

complete enrollment into HIP Plus and have income over the poverty level are subject to a six-month, non-eligibility/lockout period where they may not reenroll into HIP unless the member experiences a qualifying event.

Table 8: Results of Non-Payment by Member Characteristics

Member Characteristics	Action after 60-days with no payment	Subject to Non-eligibility period?
Approved applicant below the poverty level	Enrolled in HIP Basic.	No
Approved applicant above the poverty level	Not enrolled in HIP. No lockout applied, may reapply.	No
HIP Basic member with income above the poverty level	Disenrolled from HIP. No lockout applied, may reapply.	No
HIP Plus member with income below the poverty level	Enrolled in HIP Basic.	No
HIP Plus member with income above the poverty level	Disenrolled from HIP. Member is locked out of HIP coverage for six-months unless member experiences qualifying event.	Yes
Medically frail HIP member with income above the poverty level	Member remains enrolled but copayments are added for services received.	No

HIP members disenrolled from HIP Plus for non-payment and subject to the six-month coverage lockout may not reenroll in HIP until the six-month period expires, or the member has a qualifying event. Qualifying events include:

- Obtained and subsequently lost private insurance coverage
- Had a loss of income after disqualification due to increased income
- Took up residence in another state and later returned
- Is a victim of domestic violence
- Was residing in a county subject to a disaster declaration made in accordance with IC 10-14-3-12 at the time the member was terminated for non-payment or at any time in the 60 calendar days prior to date of member termination for non-payment
- Is medically frail

HIP has incorporated a lockout period for non-payment since initial implementation in 2008. The initial lockout period was for 12 months. This period was decreased to six months in 2015. The HIP lockout period is aligned with commercial market coverage policies, where individuals who fail to maintain coverage during the year must wait to re-enroll unless they have a special enrollment event or until the annual open enrollment opportunity.

In 2018, as reported by the Interim Evaluation Report 5,500 members were subject to a HIP lockout for non-payment.[14] Since the initiation of the program, the rates for applying the non-payment lockout as a proportion of individuals that could be subject to the lockout have remained relatively low and stable on an annual basis ranging from a low of three percent to a high of 8.5 percent.

In this renewal request, no changes are requested the non-payment policy.

4.5 Retroactive Coverage

Since initiation in 2008, HIP has included a waiver of retroactive coverage. As discussed in the proceeding sections, following application, HIP benefits do not become effective until the first of the month in which payment is made, or the 60-day payment period expires. This requirement to make a payment to initiate coverage, or to wait for 60-days for coverage to start is aligned with commercial market enrollment policies. In HIP, pregnant women that are within the HIP income eligibility receive coverage that is retroactive up to three months from the date of application. All other populations covered by HIP are not eligible for coverage prior to the month of application, and have a coverage start date in accordance with the payment date or the expiration of the 60-day payment period.

In this renewal request, no changes are requested to the retroactive coverage policy.

4.6 Gateway to Work

Gateway to Work began in 2015 to promote the connection between employment and health by integrating the State's various work-training and job-search programs with HIP. Through this initiative, all eligible HIP members who were unemployed or working less than 20 hours per week were referred to available employment, job search and training programs to assist in securing gainful employment. This voluntary referral program had few members take advantage of the job search and training opportunity; only 580 Gateway to Work orientations were attended during the first 15 months of the voluntary program.

One of the goals of the HIP demonstration as approved in 2015 was to provide HIP members with opportunities to seek job training and stable employment to reduce dependence on public assistance. To meet this goal, the Gateway to Work program was modified from a voluntary to a mandatory initiative in the 2018 approval.

Beginning in 2019, members that are not exempt and not currently working at least 20 hours per week must complete qualified activities for eight out of 12 months of the calendar year to

[14] HIP Interim Evaluation, Draft for Public Comment. November 6th, 2019. Exhibit F.4.4a, pg. 150.

maintain their benefits. The required hours phase in from zero to 20 hours over the course of 18-months, following the below schedule.

Table 9: Gateway to Work Phase In Schedule

Date Range	Required Hours
January 1, 2019 – June 30, 2019	0 hours per month (0 hours per week)
July 1, 2019 – September 30, 2019	20 hours per month (5 hours per week)
October 1, 2019 – December 31, 2019	40 hours per month (10 hours per week)
January 1, 2020 – June 30, 2020	60 hours per month (15 hours per week)
July 1, 2020 – Ongoing	80 hours per month (20 hours per week)

Compliance with the Gateway to Work requirement is designed to be checked at the end of the calendar year. To be compliant, members must have eight out of 12 months of the year where they are exempt from the requirement or have completed qualifying activities. Months in which members are not enrolled in HIP count compliant months. Effective October 2019, eligibility suspension for failure to complete the requirement was temporarily removed pending the resolution of a lawsuit challenging the approval of the Gateway to Work program.

4.6.1 Exemptions

All HIP members may participate in Gateway to Work, but members that have an exemption do not have any requirement to participate.[15] Members meeting the following criteria are considered exempt from the Gateway to Work requirement:

- Pregnant
- Primary Caregiver of Children under 13
- Medically Frail
- Full- or Part-Time Student
- Homeless
- Recently Incarcerated or Institutionalized
- Temporary Certified Illness or Incapacity
- Participating in Substance Use Disorder (SUD) treatment
- Kinship Caregivers of Abused or Neglected Children
- Primary Caregiver of Disabled Dependent
- SNAP and TANF Recipients
- Age 60 or older
- Exemptions for Good Cause
- Member of Federally Recognized Tribe

Member exemptions are applied prospectively where the exemption is already known to the State; for example, SNAP and TANF recipients. For exemptions that are not applied prospectively, members may report any exemptions for past, current and future months.

[15] In the HIP Workforce Bridge Amendment submitted in July 2019, the dependent age for caretakers was increased from under 7 to under 13 and the exemption for federally recognized tribes was added.

Member requested exemptions are reported to MCEs and documented in the Gateway to Work tracking system.

4.6.2 Qualified Activities

Members that have a requirement for Gateway to Work may meet the requirement by completing any of the following qualified activities:

- Employment and self-employment
- Homeschooling
- Job search activities
- Education related to employment
- College education
- English as a second language
- General education
- High school equivalency
- Job skills training and vocational education
- Caregiving services
- Community and public service
- Volunteer work
- Other miscellaneous non-prohibited activities

Activities that do not count for Gateway to Work include:

- Illegal activities
- Medical treatment, such as doctor's appointments, medical tests or treatment
- Taking care of own pets
- Behavioral health counseling or case management, such as therapy appointments or time billed by an entity providing case management services
- Support groups (anger management, behavior awareness, PTSD, cancer support group)
- Activities directly related to the health improvement of the member rather than their community engagement
    - Examples: swimming classes, participating in a 5k, exercise classes and smoking cessation classes

Members that have verified employment of at least 20 hours per week, for the purposes of HIP eligibility, are considered to meet the Gateway to Work requirement; these enrollees are not required to report community engagement hours. For members required to report activities, multiple modes of reporting are available, including online or by phone via the MCEs. All online tools and resources are designed to be mobile device compatible. Members may report activities for the current month or any past month during the calendar year. Member activity reports are accepted based on member self-attestation. Both MCEs and OMPP review a sample of the reported activities to verify that the member attestation is reasonable and compatible with known information about the member using a reasonable compatibility methodology.

4.6.3 Member Supports

Gateway to Work is designed to ensure member success. All members receive notification of their requirements for completing Gateway to Work. Specifically, on a monthly basis, along with the POWER Account statement, members receive an update of their status towards meeting their requirements. Gateway to Work status is also documented in FSSA's online benefits portal. Additionally, multiple options are available for members that need help understanding the requirement, identifying if they are exempt, or finding activities.

For example, members may complete an initial online assessment. This assessment will inform members if they may be exempt or are already completing activities that meet the requirement. Referrals to Gateway to Work partner resources are also provided through this process. Members who cannot complete the assessment online may call their MCE and complete the same assessment telephonically with an MCE representative.

Additionally, members who need support beyond referrals and general information have the option of completing a more in-depth assessment with their MCE. This process builds off the information provided in the initial assessment to help support identification of a more concrete plan to meet the Gateway to Work requirements. Further, members that need additional help beyond completing assessments, may receive ongoing Gateway to Work assistance through their MCE. This ongoing assistance will support members in development and monitoring of a plan to achieve Gateway to Work compliance.

In addition to MCE supports, organizations across the state have stepped up as Gateway to Work partners. Gateway to Work partners may provide many levels of support including: computer terminals where members can log their information, access state-funded job training and adult education classes, comprehensive education and support in meeting the requirements, or volunteer opportunities where members can complete activities.

4.6.4 Eligibility Suspensions

Effective October 2019, eligibility suspensions for Gateway to Work are not active pending resolution of a federal lawsuit. As designed, members that have a requirement to report but are non-compliant will have their benefits suspended if they do not meet the Gateway to Work requirement eight out of 12 months of the calendar year. Members that are not on track to meet the annual requirement by October of the calendar year will have the opportunity to go back and report earned hours for previous months and/or complete pre-suspension courses that will help count towards member compliance with the requirement. Members are evaluated for suspension in December and all existing information, including member reported hours and exemptions during the calendar year, will be considered. Members that are not exempt and do not meet the requirement to complete Gateway to Work activities for eight out of 12-months of the calendar year, inclusive of participation in pre-suspension courses, will be suspended from HIP benefits effective January 1st of the subsequent calendar year. All suspended members can have their benefits restored quickly without having to reapply. After January 1st, all suspended members will work directly with the Gateway to Work Unit to resolve their suspension. Suspension resolution can occur by the member reporting hours and meeting the current month's hours requirements, gaining an

exemption, gaining full or part-time work, or enrolling in full or part-time post-secondary training.

4.6.5 Current Gateway to Work Operations

The Gateway to Work requirement began in January 2019. Members were not required to report activities until July 2019. In July 2019, out of approximately 380,000 fully enrolled HIP members 73 percent of members were exempt, 8 percent who are not exempt meet the requirement with current reporting of employment, and the remaining 19 percent were required to report either hours or an exemption.[16] Since initial implementation, members have been reporting exemptions and hours by calling their MCEs and by accessing the online reporting tool. More detailed description of the first six months of Gateway to Work is included in the Interim Program Evaluation available concurrent with this renewal request.

Effective October 2019, the enrollment suspension for not meeting the requirement was temporarily removed pending the resolution of a lawsuit. In this renewal no changes are requested to the existing Gateway to Work approval.

4.7 HIP Workforce Bridge Account

The State requests the HIP Workforce Bridge Account be authorized as a component of the renewal, consistent with the waiver amendment submitted in July 2019.[17]

The HIP Workforce Bridge Account will provide $1,000 to pay for health care expenses that occur during a transition to commercial coverage. This will include payment for premiums, deductible costs, copayments, and co-insurance incurred through enrollment on the commercial plan. HIP members who lose eligibility for HIP due to increased income will be qualified for the Account. This Account will help to bridge the gap between the costs of HIP and costs of commercial insurance.

The HIP Workforce Bridge Account is targeted for implementation in Spring of 2020, the final year of the current HIP demonstration. It is estimated that approximately 27,000 HIP members may qualify for the account on an annual basis.

4.8 Managed Care Entity Selection Periods

In HIP, a member's MCE is the main point of contact for coverage. Beyond coordinating access and payment for health care services, HIP MCEs monitor the member deductible and POWER Account, provide member incentives, and, starting in 2019, support members with Gateway to Work. Similar to selection of coverage during commercial market enrollment periods, HIP members have an opportunity to select their plan prior to making their initial POWER Account contribution payment. Following enrollment into an MCE, members receive an opportunity to change plans once per year, during the annual open enrollment period. The open enrollment period occurs each fall, with the selection of the new MCE

[16] FSSA Data provided August 15th, 2019 via e-mail. Gateway to Work allows for retroactive reporting of exemptions, so exemption percentage for July 2019 may increase throughout the year.
[17] The HIP Workforce Bridge Account Amendment is available at: https://www.in.gov/fssa/hip/files/BridgeAmendmentRequest2019_SubmissionFINAL.PDF

taking effect on January 1 of the following calendar year. Members continue to have the opportunity to change plans for cause, in accordance with 42 CFR §438.56.

In this waiver request no changes are requested to the current process for selecting, maintaining and changing enrollment in MCEs.

4.9 HIP Maternity Coverage

Beginning in 2018, all HIP members who become pregnant and any new applicants who are pregnant and are within the HIP income level are enrolled in HIP Maternity coverage. HIP Maternity coverage provides the HIP State Plan benefit package and has no cost sharing. Pregnant women remain eligible for retroactive coverage when enrolled in HIP. All pregnancy services are considered to be covered outside of the member POWER Account, and pregnant women that complete preventive care, including prenatal visits, can qualify for rollover and reduce their costs of future enrollment in HIP Plus. In addition to the ability to earn rollover incentives while pregnant, continued enrollment in HIP during pregnancy eliminates the coverage transition between HIP and Hoosier Healthwise at pregnancy onset and the end of the 60-day post-partum period. This provides greater coverage continuity for members.

No changes are requested to the HIP Maternity policy applicable to pregnant women with income under the HIP income limit.

4.10 Non-emergency Transportation

The HIP Basic and HIP Plus alternative benefit plans are based on commercial market benefits and do not include coverage for non-emergency transportation. A waiver of non-emergency transportation has been a component of HIP since initial implementation in 2008. Pregnant members, medically frail members, and members who qualify as Section 1931 low-income parents and caretakers qualify for the full Medicaid benefit package and receive non-emergency transportation.

In this waiver renewal, no changes are requested to the non-emergency transportation policy.

4.11 Eligibility Renewal Requirements

Similar to commercial market coverage, HIP incorporates requirements that encourage members to maintain coverage. These requirements include the HIP POWER Account contribution policy, as well as the policy around HIP renewals. In the 2008 implementation, HIP excluded individuals who did not renew their HIP coverage from reenrolling in coverage for a set period of time. This policy to require renewal of HIP coverage and to exclude individuals who do not renew coverage for a period of up to six months was reauthorized in the 2018 approval and also exists in Indiana Code at 12-15-44.5-4.9(b). Individuals who fail to complete their HIP coverage renewal on time have a grace period of three months where they can complete the renewal without a penalty. Following the grace period, there is a three-month period where members are excluded from HIP enrollment. Members who do not successfully complete a renewal during enrollment, or in the grace period, are eligible to reenroll after six months from the expiration of their HIP coverage. Members who are

medically frail, pregnant, or Section 1931 low-income parents and caretakers are exempt from the exclusion period for failure to renew coverage.

While authorized in the current approval, this policy is not currently in effect. Continued authorization to implement this policy is requested.

4.12 Presumptive Eligibility

The HIP waiver currently includes the authorization for additional provider types, including Federally Qualified Health Centers, Rural Health Centers, Community Mental Health Centers and Health Department sites, to complete presumptive eligibility (PE) for HIP members. Through 2017, HIP has received over 340,000 PE applications, and has enrolled over 265,000 individuals in coverage through PE since 2015.[18] No changes to this waiver component are requested.

4.13 Medically Frail with Income Above the Poverty Level

Members in HIP who are medically frail but who have income over the poverty level are not subject to disenrollment from HIP if they fail to make their POWER Account contribution within 60 days. Medically frail members with income over the poverty level continue to owe POWER Account contributions, but also become subject to copayments when they fail to pay the required monthly POWER Account contribution. As with all HIP members, total cost sharing is limited to five percent of quarterly income. Medically frail members subject to copayments and contributions have an annual opportunity at eligibility renewal to eliminate their copayments by making a required contribution.

In this waiver renewal request, no changes are requested for the medically frail with income over the poverty level.

4.14 Transitional Medical Assistance

In the 2018 approval, Transitional Medical Assistance (TMA) was authorized as continued coverage for Section 1931 low-income parents and caretakers who had income increase over the HIP eligibility threshold. Individuals who have income that increases over the Section 1931 low-income parent and caretaker limit, but remain under the HIP income level, maintain their HIP enrollment but are not designated as TMA, as HIP provides continued comprehensive coverage. Low-income parent and caretakers who earn income over the HIP limit and designated as TMA. For these individuals, coverage is provided for six months for all income levels, regardless of the individual's payment of the HIP Plus monthly contribution. Individuals designated as TMA receive the full Medicaid benefit package with HIP Plus cost sharing. For the first six months of enrollment, TMA individuals are not disenrolled for failure to pay for HIP Plus in alignment with TMA rules. Following the initial six-month TMA period, TMA members are eligible for an additional six months of enrollment where income is below 185 percent of the federal poverty level, and the TMA member maintains HIP Plus enrollment through making the required contribution amount.

[18] HIP Annual Reports, 2015 – 2017

TMA members who do not make their POWER account payments in the second six months of enrollment will be disenrolled for non-payment.

In this waiver renewal request, no changes are requested to the TMA policy.

4.13 Substance Use Disorder

The 2018 approval included a waiver to implement enhanced benefits for substance use disorders. The request to renew the SUD waiver and the components added via the approved SMI amendment is included as part of this renewal request and detailed further in the document.

Section 5: Summary of Requested HIP Program Changes

No substantive changes are requested, with the exception of the request to incorporate the HIP Workforce Bridge Amendment requested in 2019 into the approved waiver renewal. A summary of requested non-substantive changes to the approved waiver include:

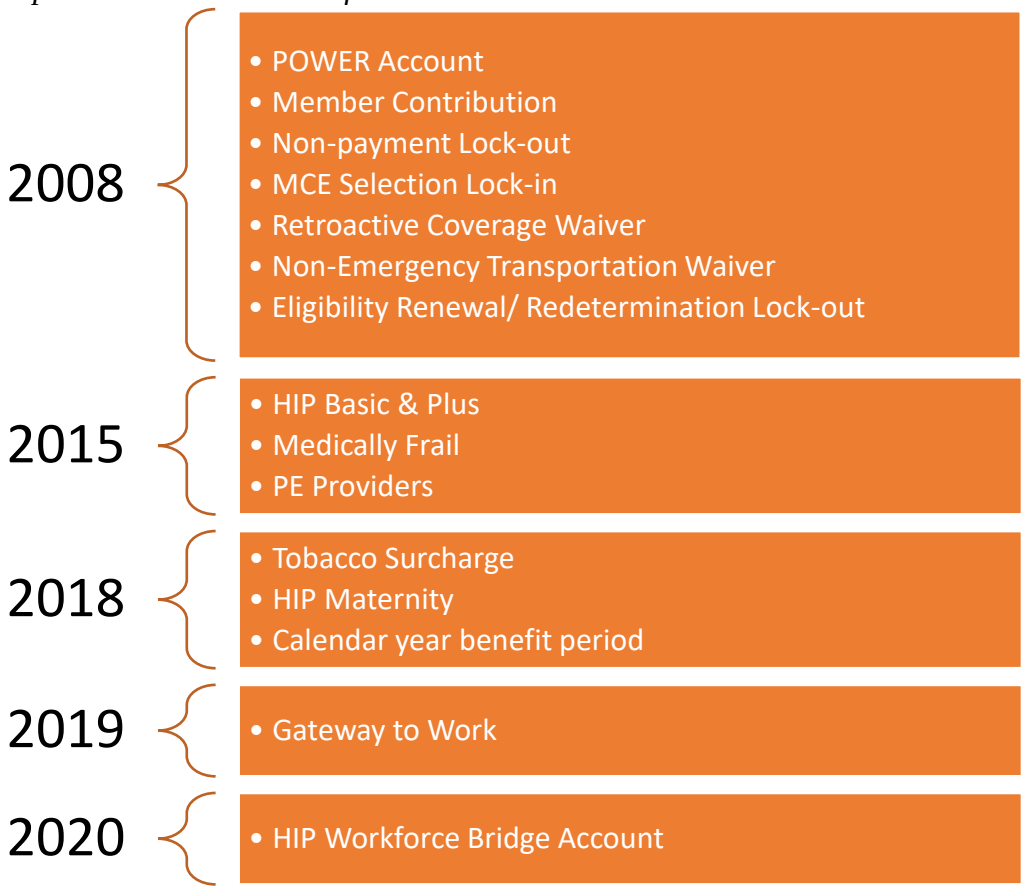
- The State requests the flexibility to modify the POWER Account contribution tiers below average limit of three percent of member income, with appropriate notice to members, stakeholders and CMS, but without requiring the submission of a waiver amendment. Modifications could include increasing or decreasing the amounts of the base contribution or the tobacco surcharge or introducing POWER Account contribution waivers such as a waiver of the contribution requirement for individuals that are also enrolled in employer sponsored coverage.
- The State requests the flexibility to modify the HIP Basic copayment amounts within the Medicaid allowable limits, with appropriate notice to members, stakeholders and CMS, but without requiring the submission of a waiver amendment. These modifications may include increases in copayment amounts within limits allowed for cost of living increases, decreases in copayment amounts, or implementation of copayment waivers on target services.

While not a change to the content approval, the substantive request of this renewal is to allow the program to be reauthorized in entirety for a period of 10 years.

5.1 10-year Approval Request

HIP is established as the Indiana program that provides coverage to low-income, non-disabled adult Hoosiers. The foundation of the HIP program, providing consumer directed coverage options that leverage commercial market policies for a Medicaid program, have been operational since 2008. When initially approved and subsequently authorized as the vehicle to cover the Medicaid expansion population in 2015, HIP pioneered innovations in Medicaid including POWER Accounts, member contributions, benefit-plan and cost-sharing variations, and commercial market policies around required monthly payment and eligibility renewals. Today, these policy innovations have been approved and implemented in Medicaid demonstration programs across the country.

Figure 2: Implementation Timeline of HIP Policies



The CMCS Informational Bulletin from November 6, 2017 covering 1115 Demonstration process improvements acknowledges that the 1115 demonstration approval process can be cumbersome and time consuming. The opportunity to renew routine and successful demonstrations for a period of up to 10 years is proposed as a solution to increase efficiency and reduce the burden associated with operating demonstrations.

From its long-term experience with HIP, Indiana knows that short approval periods requiring waiver renewal every three years do not serve to further the goals of the Medicaid program, or meaningfully enhance transparency, stakeholder input, or the federal oversight process.

As part of standard program operations, there are monthly, quarterly, and annual program reports as well as extensive program evaluation reporting completed for the 1115 demonstration. In addition, a public forum discussing the demonstration with stakeholders is held annually, and input is documented in program reporting. Further, the waiver STCs require amendments and public comment for any substantial changes to the waiver, and allow for CMS to withdraw approval for the entire demonstration or for any component of the demonstration at any time, negating the need for short approval periods. All of these activities are opportunities for meaningful transparency and stakeholder input.

Three-year renewal cycles create administrative complexity. A program may only be in effect for 12–18 months before drafting of the renewal must begin. Because renewal applications are due up to one year before the waiver authority expiration, a state must begin waiver drafting and public notice at least 18–24 months before the end of the three year-approval period. Where data on program elements is required as a component of the renewal submission, the short approval period prohibits the ability to provide meaningful data on progress and results of demonstration policies.

Indiana is committed to transparency around the demonstration, continual improvement, and support of scientifically rigorous methods to evaluate the demonstrations impacts. Renewing the long-term, core components of HIP for a 10-year period through 2030 relieves the State and CMS from the administrative requirements associated with supporting the renewal cycle, and allows for these resources to instead focus on understanding the impacts of the demonstration, and continually improve demonstration operations and monitoring. This longer approval period will also give HIP members confidence that HIP coverage is here to stay; and it will allow the State to reallocate resources from supporting the ongoing renewal process to focusing on making HIP the best program possible, and continuing to develop cutting-edge program innovations.

Section 6: HIP Program Evaluation

The Lewin Group was selected via Indiana's procurement process to complete the interim and summative independent evaluation reports for the current demonstration period (2018 to 2020). The Lewin Group and FSSA have coordinated with CMS in development of a comprehensive evaluation plan for this demonstration period. The current draft of this evaluation plan is available for review with this renewal request and incorporates the 2019 CMS 1115 evaluation guidance. The interim evaluation report is posted and submitted with this renewal request. The summative evaluation will be available by July 2022, in alignment with federal requirements in the current STCs.

For this renewal request, the State proposes that, in addition to comprehensive quarterly and annual monitoring, three separate evaluation reports be submitted covering the 10-year approval period.

- First, an initial report on the first three years of the demonstration expected to be complete in 2025
- Second, an interim report on the first eight years of the demonstration, expected to be complete in 2029 and
- Third, a final report covering the full 10-year demonstration period submitted 18-months following the expiration of the waiver in 2032. For the 10-year approval period, the state proposes to continue the currently approved evaluation design, with modifications as necessary to ensure alignment of program operations and the current program objectives detailed in Section 2.2.

Section 7: HIP Quality Reporting

Indiana has a robust quality oversight plan for continually monitoring the performance of the MCEs serving the HIP population: Anthem, CareSource, MDwise, and MHS. The Office of Medicaid Policy and Planning's (OMPP) Quality and Outcomes section is responsible for oversight of the MCEs, including managing compliance with contract requirements, monitoring program data, and reviewing required reporting documents from each MCE.

The State conducts numerous monitoring activities to assure quality and consistent delivery of healthcare services to Medicaid and HIP members. Specifically, the monitoring activities include quality management and improvement program work plans (QMIPs); data analysis; enrollee hotlines operated by the State's enrollment broker; geographic mapping for provider networks; external quality review (EQR); network adequacy assurance submissions; monthly on-site monitoring reviews; recognized performance measure reports; and surveys.

7.1 Managed Care and State Quality Assurance Monitoring

Each year, OMPP prospectively identifies priorities for improving the delivery of healthcare to Medicaid and HIP members and improving operations. These priorities are included in the State's Quality Strategy Plan (QSP). The State's QSP includes an overall framework for continuous quality improvement that utilizes several quality committees related to key agency priorities. Representation on these committees includes state agencies, including the Indiana State Department of Health, MCE staff, and other health industry experts. The 2017 and 2018 QSPs[19] contained the HIP-specific objectives and goals for quality improvement in the tables below.

Table 10: 2017 QSP HIP-Specific Goals and Objectives

	Objective	Goal
1.	HIP members shall have access to primary care within a maximum of 30 miles of the member's residence and at least two providers of each specialty type within 60 miles of member's residence.	90% of all HIP members shall have access to primary care within a minimum of 30 miles of member's residence and at least two providers of each specialty type within 60 miles of member's residence
2.	HIP members shall have access to dental and vision care within a maximum of 60 miles of the member's residence and at least two providers of each specialty type within 60 miles of the member's residence.	90% of all HIP members shall have access to dental and vision care within a minimum of 60 miles of member's residence and at least two providers of each specialty type within 60 miles of the member's residence.
3.	HIP members who obtain a preventive exam during the measurement year receive power account roll-over.	Achieve at or above 85% of the number of members who receive a preventive exam during the year.

[19] The 2019 QSP has been posted for public comment and is in the process of being finalized. Please see https://www.in.gov/fssa/files/2019%20QSP%20Plan%20-%20public%20comment%20draft%20.pdf

4.	ER admissions per 1000-member months	Achieve at or below 75 visits per 1000-member months.
5.	Percentage of members who received follow-up within 7 days of discharge from hospitalization for mental health disorders	Achieve at or above the 90th percentile for members who receive follow-up within 7 days of discharge from hospitalization for mental health disorders.
6.	Number of outpatient and emergency department visits per member months	Achieve at or above the 90% percentile of outpatient visits (HEDIS) Achieve at or below the 10th percentile of emergency department visits (HEDIS)
7.	Increase the referral of pregnant women who smoke to the Indiana Tobacco Quitline for smoking cessation services.	Achieve an increase in the percentage who are referred to and have one contact with the Indiana Tobacco Quitline.
8.	Right Choices Program (RCP)	A minimum of 90% of the findings of appeals filed by members to be removed from RCP will be upheld because the member was correctly assessed as requiring RCP services.
9.	Provide quality health care to members identified as medically frail.	Identify individuals who meet the medically frail criteria and offer access to enhanced services.

Table 11: 2018 QSP HIP-Specific Goals and Objectives

	Objective	**Goal**
1.	HIP members shall have access to primary care within a maximum of 30 miles of the member's residence and at least two providers of each specialty type within 60 miles of member's residence.	90% of all HIP members shall have access to primary care within a minimum of 30 miles of member's residence and at least two providers of each specialty type within 60 miles of member's residence.
2.	HIP members shall have access to dental care within a maximum of 30 miles of the member's residence and vision care within a maximum of 60 miles of the member's residence.	90% of all HIP members shall have access to dental care within a maximum of 30 miles of the member's residence and vision care within a maximum of 60 miles of member's residence.
3.	HIP members who obtain a preventive exam during the measurement year receive power account roll-over.	Achieve at or above 85% of the number of members who receive a preventive exam during the year.
4.	ER Admissions per 1000-member months	Achieve at or below 75 visits per 1000-member months.
5.	Percentage of members who received follow-up within 7 days of discharge from hospitalization for mental health disorders	Achieve at or above the 90th percentile for members who receive follow-up within 7 days of discharge from hospitalization for mental health disorders.

6.	Percentage of members who had a preventive care visit	Achieve at or above the 90th percentile for the percentage of members who had a preventive care visit.
7.	Frequency of prenatal and post-partum care	Achieve at or above the 90th percentile for the frequency of prenatal care and at or above the 90th percentile for the frequency of post-partum care.
8.	Increase the referral of pregnant women who smoke to the Indiana Tobacco Quitline for smoking cessation services.	Achieve an increase in the percentage who are referred to and have one contact with the Indiana Tobacco Quitline.
9.	Right Choices Program	A minimum of 90% of the findings of appeals filed by members to be removed from RCP will be upheld because the member was correctly assessed as requiring RCP services.

The QSP framework also includes MCE-led quality improvement projects (QIPs) that promote innovation and health outcomes improvement. These QIPs are submitted to OMPP and reviewed for performance.

Additionally, each of the contracted health plans are required to develop and maintain a QMIP that incorporates and addresses data from the plans' Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys and quality metrics obtained from the Healthcare Effectiveness Data and Information Set (HEDIS) collected by the National Committee for Quality Assurance (NCQA). The QMIPs also must address any opportunities for improvement identified in the EQR, which is further discussed below.

The MCEs serving the HIP population are required to submit reports to OMPP on a monthly and quarterly basis, which are reviewed by staff for compliance with contractual requirements. Additionally, OMPP also conducts a monthly on-site meeting at each of the MCEs' offices to discuss focus areas, observe process demonstrations, and address concerns from the monthly and quarterly reports. The contracted plans report on various operational and programmatic factors, including member access to primary medical providers, dentists, behavioral health providers, and specialists. The reports for 2017 indicated the following HIP access statistics for Indiana's 92 counties:

- Primary medical providers: HIP members statewide largely resided in counties in which the average mileage from a member's home address to an available primary medical provider is fewer than 30 miles. The MCEs ranged from a low of 25 counties where the distance from a member to an available provider was more than 30 miles to a high of 37 counties.[20]
- Dentists: HIP members statewide largely resided in counties in which the average mileage from a member's home address to an available dentist is fewer than 30 miles.

[20] https://www.in.gov/fssa/files/Website_Report_4A_Primary_Care%5b1%5d.pdf

The MCEs ranged from a low of seven counties where the distance from a member to an available provider was more than 30 miles to a high of 16 counties.[21]

- Behavioral health providers: HIP members statewide largely resided in counties in which the average mileage from a member's home address to an available behavioral health provider is fewer than 45 miles. The MCEs ranged from a low of six counties where the distance from a member to an available provider was more than 45 miles to a high of 10 counties.[22]
- Specialists: HIP members statewide largely resided in counties in which two providers in each identified specialist category were within 60 miles of the member's home address. Category-specific details are available on OMPP's website at https://www.in.gov/fssa/files/Website_Report_4E_Specialists_HIP%5b1%5d.pdf.

In addition to monitoring of member access to healthcare services, the State strives to ensure that the care provided to HIP members is of the highest quality. CAHPS surveys of members in 2017 and 2018 indicate that across all MCEs[23], an average of 79.7 percent of members were satisfied with their personal doctor in 2017 and 80.4 percent of members were satisfied with their personal doctor in 2018, as indicated by a ranking of 8-10 on a 1-10 scale.[24] Additionally, 75.7 percent and 77.1 percent of members were satisfied with their personal healthcare in 2017 and 2018, respectively.[25]

7.2 External Quality Review

The State utilizes Burns & Associates, Inc. to conduct an annual EQR of each of the MCEs. The EQR includes all of Indiana's Medicaid managed care programs, including HIP, Hoosier Healthwise, and Hoosier Care Connect. In addition to validating general performance measures and the performance improvement projects, the 2017 EQR for the 2016 calendar year (CY) focused on validation of performance measures, validation of performance improvement projects, and focus studies on lead testing and related outreach efforts, medication adherence, potentially preventable readmissions, and claims processing. Of note specific to HIP, the EQR includes an evaluation of the rate of potentially preventable readmissions (PPRs). This evaluation found that the PPR rate for HIP dropped from 8.8 percent in CY 2014 to 6.7 percent in CY 2016.[26] EQR reports can be reviewed online at: https://www.in.gov/fssa/ompp/5533.htm

[21] https://www.in.gov/fssa/files/Website_Report_4B_Dentist%5b1%5d.pdf
[22] https://www.in.gov/fssa/files/Website_Report_4C_Behavioral_Health%5b1%5d.pdf
[23] Anthem, MDwise, and MHS for CY2017; Anthem, CareSource, MDwise, and MHS for CY2018.
[24] https://www.in.gov/fssa/files/Website_Report_6D_HIP_CAHPS%5b1%5d.pdf
[25] *Id.*
[26] https://www.in.gov/fssa/files/FINAL%20REPORT%20External%20Quality%20Review%20of%20Indiana%27s%20Health%20Coverage%20Programs_Review%20Year%202016.pdf

Section 8: Requested Waivers

The State requests a renewal of all currently approved waivers with minor, non-substantive changes. The state also requests incorporation of the waivers granted for the HIP Workforce Bridge Amendment in the renewal. The waivers requested for the renewal period include the below.

1. Health Plan Enrollment

Expenditures under contracts with managed care entities that do not meet the requirements in section 1903(m)(2)(A) of the Act specified below. Indiana's managed care organizations (MCO) participating in the demonstration will have to meet all the requirements of section 1903(m) except the following:

a. Section 1903(m)(2)(A)(vi) of the Act insofar as it requires compliance with requirements in section 1932(a)(4) of the Act and 42 CFR 438.56(c)(2)(i) that enrollees be permitted an initial period to disenroll without cause, except as described in the terms and conditions.

b. Section 1903(m)(2)(A)(vi) of the Act insofar as it requires compliance with requirements in section 1932(a)(4) of the Act and 42 CFR 438.56(g) that automatic MCO reenrollment occur only if the beneficiary's disenrollment was due to a Medicaid eligibility lapse of two months or less, as described in the terms and conditions.

2. Premiums Section 1902(a)(14) insofar as it incorporates Section 1916 and 1916A

To enable the state to charge monthly contributions for HIP Plus at a minimum amount of one-dollar per month and not to exceed a maximum amount of three-percent of member income.

3. Reasonable Promptness Section 1902(a)(8)

To enable enrollment in HIP Plus on the first day of the month in which an individual makes their initial contribution to the POWER Account, or, for individuals with incomes at or below 100 percent FPL who fail to make an initial POWER Account payment within 60-days following the date of invoice, the first day of the month in which the 60-day payment period expires, except for individuals who are found eligible through presumptive eligibility.

4. Provision of Medical Assistance Section 1902(a)(8) and 1902(a)(10)

To the extent necessary to enable Indiana to suspend eligibility for, and not make medical assistance available to, beneficiaries who fail to comply with community engagement requirements, unless the beneficiary is exempted.

5. Eligibility Section 1902(a)(10) and 1902(a)(52)

To the extent necessary to enable Indiana to prohibit reenrollment, and deny eligibility, for up to six months, for individuals with income over 100 percent of the FPL who are disenrolled for failure to make POWER Account premium contributions within 60 days of the date of invoice, subject to the exceptions and qualifying events.

To the extent necessary to enable Indiana to prohibit reenrollment, and deny eligibility, for up to three months following the end of the 90-day reconsideration period for individuals who are

disenrolled for failure to provide the necessary information for the state to complete an annual redetermination, subject to the exceptions and qualifying events.

To the extent necessary to enable Indiana to make a determination of ineligibility, and terminate eligibility for, beneficiaries who are in a suspension of coverage for failure to meet the approved community engagement requirements on their redetermination date, unless the beneficiary meets the requirement or is exempted as described in the STCs during the month of redetermination.

6. Methods of Administration Section 1902(a)(4) insofar as it incorporates 42 CFR 431.53
To the extent necessary to relieve Indiana of the requirement to assure transportation to and from medical providers for HIP demonstration populations. No waiver of methods of administration is authorized for pregnant women, individuals determined to be medically frail, and section 1931 parents and caretaker relatives.

7. Comparability and Amount, Duration and Scope of Services Sections 1902(a)(17) and 1902(a)(10)(B)
To the extent necessary to enable the state to vary cost sharing requirements for beneficiaries for cost sharing to which they otherwise would be subject under the state plan, such that beneficiaries who are in HIP Plus will be charged only one copayment (for non-emergency use of the emergency department) and individuals who are in HIP Basic will be subject to copayments within Medicaid permissible levels.

To the extent necessary to enable Indiana to vary contribution requirements, for different HIP Plus program beneficiaries based on income and on tobacco use, and in a manner consistent with all otherwise applicable law. To allow for variations or waivers of POWER Account contribution requirements, within established limits, based on target initiatives such as encouraging uptake of employer insurance.

To allow the HIP Workforce Bridge Account to be available solely to defined eligible individuals that are disenrolled from HIP due to an increase in income.

To allow the state to provide only a limited defined benefit via the HIP Bridge Account, that is limited to cost-sharing assistance up to an amount of $1,000, regardless of health care costs incurred by the member. To allow any balance payable in excess of $1,000, to be assigned to member responsibility without regard to cost-sharing limitations.

8. Retroactivity Section 1902(a)(34)
To enable the state not to provide three months of retroactive eligibility for beneficiaries receiving coverage through the HIP program as described in the STCs, except for pregnant women.

Section 9: Demonstration Financing and Budget Neutrality

The HIP component of the demonstration does not include Budget Neutrality Component and all financing allocations are assumed to exist both with and without the waiver, no changes requested in this submission are expected to have an impact on waiver financing. Budget Neutrality is incorporated in the SUD/SMI component of this waiver renewal and is included as a component of this submission.

Section 10: Public Notice and Comment

Public notice of the HIP and SUD Renewal request was provided November 6th, 2019 and can be accessed at https://www.in.gov/fssa/hip/. Two public hearings were held:

1) Tuesday November 19th at 2:00 pm at the Indiana State Library, History Reference Room 211, 315 W. Ohio St., Indianapolis, IN 46202. This hearing was a special session of the Medical Advisory Commission.
2) Wednesday November 20th at 10 am at Indiana Government Center South, Conference Room 18, 302 W Washington St, Indianapolis, IN 46204. This hearing was accessible via web conference at https://Indiana.AdobeConnect.com/indiana.

Oral testimony was recorded via court reporter during these hearings. Written comments were received via mail at 402 West Washington Street, Room W374, Indianapolis, Indiana 46204, and via electronic mail at hip@fssa.in.gov through December 6th, 2019.

Copies of the public notice documents are provided in Attachment A. In addition to the formal public notice, FSSA also sent an e-mail to a stakeholder communication list that includes over 1,600 e-mail addresses providing information on the start of the comment period, the hearing dates, and the location of the posted documents.

In total, a combined 32 oral and written comments and a report were received. All 32 comments and the report received addressed elements of HIP, while six of these comments also addressed the SUD/SMI renewal request and are summarized separately in the SUD/SMI document. Comment sources included provider associations, community organizations, advocacy groups, health plans, a university, and HIP members. Organizations that commented both orally during the hearing, and submitted written comment were considered as one comment.

Section 10.1 Summary of Public Comments

Comments received for HIP included comments with overarching support or opposition, and comments specific to member required contributions, POWER Accounts, co-payments, Gateway to Work, retroactive coverage waiver, non-emergency transportation waiver, the process to enroll in and renew HIP coverage, and the 10-year extension request.

Many of the comments received were overall supportive of Medicaid Expansion, but not supportive of the elements of HIP that can result in coverage restrictions for HIP members. Comments supported HIPs promotion of preventive care and the programs ability to be more than just health insurance with linking of individuals to other needed services. Some comments called for the elimination of HIP and the implementation of a traditional Medicaid

expansion. Other commenters were in full support of HIP, and all requested elements of this HIP extension request.

Commenters frequently cited the independent interim evaluation report posted concurrently with the renewal for public comment. Continued rigorous evaluation, reporting and data sharing was requested by provider groups and community organizations.

POWER Account Contributions

Eighteen comments received specifically were in opposition to required POWER account contributions requesting that the policy be eliminated or changed. Commenters noted that POWER Account contributions create financial and administrative barriers and prohibit access to care. Medicaid members commented that not receiving accurate communication about their contributions made it hard to know what to pay and when and that making the payment could be a financial challenge. One comment noted that specifically for rural Hoosiers without checking accounts, cell or internet access, that getting to the store to get stamps and mail payments was a barrier. Changes in contribution amounts during the year were noted as problematic and concerns were raised about the impact of POWER Account contributions on increasing member churn. One commenter noted that due to the POWER Account contributions, many individuals may not enroll in HIP, or only enroll in HIP Basic coverage which prohibits care access. Two commenters cited studies showing that adding or increasing premiums for low income individuals results in a decrease in the number of people covered. Commenters cited the draft interim evaluation report noting the racial disparities in disenrollment from HIP Plus as a reason for not supporting POWER Account contributions. Multiple commenters requested that research be conducted into the root cause of this disparity.

Two commenters requested that the required contribution be eliminated for individuals under the poverty level, and one noted that if eliminating the requirement under the poverty level was not a possibility that making the contribution be the same amount for the entire year or eliminating it for individuals only under 50 percent of the poverty level was requested.

Comments from health plans and provider associations were received that supported HIP's incorporation of personal responsibility including required contribution and that it resulted in increased engagement of HIP Plus members.

Tobacco Surcharge

Five comments received included comments on the HIP's tobacco surcharge. Four advocacy groups commented in opposition to the tobacco surcharge, noting that there is no evidence-based support for tobacco surcharges decreasing tobacco use and increasing utilization of cessation services. A provider association commented in support of the tobacco surcharge noting that it promoted efficient use of the health care system and positively impacted public health.

POWER Accounts

Eight comments received specifically commented on POWER Accounts. Six of these commenters including advocacy groups and one Medicaid member noted that the POWER

Account structure created confusion and barriers for patients to access care. The report submitted as a comment noted that POWER Accounts generate statements with health care cost information, but that interviews and focus groups with members did not reveal that the statement was understood by members or used to inform purchasing decisions. An education gap was also noted, in that members did not know about rollover. One comment was received from a provider association noting support for the preventive care incentive present in the accounts.

HIP Basic Copayments

Five comments received noted that HIP Basic copayments were prohibitive to members receiving needed care. One commenter noted the increased price sensitivity of low-income individuals to even nominal copayments. Commenters citied the reduced utilization or primary care and increased utilization of emergency care observed from HIP Basic members in the interim evaluation report. Copayments discouraging visits to primary care and filling prescription medications were noted as areas of concern.

Non-emergency ER use Copayment

Six comments were received that referenced the non-emergency ER copayment. Five advocacy organizations commented in opposition to this policy as it can deter people from seeking needed care in an emergency. One provider organization commented in support of the non-emergency ER copayment.

Gateway to Work

Twenty-four comments were received relating to Gateway to Work. The majority of these comments requested that the program requirement be discontinued in the waiver renewal and expressed concern about potential coverage losses resulting from the program, additional administrative burden on members and the state, member's ability to comply with the reporting requirement if they do not have phone or email, concerns about members understanding the requirement and the exemption process. Related to exemptions, one commenter requested that cystic fibrosis be added as an exemption type. A member commented that the mail received regarding GTW was confusing, sometimes received late, and that the medical exemption process was confusing to navigate. The Interim Evaluation report was cited noting that through June 2019 only 1 percent of individuals had reported activities for Gateway to Work. Commenters also expressed concern about the costs of operating the program.

Comments received in support of the program applauded the focus on social determinants of health, building life skills and promoting completion high-school equivalency and technical certifications. One commenter noted that the education, training, and employment promoted by Gateway to Work will help HIP members to take advantage of the expected need for additional workers Indiana's economy over the next 10-years. One commenter specifically requested that the use of Gateway to Work infrastructure developed to connect individuals to resources and opportunities continue to be maximized even though the requirement is on hold, as HIP members benefit from being connected to resources, education, training and employment.

Retroactive Coverage Waiver

Eight comments were received specific to HIP's waiver of retroactive coverage. These comments noted that the Medicaid application process is lengthy and complicated and that there is substantial burden on individuals in gaining and maintaining Medicaid. Individuals may lose coverage due to administrative reasons that result in coverage gaps without availability retroactive coverage. Individuals may also not apply for coverage until they are sick and without retroactive coverage, they may incur Medical debt. Specific to HIP, the coverage start date of HIP Basic, following sixty days of non-payment for Plus was cited as creating coverage gap issues exacerbated by the retroactive coverage waiver.

HIP Workforce Bridge

Nine comments were received regarding the pending HIP Workforce Bridge initiative which is incorporated as an element of the requested renewal. All comments received were in support of this initiative. One of the comments requested that the amount of the account be increased, and an additional comment requested that limits be established on the types of plans that premiums can be reimbursed for from the account.

Non-Emergency Medical Transportation

Eight comments were received regarding non-emergency transportation (NEMT) and the NEMT waiver applicable to non-medically frail individuals in the adult group in HIP. All comments made the case for the importance of NEMT to the HIP population and opposed the NEMT waiver. Commenters made noted that individuals were more likely to keep medical appointments with access to NEMT, that NEMT was becoming a more common benefit in commercial plans specially Medicare Advantage plan options, and that transportation to medical appointments was specifically challenging for individuals managing multiple chronic conditions. Suggestions were also received for improving the current NEMT system in Indiana.

Enrollment and Renewal Processes

Eight comments were received regarding the processes to enroll in HIP coverage, maintain HIP coverage, and renew HIP coverage. Medicaid members, community organizations and a University provided examples of cases where there were challenges in collecting, submitting, and having documentation processed. Members provided comments relating to confusing and delayed communication. Commenters noted that the start of coverage was delayed by administrative issues with submission of required paperwork, and the delay in coverage resulted in members not being able to go to the doctor. The burden of managing the documentation and verifications required is a challenge for HIP members. One commenter requested that HIP allow a continuous 1-year eligibility period without requiring mid-year verifications related to changes.

10-Year Renewal Request

Ten comments were received opposing the 10-year renewal requests. Three of these comments requested that HIP be discontinued entirely and replaced with a traditional Medicaid expansion. One comment indicated that they did not see the NEMT waiver as routine or noncomplex, and other commenters added that Gateway to Work, POWER Account contribution tiers and the tobacco surcharge changed in the 2018 approval and

information on their efficacy is not yet available to support a 10-year approval. The existing legal challenge of the current HIP approval was noted by one commenter. Six of the comments opposing a 10-year approval supported a 5-year approval of HIP.

Comments from Health Plans and provider associations noted support of the long-term extension of the HIP program.

Section 10.2 Response to Comments & Changes Made as a Result of Public Comment

FSSA appreciates the comments received on the HIP extension request and notes the substantive content and evident thoughtfulness of commenters. The engagement of stakeholders is a defining feature of the HIP program and the comments received during the extension period comment opportunity clearly demonstrate the value of this engagement.

POWER Accounts, Required Contributions, Retroactive Coverage, Non-Emergency Transportation, and Non-emergency ER Copayment

Commenters' concerns related to coverage losses and barriers to accessing coverage presented by HIP policies including required contributions, the retroactive coverage waiver and HIP Plus and Basic enrollment timelines, confusing around the complexity and efficacy of POWER Accounts, and the Non-Emergency ER Copayment are appreciated. In particular, providing examples of specific challenges and barriers presented to members as a result of these policies provide valuable information to support continued program improvement. FSSA is committed to ensuring members understand HIP policies minimizing administrative barriers to compliance. Where commenters noted barriers specifically for rural members in making payments due to not receiving a pre-paid postage envelope to mail their payment, FSSA will move to address this barrier and require pre-paid postage envelopes be provided for submission of payments. This will not require a change to the waiver extension application.

Policies covering POWER Accounts, required contributions, retroactive coverage, non-emergency transportation and non-emergency ER copayments as described in this waiver extension are drafted to align with state law authorizing the HIP program. In Indiana Code, at IC 12-15-44.5 these policies are established. Due to the requirements present in Indiana Code concerning these policies, there are no changes made to this application as a result of public comments received.

HIP Basic Copayments

FSSA appreciates comments noting that members with HIP Basic found the copayments a disincentive to seeking appropriate care, particularly in filling prescriptions and getting primary care. As noted by commenters, negative utilization differences between HIP Basic and HIP Plus members are reported in the independent interim evaluation. Like commenters FSSA is concerned about the utilization difference between HIP Basic and HIP Plus and the potential that HIP Basic copayments are contributing to this difference. The existing request present in this waiver extension application to allow for modification of copayments without submission of a waiver amendment but with appropriate notification would allow for FSSA to adjust or waive HIP Basic copayments to address utilization concerns. As such, no changes are made to this application based on comments received.

Gateway to Work

FSSA acknowledges commenters concerns that Gateway to Work will result in coverage losses, that it increases administrative burden for individuals, and is costly to the state. The purpose of Gateway to Work is to connect individuals to educational, training, work and volunteer opportunities and to resources that support member success. FSSA is committed to minimizing any coverage loss resulting from this program. Comments highlighting the administrative challenges of Gateway to Work and specifically the exemption process and monthly reporting will be taken into consideration in improving the program. As designed, while monthly reporting is encouraged, HIP members have until the end of each calendar year to correct any non-compliant months prior to compliance actions being taken in following year – so members that cannot report monthly or only learn they need an exemption later in the year are not subject to penalties. In addition, related to the request to add cystic fibrosis as an exemption type, FSSA is not adding new exemption types, as the requested exemption type proposed by commenters would be eligible for a medical exemption under current policy.

At this time, no changes related to the design of Gateway to Work are made to the extension request as a result of public comment.

Tobacco Surcharge

FSSA appreciates comments related to the tobacco surcharge. Based on program design, the first year the tobacco surcharge applied was in 2019. At this point there is not enough information to provide evidence of the efficacy or inefficacy of the policy. As such, no changes are made related to the tobacco surcharge.

10-year request

FSSA appreciates comments in support of a long-term renewal of HIP. Some commenters noted that due to the inclusion of policies that started in 2018 and 2019, that a 10-year renewal of those policies seems premature. Most commenters opposed to a 10-year extension supported a 5-year extension of HIP. Due to the long standing and proven core features of HIP and the minimal changes made in the 2018 approval, no changes are made to the request for a 10-year approval of the HIP demonstration at this time.

Support for the HIP Workforce Bridge

FSSA appreciates comments of support related to the HIP Workforce Bridge. One commenter that requested that HIP Workforce Bridge be limited to only reimburse ACA compliant plans, FSSA supports access to comprehensive coverage on leaving HIP, however realizes that all individual situations are different and so is committed to linking individuals who receive accounts with qualified Navigators to support individuals in the best coverage decision. Related to the request to increase the value of the account, current funding allocation for HIP Bridge accounts do allow for an increased account value. No changes are requested to the HIP Workforce Bridge component in this extension request as a result of public comment.

Administrative Issues and Commenter Recommendations

A major theme of the comments received both in writing and via testimony at the hearings, related to administrative challenges with applying for, enrolling in, and maintaining HIP coverage. Commenters requested consideration of continuous eligibility policies. FSSA notes that the application, verification and redetermination processes are not unique to HIP. Minimizing barriers to individuals gaining and maintaining coverage is a key goal and the causes of the administrative issues reported will be investigated to target improvement. This process does not require changes to this extension request.

Commenters also recommended continued reporting and rigorous program evaluation and stakeholder engagement, as well as further investigation of the underlying causes of the racial disparities noted in the interim evaluation report. While no changes are made to this extension request as a result of these comments, FSSA agrees with commenter suggestions and is committed to ongoing reporting and stakeholder engagement and identifying and addressing root causes of barriers to disparities and barriers to coverage.

Section 11: Tribal Notice

Notice of the waiver renewal request was provided to Indiana's federally recognized tribe, the Pokagon Band of Potawatomi Indians, on November 1, 2010. The notice and opportunity for consultation was provided in accordance with 42 CFR 431.408(b).

No tribal comment or request to meet was received during the tribal notice period.

Section 12: HIP Demonstration Administration

Name and Title: Natalie Angel, Healthy Indiana Plan Director
Telephone: (317) 234-5547
Email Address: Natalie.Angel@fssa.in.gov

ATTACHMENT A: Public Notices

OFFICE OF THE SECRETARY OF FAMILY AND SOCIAL SERVICES ADMINISTRATION
NOTICE OF PUBLIC HEARING

In accordance with 42 CFR §431.408(a)(2)(ii), the Indiana Family and Social Services Administration (FSSA) will be holding public hearings on a proposed extension of the Healthy Indiana Plan Section 1115 demonstration waiver (HIP Waiver) that will be submitted to the Centers for Medicare and Medicaid Services (CMS). Through this The Healthy Indiana Plan (HIP) has been a feature of Indiana's Medicaid program since 2008. The current approval to operate HIP expires December 31, 2020. FSSA is seeking a ten year extension of the HIP Waiver with no substantive changes. The extension request includes incorporation of the HIP Bridge Account amendment, which was submitted to CMS on July 25, 2019. FSSA will be requesting the following non-substantive, technical changes through the extension request:

- Flexibility to modify the POWER Account contribution tiers below average limit of three percent of member income, with appropriate notice to members, stakeholders and CMS, but without requiring the submission of a waiver amendment. Modifications are not currently proposed but could, for example, include increasing or decreasing the amounts of the POWER Account base contribution or the tobacco surcharge.
- Flexibility to modify the HIP Basic copayment amounts within the Medicaid allowable limits, with appropriate notice to members, stakeholders and CMS, but without requiring the submission of a waiver amendment. Modifications are not currently proposed but these modifications may include increases in copayment amounts within limits allowed for cost of living increases, decreases in copayment amounts, or implementation of copayment waivers on target services.

Additionally, through this waiver extension application, FSSA is seeking federal approval for a five-year extension of the substance use disorder (SUD) and requested serious mental illness (SMI) components of the HIP Waiver. This includes authority to reimburse institutions for mental disease (IMDs) for short term stays for individuals diagnosed with SMI or SUD.
Hearings will be held as follows:

1) Tuesday November 19th at 2:00 pm at the Indiana State Library, History Reference Room 211, 315 W. Ohio St., Indianapolis, IN 46202. This hearing will be a special session of the Medical Advisory Commission.
2) Wednesday November 20th at 10 am at Indiana Government Center South, Conference Room 18, 302 W Washington St, Indianapolis, IN 46204. This hearing will be also be accessible via web conference at https://Indiana.AdobeConnect.com/indiana.

All information regarding the submission, including the public notice, the HIP Waiver extension, and other documentation regarding the proposal are available for public review at the FSSA, Office of General Counsel, 402 W. Washington Street, Room W451, Indianapolis, Indiana 46204. The full Public Notice and HIP Waiver documents are also available to be viewed online at https://www.in.gov/fssa/hip/.
Written comments may be sent to the FSSA via mail at 402 West Washington Street, Room W374, Indianapolis, Indiana 46204, Attention: Natalie Angel or via electronic mail at hip@fssa.in.gov through **December 6th, 2019**.

OFFICE OF THE SECRETARY OF FAMILY AND SOCIAL SERVICES ADMINISTRATION

NOTICE OF PUBLIC COMMENT PERIOD TO EXTEND THE HEALTHY INDIANA PLAN 1115 DEMONSTRATION

Pursuant to 42 CFR § 431.408(a), notice is hereby given that the Indiana Family and Social Services Administration (FSSA) will provide the public the opportunity to review and provide input on a proposed extension of the Healthy Indiana Plan Section 1115 demonstration waiver (HIP Waiver). This notice provides details about the waiver amendment submission and serves to open the 30-day public comment period, which closes on December 6, 2019.

In addition to the 30-day public comment period in which the public will be able to provide written comments to the FSSA via US postal service or electronic mail, the FSSA will host two public hearings in which the public may provide verbal comments. Hearings will be held at the following dates, times, and locations:

1) Tuesday, November 19th at 2:00 pm at the Indiana State Library, History Reference Room 211, 315 W. Ohio St., Indianapolis, IN 46202. This hearing will be a special session of the Medical Advisory Commission.
2) Wednesday, November 20th at 10:00 am at the Indiana Government Center South, Conference Room 18, 302 W. Washington St., Indianapolis, IN 46204. This hearing will be also be accessible via web conference at https://Indiana.AdobeConnect.com/indiana.

Prior to finalizing the proposed HIP Waiver extension, the FSSA will consider all the written and verbal public comments received. The comments will be summarized and addressed in the final version to be submitted to the Centers for Medicare and Medicaid Services (CMS).

EXTENSION PROPOSAL SUMMARY AND OBJECTIVES

The Healthy Indiana Plan (HIP) has been a feature of Indiana's Medicaid program since 2008. The current approval to operate HIP expires December 31, 2020. Based on the long-tenure and demonstrated success of HIP, FSSA is seeking a ten year extension of the HIP Waiver with no substantive changes. The extension request includes incorporation of the HIP Bridge Account amendment, which was submitted to CMS on July 25, 2019. FSSA will be requesting the following non-substantive, technical changes through the extension request:

- Flexibility to modify the POWER Account contribution tiers below average limit of three percent of member income, with appropriate notice to members, stakeholders and CMS, but without requiring the submission of a waiver amendment. Modifications are not currently proposed but could, for example, include increasing or decreasing the amounts of the POWER Account base contribution or the tobacco surcharge.
- Flexibility to modify the HIP Basic copayment amounts within the Medicaid allowable limits, with appropriate notice to members, stakeholders and CMS, but without requiring the submission of a waiver amendment. Modifications are not currently proposed but these modifications may include increases in copayment amounts within limits allowed for cost of living increases, decreases in copayment amounts, or implementation of copayment waivers on target services.

Additionally, through this waiver extension application, FSSA is seeking federal approval for a five-year extension of the approved substance use disorder (SUD) and requested serious mental illness (SMI) components of the HIP Waiver. This includes authority to reimburse institutions for mental disease (IMDs) for short term stays for individuals diagnosed with SMI or SUD.

BENEFICIARIES & ELIGIBILITY

All current HIP eligibility limits and requirements will remain unchanged. HIP continues to target non-disabled adults between the ages of 19 and 64 with a household income less than 133% of the federal poverty level (FPL) with a 5% of income disregard, including individuals eligible for the adult group, low- income parents and caretakers eligible under Section 1931 of the Social Security Act (Section 1931), pregnant women with income within the HIP limit, and individuals eligible for transitional medical assistance.

HIP includes Gateway to Work a community engagement initiative that connects HIP members with ways to look for work, train for jobs, finish school and volunteer. While eligibility suspensions for not completing Gateway to Work are on hold, this HIP Waiver extension requests the ability to continue the Gateway to Work program.

Additionally, all Medicaid enrollees ages 21-64, eligible for full Medicaid benefits, and with a SMI or SUD diagnosis would be eligible for short term stays in an IMD under the SUD and requested SMI component of the waiver extension.

The HIP Waiver extension includes incorporation of the HIP Bridge Account amendment, currently under review by CMS, under which Indiana will adopt limited coverage for the group of adults who have income over the income eligibility level for the new adult group identified in § 1902(a)(10)(A)(ii)(XX) of the Social Security Act and in 42 CFR § 435.218. Individuals with MAGI-based income above 133 percent of the federal poverty level (FPL) who have lost HIP coverage solely due to an increase in income will be eligible for the defined benefit HIP Bridge Account for 12-months following HIP disenrollment. There will be no income limits on eligibility for the account.

ENROLLMENT & FISCAL PROJECTIONS

The HIP Waiver extension will have no impact on expected annual Medicaid enrollment as HIP is requested to be continued with no substantial changes. Further, it is expected to be budget neutral as outlined in the table below.

Without-Waiver Total Expenditures

	DEMONSTRATION YEARS (DY)					TOTAL
	2021	2022	2023	2024	2025	
IMD Services MEG 1 (Fee-for-Service Inpatient)	$16,033,187	$16,987,010	$17,997,573	$19,068,244	$20,202,611	$90,288,625
IMD Services MEG 2 (Fee-for-Service Residential)	$5,130,495	$5,435,710	$5,759,076	$6,101,687	$6,464,681	$28,891,648
IMD Services MEG 3 (Managed Care)	$8,752,467	$9,273,174	$9,824,822	$10,409,288	$11,028,510	$49,288,261

TOTAL	$29,916,150	$31,695,893	$33,581,470	$35,579,219	$37,695,802	$168,468,534

With-Waiver Total Expenditures

	DEMONSTRATION YEARS (DY)					TOTAL
	2021	**2022**	**2023**	**2024**	**2025**	
IMD Services MEG 1 (Fee-for-Service Inpatient)	$16,033,187	$16,987,010	$17,997,573	$19,068,244	$20,202,611	$90,288,625
IMD Services MEG 2 (Fee-for-Service Residential)	$5,130,495	$5,435,710	$5,759,076	$6,101,687	$6,464,681	$28,891,648
IMD Services MEG 3 (Managed Care)	$8,752,467	$9,273,174	$9,824,822	$10,409,288	$11,028,510	$49,288,261
TOTAL	$29,916,150	$31,695,893	$33,581,470	$35,579,219	$37,695,802	$168,468,534

BENEFITS, COST SHARING, AND DELIVERY SYSTEM

The HIP Waiver extension does not propose any changes to benefits, cost sharing, or delivery system. However, it does incorporate the changes requested specific to the HIP Bridge Account amendment, currently under review by CMS, under which HIP members who qualify for the HIP Bridge Account will receive the benefits and cost sharing applicable to the HIP Bridge Account.

All HIP members will continue to receive a comprehensive benefit package, consistent with private market plans and compliant with all mandated essential health benefits as required by the Patient Protection and Affordable Care Act (ACA). The HIP benefit package does not include non-emergency transportation. Notwithstanding the foregoing, low-income parents and caretakers eligible under Section 1931, pregnant women, low-income 19 and 20-year-old dependents, individuals eligible for transitional medical assistance, and individuals identified as medically frail receive the same benefits as the Medicaid State Plan, including non-emergency transportation and other services not otherwise available to HIP members. Except for members receiving these HIP State Plan benefits, vision and dental services are only available through the HIP Plus plan. Participation in HIP Plus requires members to regularly contribute to their POWER account. The HIP Basic plan is only available to members below the federal poverty level who fail to make their monthly POWER account contributions. The HIP Basic plan does not cover vision and dental services and includes Medicaid allowable copayment amounts.

For all plans, preventive services, such as annual examinations, smoking cessation programs, and mammograms, are covered without charge to the members and are not included in the deductible amount. After the plan deductible is met by way of the $2,500 POWER account, the HIP program includes a comprehensive health plan benefits package.

All HIP medical benefits are currently provided through four (4) MCEs: Anthem, MDwise, Managed Health Services (MHS), and CareSource. Once an MCE has been selected, the member must remain in the MCE for 12 months, with limited exceptions. Members who do not select an MCE will be auto-assigned to an MCE have the opportunity to change the assigned MCE before the first POWER account contribution is made.

Enrollees receiving services under the SUD and requested SMI component of the waiver extension will continue to receive services through their current delivery system.

HYPOTHESES & EVALUATION

The HIP Waiver extension will not propose any changes to the evaluation design or hypotheses. Enhanced program goals, which include the below and will be incorporated into the existing evaluation design posted with the extension documentation, are proposed in the extension request. The enhanced program goals for the HIP extension include period the following:

- Provide timely and geographically appropriate access to healthcare services.
- Promote appropriate utilization of healthcare by maintaining low inappropriate use of the emergency department and supporting utilization of needed services from qualified non-emergency providers.
- Promote control of chronic conditions, delivery of needed care, and increase in member health and wellbeing.
- Increase community engagement leading to increased educational attainment, sustainable employment and member self-sufficiency.
- Reduce the number of uninsured Hoosiers, decrease gaps in coverage, and promote uptake of commercial insurance when leaving HIP.
- Meaningfully increase use of tobacco cessation services and meaningfully decrease tobacco use status for HIP members.
- Encourage healthy behaviors and appropriate care, including early intervention, prevention, and wellness.
- Leverage HIP policies to support the goals of HIP by promoting continuous coverage and improved health outcomes.
- Generate actionable information on social determinants of health.

WAIVER & EXPENDITURE AUTHORITY

FSSA requests an extension of all currently approved waivers and the waiver authority currently under review with CMS for the HIP Workforce Bridge amendment. As specified in the HIP Waiver extension, the requested waivers include:

1. **Premiums Section 1902(a)(14) insofar as it incorporates Section 1916 and 1916A**
   To enable the State to charge monthly contributions for HIP Plus at a minimum amount of one-dollar per month and not to exceed a maximum amount of three-percent of member income.

2. **Reasonable Promptness Section 1902(a)(8)**
   To the extent necessary to enable enrollment in HIP Plus on the first day of the month in which an individual makes their initial contribution to the POWER Account, or, for individuals with incomes at or below 100 percent FPL who fail to make an initial POWER Account payment within 60 days following

the date of invoice, the first day of the month in which the 60-day payment period expires, except for individuals who are found eligible through presumptive eligibility.

3. **Provision of Medical Assistance Sections 1902(a)(8) and 1902(a)(10)**
To the extent necessary to enable Indiana to suspend eligibility for, and not make medical assistance available to, beneficiaries who fail to comply with community engagement requirements, unless the beneficiary is exempted.

4. **Eligibility Sections 1902(a)(10) and 1902(a)(52)**
To the extent necessary to enable Indiana to make a determination of ineligibility, and terminate eligibility for, beneficiaries who are in a suspension of coverage for failure to meet the approved community engagement requirements, unless the beneficiary meets the requirement or is exempted as described in the STCs.

To the extent necessary to enable Indiana to prohibit reenrollment, and deny eligibility, for up to six months, for individuals with income over 100 percent of the FPL who are disenrolled for failure to make POWER Account premium contributions within 60 days of the date of invoice, subject to the exceptions and qualifying events.

To the extent necessary to enable Indiana to prohibit reenrollment, and deny eligibility, for up to three months following the end of the 90-day reconsideration period for individuals who are disenrolled for failure to provide the necessary information for the state to complete an annual redetermination, subject to the exceptions and qualifying events.

5. **Methods of Administration Section 1902(a)(4) insofar as it incorporates 42 CFR 431.53**
To the extent necessary to relieve Indiana of the requirement to assure transportation to and from medical providers for HIP demonstration populations. No waiver of methods of administration is authorized for pregnant women, individuals determined to be medically frail, and section 1931 parents and caretaker relatives.

6. **Comparability and Amount, Duration and Scope of Services Sections 1902(a)(17) and 1902(a)(10)(B)**
To the extent necessary to enable the State to vary cost sharing requirements for beneficiaries for cost sharing to which they otherwise would be subject under the state plan, such that beneficiaries who are in HIP Plus will be charged only one copayment (for non-emergency use of the emergency department) and individuals who are in HIP Basic will be subject to copayments within Medicaid permissible levels.

To the extent necessary to enable Indiana to vary contribution requirements, for different HIP Plus program beneficiaries based on income and on tobacco use, and in a manner consistent with all otherwise applicable law. To allow for variations or waivers of POWER Account contribution requirements, within established limits, based on target initiatives such as encouraging uptake of employer insurance.

To allow the HIP Workforce Bridge Account to be available solely to defined eligible individuals that are disenrolled from HIP due to an increase in income.

To allow the State to provide only a limited defined benefit via the HIP Bridge Account, that is limited to cost sharing assistance up to an amount of $1,000, regardless of health care costs incurred by the

member. To allow any balance payable in excess of $1,000, to be assigned to member responsibility without regard to cost-sharing limitations.

7. **Retroactivity** **Section 1902(a)(34)**

To enable the State not to provide three months of retroactive eligibility for beneficiaries receiving coverage through the HIP program as described in the STCs, except for pregnant women.

FSSA also requests extension of the following expenditure authorities that are currently approved or pending approval by CMS:

1. Expenditures under contracts with managed care entities that do not meet the requirements in section 1903(m)(2)(A) of the Act specified below. Indiana's managed care organizations (MCO) participating in the demonstration will have to meet all the requirements of section 1903(m) except the following:

    a. Section 1903(m)(2)(A)(vi) of the Act insofar as it requires compliance with requirements in section 1932(a)(4) of the Act and 42 CFR 438.56(c)(2)(i) that enrollees be permitted an initial period to disenroll without cause, except as described in the terms and conditions.
    b. Section 1903(m)(2)(A)(vi) of the Act insofar as it requires compliance with requirements in section 1932(a)(4) of the Act and 42 CFR 438.56(g) that automatic MCO reenrollment occur only if the beneficiary's disenrollment was due to a Medicaid eligibility lapse of two months or less, as described in the terms and conditions.

2. Expenditures for otherwise covered services furnished to otherwise eligible individuals who are primarily receiving treatment and withdrawal management services for substance use disorder (SUD) who are short-term residents in facilities that meet the definition of an institution for mental disease (IMD) and expenditures for otherwise covered services furnished to otherwise eligible individuals for short term stays for acute care in a psychiatric hospital that qualifies as an IMD.

REVIEW OF DOCUMENTS & SUBMISSION OF COMMENTS

All information regarding the submission, including the public notice, the HIP Waiver extension, and other documentation regarding the proposal are available for public review at the FSSA, Office of General Counsel, 402 W. Washington Street, Room W451, Indianapolis, Indiana 46204. The full Public Notice and HIP Waiver documents are also available to be viewed online at https://www.in.gov/fssa/hip/.

Written comments may be sent to the FSSA via mail at 402 West Washington Street, Room W374, Indianapolis, Indiana 46204, Attention: Natalie Angel or via electronic mail at hip@fssa.in.gov through **December 6, 2019**.

INDIANA FAMILY AND SOCIAL SERVICES ADMINISTRATION
NOTICE OF TRIBAL COMMENT PERIOD FOR §1115 WAIVER EXTENSION

In accordance with 42 CFR § 431.408(b), notice is hereby given to the Pokagon Band of the Potawatomi that the Indiana Family and Social Services Administration (FSSA) will be seeking renewal of its Healthy Indiana Plan Section 1115 demonstration waiver (HIP Waiver) to the Centers for Medicare and Medicaid Services (CMS).

This notice also serves to open the **30-day tribal comment period, which closes December 1st at 5:00 pm.**

RENEWAL REQUEST SUMMARY

The Healthy Indiana Plan (HIP) has been a feature of Indiana's Medicaid program since 2008. The current approval to operate HIP expires December 31, 2020. Based on the long-tenure and demonstrated success of HIP, FSSA is seeking a ten year extension of the HIP Waiver with no substantive changes. The extension request includes incorporation of the HIP Workforce Bridge amendment, for which tribal notice was provided on May 15, 2019. FSSA will be requesting the following non-substantive, technical changes through the extension request:

- Flexibility to modify the POWER Account contribution tiers below average limit of three percent of member income, with appropriate notice to members, stakeholders and CMS, but without requiring the submission of a waiver amendment. Modifications are not currently proposed but could for example include increasing or decreasing the amounts of the POWER Account base contribution or the tobacco surcharge.
- Flexibility to modify the HIP Basic copayment amounts within the Medicaid allowable limits, with appropriate notice to members, stakeholders and CMS, but without requiring the submission of a waiver amendment. Modifications are not currently proposed but these modifications may include increases in copayment amounts within limits allowed for cost of living increases, decreases in copayment amounts, or implementation of copayment waivers on target services.

Additionally, through this waiver extension application, FSSA is seeking federal approval for a five-year extension of its substance use disorder (SUD) and requested serious mental illness (SMI) components of the HIP Waiver. This includes authority to reimburse institutions for mental disease (IMDs) for short term stays for individuals diagnosed with SMI or SUD.

TRIBAL IMPACT

As only technical changes related to POWER Account and cost sharing are proposed through this extension application, there will be no impact to tribal enrollees. Members of the Pokagon Band of the Potawatomi located in Indiana will continue to be eligible to obtain coverage under HIP when they meet the current criteria for eligibility. All eligible tribal members will also continue to receive HIP services in a manner consistent with federal regulations, including the American Recovery and Reinvestment Act of 2009, which in relevant part precludes states from imposing Medicaid premiums or other cost-sharing on members of federally-recognized Indian tribes. As occurs today, all eligible tribal members who participate in the demonstration will be enrolled in the HIP Plus plan with no POWER Account contribution or cost-sharing requirements. Further, tribal members will continue to have the option to voluntarily participate in HIP. If an enrollment option is not specified, members will be enrolled in a managed care entity (MCE) by default, and will be given the option to disenroll and receive benefits through the Medicaid fee-for-service program. Pending CMS approval of the HIP Workforce Bridge Amendment, for which tribal notice was provided on May 15, 2019, those who opt to participate will receive an exemption to any active Gateway to Work requirements in place of the current activity credit received for participation in the Pathways program. Exempt members do not have a Gateway to Work requirement when it applies but may still access Gateway to Work resources and participate on a voluntary basis. In addition, tribal members will be eligible to receive the HIP Bridge Account, if applicable.

Additionally, through extension of FSSA's IMD waiver, members of the Pokagon Band of the Potawatomi located in Indiana and enrolled in full Medicaid benefits will continue to have access to: (1) short term stays for acute care in a psychiatric hospital that qualifies as an IMD; and (2) treatment and withdrawal management services for SUD in IMDs.

REVIEW OF DOCUMENTS AND SUBMISSION OF COMMENTS

Written comments may be sent to the FSSA via mail at 402 West Washington Street, Room W374, Indianapolis, Indiana 46204, Attention: Amy Owens or via electronic mail at amy.owens@fssa.in.gov **through December 1st, 2019**. Additionally, we would be happy to schedule a phone or in-person consultation to discuss the program in further detail.

Indiana Family and Social Services Administration

Renewal Request for the
Healthy Indiana Plan (HIP)
Section 1115 Waiver –

Substance Use Disorder &
Serious Mental Illness IMD Waiver
(Project Number 11-W-00296/5)

January 31, 2020

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Section 1: Summary of IMD Waiver Renewal Request

The State of Indiana is requesting from the Centers for Medicare & Medicaid Services (CMS) approval of a five-year extension of its substance use disorder (SUD) and serious mental illness (SMI) components of the Medicaid demonstration entitled, "Healthy Indiana Plan (HIP)" (Project Number l l-W-00296/5) in accordance with sections 1115(a) and 1915(h)(2) of the Social Security Act (the Act). On September 1, 2015, then-Governor Mike Pence issued Executive Order 15-09, establishing the Governor's Task Force on Drug Enforcement, Treatment, and Prevention to identify best practices and make informed recommendations for policy makers. The task force included membership from the Indiana General Assembly, the Governor's Office, the Indiana State Department of Health, the Indiana Department of Correction, the Indiana Department of Child Services, the Indiana Family and Social Services Administration, and other organizations and associations throughout Indiana. Implementation of this 1115 SUD demonstration was one of several recommendations issued in the final report of the Task Force, and realized under Indiana's current Governor, Eric Holcomb.

On January 17, 2017, Governor Eric Holcomb introduced his "Next Level Legislative Agenda" representing five pillars designed to address key challenges facing the state, including the fourth pillar: "Attack the Drug Epidemic." During his speech he shared that deaths from drug overdoses had increased by 500 percent since 2000, and that Indiana was ranked 15th in the country in overdose fatalities. To provide impetus, direction and oversight to combat the crisis, he appointed Jim McClelland as the Executive Director for Drug Prevention, Treatment and Enforcement, and supported legislation to create the Indiana Commission to Combat Drug Abuse, comprising key community members, leadership from State agencies, and legislators. The Commission created a strategic approach to addressing substance abuse in Indiana that focused on the reduction of the incidence of individuals with substance use disorders (SUD); additional harms that can result from substance abuse; improved treatment for individuals with SUD; and supported community-based collaborations aimed on prevention, treatment and recovery.

The Indiana Family and Social Services Administration (FSSA) has leveraged this demonstration as part of an intense and integrated effort to mitigate the adverse impact of the opioid epidemic while continuing to monitor prevalence and access to treatment for other substances of abuse impacting the State of Indiana. FSSA is responsible for the administration and oversight of Indiana's Medicaid program and consists of six divisions including the Office of Medicaid Policy and Planning (OMPP), Division of Mental Health and Addiction (DMHA), Office of Healthy Opportunities (OHO), Division of Aging, Division of Family Resources, and Division of Disability and Rehabilitative Services. In addition to maintaining SUD services and supports that have been integrated into Medicaid's Indiana Health Coverage Program (IHCP) network for decades, the FSSA's OMPP has worked closely with the DMHA to add reimbursement for inpatient and residential services provided in Institutions for Mental Diseases (IMDs) under this demonstration; obtained a State Plan Amendment to offer intensive outpatient treatment (IOT) and peer recovery services for members; and removed barriers to Medication Assisted Treatment (MAT) for members. More recent efforts have introduced new providers into the IHCP network

by adding SUD services to long-standing practices in other specialties and making SUD services newly available to IHCP members.

Further, the provision of services in an IMD for individuals with SMI is part of broader efforts within the FSSA to ensure a comprehensive continuum of behavioral health services and is intended to improve access to acute care for Medicaid enrollees with SMI. This component of the waiver seeks to address the historical reliance on general hospital emergency rooms to handle individuals in acute psychiatric crisis.

Section 2: Historical Narrative Summary

On February 1, 2018, CMS approved an extension to Indiana's existing Section 1115 Medicaid demonstration waiver. The added goals of the waiver extension were aligned with the milestones outlined by CMS, as follows:

- Increased rates of identification, initiation, and engagement in treatment;
- Increased adherence to and retention in treatment;
- Reductions in overdose deaths, particularly those due to opioids;
- Reduced utilization of emergency departments and inpatient settings for treatment where utilization is preventable or medically inappropriate through improved access to other continuum of care services;
- Fewer readmissions to the same or higher level of care where the readmission is preventable or medically appropriate; and
- Improved access to care for physical health conditions among beneficiaries.

This waiver contributes to a comprehensive statewide strategy to combat SUD, including prescription drug abuse and opioid use disorders (OUD). The strategies within the waiver included the expansion of coverage for a full-range of SUD treatment services to Indiana Health Coverage Programs (IHCP) for members enrolled in Traditional Medicaid (full, fee-for-service coverage) or in any managed care program, including Healthy Indiana Plan (HIP), Hoosier Care Connect, and Hoosier Healthwise. Changes under the new SUD waiver included the following:

- Expanding coverage of inpatient SUD treatment provided in IMDs;
- Adding coverage for short-term residential SUD treatment; and
- Establishing a new provider type and specialty for residential treatment.

The waiver, currently approved through December 31, 2020, allows for Indiana Medicaid beneficiaries to continue to have access to all current mental health and SUD benefits. In addition, all beneficiaries, ages 21 through 64, gained access to expanded covered services provided while residing in an IMD for SUD short-term residential stays. The SUD program specifically allowed beneficiaries with SUD to access benefits that include SUD residential treatment, crisis stabilization and withdrawal management services provided in IMDs, which would otherwise be excluded from federal reimbursement. Under this demonstration, beneficiaries have access to high quality, evidence-based OUD and other SUD treatment services ranging from acute withdrawal management to on-going chronic care for these conditions in

cost-effective settings while also improving care coordination and care for comorbid physical and mental health conditions.

Indiana, as part of its evaluation plan, established six milestones for the SUD demonstration:

- Access to critical levels of care for SUD treatment;
- Use of evidence-based SUD-specific patient placement criteria; prior-authorization, providers, payers; matching need to capacity
- Use of nationally recognized SUD-specific program standards to set provider qualifications for residential treatment facilities;
- Sufficient provider capacity at critical levels of care, including medication assisted treatment for OUD;
- Implementation of comprehensive treatment and prevention strategies to address opioid abuse and OUD; and
- Improved care coordination and transition between levels of care.

In addition to the achievement of the metrics reported in the interim evaluation (attached to this extension application), the state took the following steps to support realization of these milestones.

1. Access to critical levels of care for SUD treatment.

Under the waiver, reimbursement for SUD inpatient stays for medically monitored detox in IMDs became available for all IHCP members in February 2018. Effective March 1, 2018, the IHCP began providing coverage for short-term low-intensity (American Society of Addiction Medicine [ASAM] Level 3.1) and high-intensity residential treatment (ASAM Level 3.5) for SUD in settings of all sizes, including facilities that qualify as IMDs.

FSSA requested this SUD waiver demonstration program as an outgrowth of recommendations made by the State's Taskforce on Drug Enforcement, Treatment, and Prevention. As such, the demonstration is one component of a broader strategy to address substance use disorders, including OUD within the State. Through a state plan amendment effective July 1, 2019, the IHCP modified the coverage of crisis intervention, intensive outpatient treatment (IOT), and peer recovery services to better serve IHCP members. For dates of service (DOS) on or after July 1, 2019, crisis intervention, IOT and peer recovery services will no longer be restricted to members eligible for the Medicaid Rehabilitation Option (MRO) benefit plan. In addition, all three services will no longer be carved out of managed care to support improved care coordination.

The State has also increased access to services, funded through other state and federal dollars, to compliment the new waiver services added to the SUD continuum of care for Hoosiers. Planning for use of State Targeted Response (STR) and State Opioid Response (SOR) federal funds considered the existing Medicaid service array and filling service gaps that remained. Indiana's DMHA is expanding access to four levels of recovery housing based on standards from the National Alliance for Recovery Residences' Oxford Model, including in rural areas of the state. In addition, SOR funding is being leveraged to expand the number of DATA-Waived Providers Across Indiana. DMHA is also committed to funding the addition of three additional training

tracks to the existing Indiana Opioid Addiction Treatment ECHO (I-ECHO) project that utilizes both didactic and case-learning approaches. The latter two initiatives will support existing Medicaid enrolled SUD providers as well as potentially expand the Medicaid SUD provider network.

2. Use of Evidenced-Based SUD-Specific Patient Placement Criteria

Prior authorization is required for all SUD residential stays, with medical necessity/admission criteria based on the ASAM Patient Placement Criteria Level 3.1 (Clinically Managed Low-Intensity Residential Services) and Level 3.5 (Clinically Managed High-Intensity Residential Services). In addition, DMHA is working to modify the Adults Needs and Strengths Assessment (ANSA) utilized by all contracted providers to incorporate ASAM criteria and develop the algorithms to recommend the level of treatment and services that incorporate the use of evidence-based practices.

In the fourth quarter of 2018, the SUD Work Group was created to engage stakeholders in a review of the strengths and challenges specific to the elements of 1115 Waiver implementation. The charge of this cross-collaborative group included examining concerns shared by stakeholders regarding access to the newly developed SUD residential treatment services. To date, the Work Group has examined issues pertaining to the prior authorization (PA) process, SUD treatment criteria interpretation and application, and transitions of care. Recommendations from this ongoing workgroup are being implemented through an FSSA project team. This core team meets biweekly. Quarterly SUD Work Group meetings continue as well as combined quarterly meetings with the Medicaid managed care plans and SUD providers. One outcome of this collaboration was the consensus that as of February 11, 2019, all plans will authorize a minimum length of stay of at least 14 days before re-evaluation/concurrent review, unless less than 14 days is requested by the provider.

Effective March 15, 2019, the IHCP began encouraging providers to use three new forms when requesting PA for inpatient and residential treatment for SUD. These forms provide prompts for information specific to residential and inpatient treatment and apply to these services rendered under both the fee-for-service (FFS) and the managed care delivery systems.

- Residential/Inpatient Substance Use Disorder Treatment Prior Authorization Request Form – This form is recommended for use to request PA for inpatient and residential SUD treatment services, rather than using the standard universal PA request form.
- Initial Assessment Form for Substance Use Disorder Treatment Admission – This assessment form can be completed and submitted as an attachment to the SUD residential and inpatient treatment PA request form for initial admissions.
- Reassessment Form for Continued Substance Use Disorder Treatment – This assessment form can be completed and submitted for requests to extend authorization for residential and inpatient SUD treatment.

These forms incorporate ASAM criteria associated with the specific member and requested service. Effective June 25, 2019, each of these substance use disorder PA request forms and any attachments can be submitted on the IHCP Provider Portal.

3. Use of nationally recognized SUD-specific program standards to set provider qualifications for residential treatment facilities.

In an effort to raise the standards of care for addictions providers in Indiana, FSSA's OMPP partnered with the DMHA on an ASAM level of care designation process, beginning with ASAM Level 3.1 and 3.5 residential addiction treatment facilities. By July 1, 2018, all facilities seeking Medicaid reimbursement for residential SUD treatment were required to be enrolled as a new provider specialty, SUD Residential Addiction Treatment Facility (provider specialty 836, within provider type 35 [addiction services]). The first step in the enrollment process is to be certified as an *addiction treatment services provider, regular certification* and *residential sub-acute facility* by DMHA. To be certified and to maintain regular certification as an addiction treatment services provider, an entity must maintain accreditation from an approved accrediting agency.[1] After obtaining the required certifications from DMHA, each facility is required to obtain ASAM designation from DMHA. Once a provider has received certification as an *addiction treatment services provider, regular certification and residential sub-acute facility* with the applicable ASAM designation, the final step is enrollment as an IHCP provider. The State plans to expand the designation process to all ASAM levels of care. 116 individuals from the State, including SUD providers, managed care entities (MCEs) staff , and other stakeholder organizations attended ASAM training in early April 2019. DMHA is planning to provide additional training opportunities later in the calendar year.

4. Sufficient provider capacity at critical levels of care, including medication assisted treatment for opioid use disorder (OUD).

On February 19, 2019, the IHCP clarified billing guidelines for the SUD initial assessments; crisis intervention; and first dose induction of buprenorphine Observation. The guidance applied to enrolled IHCP providers, including affirmation that midlevel practitioners, such as licensed clinical addiction counselors, can provide these services within their scope of practice under the supervision of an enrolled IHCP provider.

In August 2019, the State applied for the Notice of Funding Opportunity under the Section 1003 Demonstration Project to Increase Substance Use Provider Capacity. The State received a notice of funding award in September 2019. Efforts under the planning phase of this opportunity align and will strengthen, as opposed to duplicate, waiver activities and goal achievement by providing a review of the existing Medicaid SUD full continuum provider network, including providers of new services under this waiver. Post-Planning Phase goals include: (1) increased access to SUD services through expanded provider participation; (2) increased access to services at each point in the prevention and treatment continuum (per ASAM levels of treatment and assessment criteria); (3) increased quality and positive outcomes through adoption of evidenced-based

[1] Current approved accreditation bodies include the Rehabilitation Accreditation Commission (CARF); Joint Commission on Accreditation of Healthcare Organizations; Council on Accreditation of Services for Families and Children (COA); and the National Committee for Quality Assurance (NCQA).

practices; and (4) increased quality and positive outcomes through provider technical assistance, monitoring, and reimbursement strategies.

5. Implementation of comprehensive treatment and prevention strategies to address opioid abuse and OUD

Consider options for emergency responder reimbursement of naloxone-end of 2018

FSSA requested this SUD waiver demonstration program as an outgrowth of recommendations made by the State's Taskforce on Drug Enforcement, Treatment, and Prevention. As such the demonstration is one component of a broader strategy to address substance use disorders, including OUD within the State. Through a state plan amendment effective July 1, 2019, the IHCP modified the coverage of crisis intervention, intensive outpatient treatment (IOT), and peer recovery services to better serve IHCP members. For dates of service (DOS) on or after July 1, 2019, IOT and peer recovery services will no longer be restricted to members eligible for the Medicaid Rehabilitation Option (MRO) benefit plan. In addition, these two services will no longer be carved out of managed care in order to support improved care coordination. Further, a multiagency group with representation from behavioral health, Medicaid and public health has convened to pursue emergency responder reimbursement of naloxone.

DMHA is currently leveraging SOR funding to expand treatment service capacity by: (1) implementing an Addiction Provider Development and Sustainability (APDS) Program that provides funding for SUD-focused MA/MSW internships within community mental health center (CMHC) settings; (2) expanding SUD-specific Project ECHO curriculum and participation; and (3) partnering with academia to implement a Leadership and Organizational Change for Implementation (LOCI) intervention to develop and create an organizational change strategy to improve organizational leadership and create or enhance organizational climate for evidence-based practice (EBP) implementation. As part of the LOCI project, DMHA intends to pilot implementation of Motivational Enhancement Therapy-Cognitive Behavioral Therapy (MET/CBT). Creation of this framework could support a future DMHA/OMPP partnership to pilot other SUD-related EBPs and, if hypothesized outcomes are achieved, consider state plan amendments to add services or create incentives though reimbursement strategies for statewide adoption.

6. Improved care coordination and transition between levels of care.

In 2017, 77.1% of all Indiana Medicaid members were enrolled with a managed care entity (MCE). The OMPP requires all four contracted MCEs to provide care coordination across primary, behavioral and other specialty care. OMPP amended contracts to require that MCEs employ or contract with case managers with training, expertise and experience in providing case management services for members receiving behavioral health services. At a minimum, the MCE must offer to provide case management services to any member at risk for inpatient psychiatric or substance abuse hospitalization, and to members discharged from an inpatient psychiatric or substance abuse hospitalization, for no fewer than ninety (90) calendar days following that inpatient hospitalization. Case managers must also contact members during an inpatient hospitalization, or immediately upon receiving notification of a member's inpatient behavioral

health hospitalization, and schedule an outpatient follow-up appointment for within seven days of discharge.

As previously noted, access to peer recovery services was expanded through a state plan amendment to eliminate a restriction of these services to an individual ineligible for the MRO benefit plan. Peer recovery services are individual face-to-face services that provide structured, scheduled activities that promote socialization, recovery, self-advocacy, development of natural supports, and maintenance of community living skills, including support through transitions in care. In support of the expansion and utilization by provider agencies, guidance was provided regarding peer recovery services, including the requirement that they must be delivered by individuals certified in peer recovery services per the DMHA standards and must be performed under the supervision of a licensed professional or a qualified behavioral health professional (QBHP).[2]

Section 2.1: SMI Waiver Amendment

On August 30, 2019, FSSA submitted an amendment to the SUD demonstration to request authority to reimburse for acute inpatient stays in IMDs for individuals diagnosed with SMI. This request was part of broader efforts within the FSSA to ensure a comprehensive continuum of behavioral health services and to improve access to acute care for Medicaid enrollees with SMI and serious emotional disturbance (SED). The amendment was approved on December 20, 2019, with an effective date of January 1, 2020.

The State's goals, through this waiver amendment included:

- Reduced utilization and lengths of stay in EDs among Medicaid beneficiaries with SMI or SED while awaiting mental health treatment in specialized settings;
- Reduced preventable readmissions to acute care hospitals and residential settings;
- Improved availability of crisis stabilization services utilizing multiple service models to meet the unique needs across the state;
- Improved access to community-based services to address the chronic mental health care needs of beneficiaries with SMI or SED including through increased integration of primary and behavioral health care; and
- Improved care coordination, especially continuity of care in the community following episodes of acute care in hospitals and residential treatment facilities.

As the waiver amendment has been recently implemented, evidence regarding the progress toward meeting these goals is not yet available.

[2] *BR201925* - IHCP bulletin clarified qualifications and supervision requirements for peer recovery specialist providers (June 18, 2019).

Section 3: Program Changes

In spring 2016, the Indiana General Assembly passed Senate Enrolled Act 297, which required Medicaid coverage for inpatient detoxification services for the treatment of opioid or alcohol dependence in accordance with the most current edition of ASAM or other comparable clinical criteria. Signed by Governor Holcomb on May 1, 2019, House Enrolled Act 1543 updated the requirement of providers to provide inpatient detoxification exclusively in accordance with the most current edition of ASAM criteria.

Section 4: Eligibility, Benefits and Cost Sharing

4.1: Demonstration Eligibility

The State requests no modifications to demonstration eligibility. Under this extension request, all enrollees eligible for a mandatory or optional eligibility group approved for full Medicaid coverage, and between the ages of 21 – 64, will be eligible for the SUD and SMI/SED benefits authorized through the waiver, as further described in Section 4.2. Only the eligibility groups outlined in Table 1 below will not be eligible for services under the waiver as they receive limited Medicaid benefits only.

Table 1: Eligibility Groups Excluded from the Demonstration

Eligibility Group Name	Social Security Act & CFR Citations
Limited Services Available to Certain Aliens	42 CFR §435.139
Qualified Medicare Beneficiaries (QMB)	1902(a)(10)(E)(i) 1905(p)
Specified Low Income Medicare Beneficiaries (SLMB)	1902(a)(10)(E)(iii)
Qualified Individual (QI) Program	1902(a)(10)(E)(iv)
Qualified Disabled Working Individual (QDWI) Program	1902(a)(10)(E)(ii) 1905(s)
Family Planning	1902(a)(10)(A)(ii)(XXI)

4.2: Benefits

Indiana Medicaid provides comprehensive SUD and SMI/SED treatment services to enrollees. Throughout the development of the 2017 SUD waiver application process, the State conducted an assessment of available services compared with the standards outlined through the American Society of Addiction Medicine (ASAM). Many services that align with an ASAM level of care were previously covered. However, through the waiver, in conjunction with State Plan authority, Indiana has been able to provide coverage for a more complete continuum of services. This includes services provided in residential and inpatient treatment settings that qualify as an IMD, which are not otherwise matchable expenditures under Section 1903 of the Social Security Act.

Additionally, in development of the waiver amendment to provide coverage for acute inpatient stays in an IMD for SMI/SED, the State undertook a comprehensive review of its community-based mental health service array. As a result of this process and in accordance with the State's

SMI/SED Demonstration Implementation Plan, FSSA is in the process of piloting programs to increase access to crisis stabilization services.

The State requests no modification to covered benefits through this extension application. Services authorized through the waiver will continue to be available for all Medicaid enrollees, unless otherwise excluded as described in Section 4.1.

Table 2: SUD and SMI Benefits Coverage with Expenditure Authority

Benefit	Medicaid Authority	Expenditure Authority
SUD Residential Treatment	§1115 Waiver	Services provided to individuals in IMDs
Withdrawal Management	State Plan	Services provided to individuals in IMDs
Opioid Treatment Program Services	State Plan	Services provided to individuals in IMDs
Addiction Recovery Management Services	State Plan	Services provided to individuals in IMDs
Acute inpatient stays for SMI	State Plan	Services provided to individuals in IMDs

4.3 Cost Sharing

All cost-sharing for SMI/SED and SUD services provided through this waiver will be consistent with the Medicaid State Plan applicable to an enrollee's specific eligibility category. No modifications are proposed through this renewal request.

4.4 Delivery System and Payment Rates for Services

No modifications to the current Indiana Medicaid fee-for-service or managed care arrangements are proposed through this renewal. All enrollees will continue to receive services through their current delivery system. Additionally, payment methodologies will be consistent with those approved in the Medicaid State Plan.

Section 5: Waivers & Expenditure Authority

The State requests continuation of the current expenditure authority under Section 1115 for otherwise covered services furnished to otherwise eligible individuals for: (1) short term stays for acute care in a psychiatric hospital that qualifies as an IMD; and (2) treatment and withdrawal management services for SUD in facilities that meet the definition of an IMD. No additional waivers of Title XIX or Title XXI are requested in relation to the SUD/SMI initiatives through this extension application.

Section 6: Reporting

FSSA has a robust quality oversight plan for continually monitoring the services and outcomes delivered under the waiver. Oversight is conducted through a variety of strategies, including but not limited to:

- MCE monthly and quarterly reporting on compliance with contractual requirements related to behavioral health
- Annual external quality reviews (EQR) of MCEs
- Quality strategy plan which includes an overall framework for continuous quality improvement
- MCE-led quality improvement projects
- Quarterly and annual reporting in accordance with the CMS required "Medicaid Section 1115 SUD Demonstration Monitoring Protocol" and associated quantitative monitoring metrics

A summary of key findings gleaned from these oversight strategies is provided in the subsections below.

6.1: External Quality Review Organization Reports

FSSA contracts with Burns and Associates to conduct an annual EQR in accordance with the requirements at 42 CFR §438.350. The most recent EQR revealed positive findings on MCE performance related to the provision of behavioral health services. Specifically, all MCEs received the maximum score on the following contract provisions and federal regulations:

- The MCE shall employ or contract with case managers with training, expertise and experience in providing case management services for members receiving behavioral health services.
- At minimum, the MCE shall provide case management services for members discharged from an inpatient psychiatric or substance abuse hospitalization for no fewer than 90 days following hospitalization.
- With the appropriate consents, MCE case managers shall notify both primary medical providers (PMP) and behavioral health providers when a member is hospitalized or receives emergency treatment for behavioral health issues, including substance abuse. This notice must be provided within five calendar days of the inpatient admission or emergency treatment.
- The MCE shall, on at least a quarterly basis, send a behavioral health profile to the respective PMP. The profile lists the physical and behavioral health treatment received by the member during the previous reporting period.
- The MCE will contractually mandate that its behavioral health care network providers notify a member's MCE within five calendar days of the member's visit, and submit information about the treatment plan, the member's diagnosis, medications, and other pertinent information.
- The MCE shall, at a minimum, establish referral agreements and liaisons with both contracted and non-contracted community mental health centers (CMHCs), and shall provide physical health and other medical information to the appropriate CMHC for every member.
- MCE case managers shall regularly and routinely consult with both the member's physical and behavioral health providers to facilitate the sharing of clinical information,

and the development and maintenance of a coordinated physical health and behavioral health treatment plan for the member.

- In urban areas, the MCE must provide at least one behavioral health provider within 30 miles or 30 minutes; in rural areas, one within 45 minutes or 45 miles.
- For behavioral health providers, require that members receiving inpatient psychiatric services are scheduled for outpatient follow-up and/or continuing treatment prior to discharge. This treatment must be provided within seven calendar days from the date of the member's discharge.

6.2: Quality Assurance Monitoring

FSSA's 2019 Indiana Medicaid Managed Care Quality Strategy Plan, developed in accordance with 42 CFR §438.340, also includes a series of behavioral health initiatives, with goals aligned to those of the IMD waivers.

Table 3: 2019 Behavioral Health Quality Strategy Initiatives

OBJECTIVE	METHODOLOGY	GOAL
Hoosier Healthwise and Healthy Indiana Plan Initiatives		
Improvement in Behavioral Health (HEDIS) Percentage of members who received follow-up within seven days of discharge from hospitalization for mental health disorders	HEDIS measures for tracking the percentage of members receiving follow-up.	Achieve at or above the 90th percentile for members who receive follow-up within seven days of discharge from hospitalization for mental health disorders (HEDIS).
Traditional Medicaid Initiatives		
Improvement in Behavioral Health (HEDIS-like) Percentage of members who received follow-up within seven days of discharge from hospitalization for mental health disorders	Administrative reporting through the FSSA enterprise data warehouse (EDW) using HEDIS specifications.	Maintain with de minimis reduction in performance.
Hoosier Care Connect Initiatives		
Improvement in Behavioral Health (HEDIS) Percentage of members who received follow-up within seven days of discharge from hospitalization for mental health disorders – with Medicaid rehabilitation option (MRO)	HEDIS-like measure based on specifications developed by OMPP, including MRO HCPCS codes.	Achieve at or above 75th percentile for members who receive follow-up within seven days of discharge from hospitalization for mental health disorders – with Medicaid MRO services.

In alignment with the Quality Strategy Plan, FSSA's managed care contracts have a financial incentive for improvements in performance on the follow up after hospitalization for mental

health disorders HEDIS measure. A portion of the capitation is withheld with the ability for the MCE to receive the funding based on performance.

In addition to the ongoing activities associated with the Quality Strategy Plan, FSSA conducts targeted studies and oversight of services rendered under the waiver. For example, Burns and Associates has been engaged to conduct two separate studies of service authorizations granted under the waiver. The first study was conducted in Spring 2019 pertaining to authorizations in CY 2018. Findings revealed MCEs are processing authorization requests for SUD services within contractually required timelines. One MCE was slightly above the target, which FSSA continues to monitor. Additionally, a sample of service denials and approvals were reviewed by an independent physician; the physician concurred with the majority of clinical decisions (96%) rendered by the MCE's. Ongoing monitoring in this area is planned with a second study to be conducted in Spring 2020 pertaining to 2019 authorizations.

6.3: Additional Documentation on Quality and Access

FSSA monitors access to behavioral health services through a variety of strategies. For example, through regular review of MCE data on compliance with contractual requirements for network adequacy, which were developed in accordance with 42 CFR §438.68. All MCEs are currently demonstrating compliance with the access requirements for behavioral health providers for Hoosier Healthwise, HIP and Hoosier Care Connect.

The State also conducts ongoing waiver monitoring in accordance with CMS requirements for the "Medicaid Section 1115 SUD Demonstration Monitoring Protocol" and through submission of quarterly and annual reports following CMS required quantitative monitoring metrics. As the SMI portion of the IMD waiver has recently been implemented, outcomes are not yet available regarding the State's progress in meeting the milestones of this portion of the waiver. FSSA has implemented ongoing monitoring in accordance with CMS requirements for the SMI waiver.

High level findings from the most recently completed annual report are provided below. FSSA will continue to submit quarterly and annual monitoring reports in accordance with CMS requirements through the extension period.

Table 4: Summary Findings from Annual SUD Monitoring Protocol

Metric Name	Metric Description	Outcomes
Average Length of Stay in an IMD	The average length of stay for beneficiaries discharged from IMD residential treatment for SUD	7 days
SUD Provider Availability – MAT	The number of providers enrolled in Medicaid and qualified to deliver SUD services during the measurement period and who meet the standards to provide buprenorphine or methadone as part of MAT	725
Initiation and Engagement of Alcohol and Other Drug (AOD)	Initiation of AOD Treatment—percentage of beneficiaries who initiated treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial	55.34%

Metric Name	Metric Description	Outcomes
Dependence Treatment (IET) [NCQA; NQF #0004; Medicaid Adult Core Set]	hospitalization, telehealth, or MAT within 14 days of the diagnosis	
	Engagement of AOD Treatment—percentage of beneficiaries who initiated treatment and who had two or more additional AOD services or MAT within 34 days of the initiation visit	29.74%
Use of Opioids at High Dosage and from Multiple Providers in Persons Without Cancer [PQA; NQF #2951]	Rate per 1,000 beneficiaries age 18 and older included in the denominator without cancer who received prescriptions for opioids with a daily dosage greater than 120 morphine milligram equivalents for 90 consecutive days or longer. Patients in hospice are also excluded.	40.9
Use of Opioids from Multiple Providers in Persons Without Cancer [PQA; NQF #2950]	Rate per 1,000 beneficiaries included in the denominator without cancer who received prescriptions for opioids from four or more prescribers and four or more pharmacies.	27.34
Use of Opioids at High Dosage from Multiple Providers in Persons Without Cancer [PQA, NQF #2951]	Rate per 1,000 beneficiaries included in the denominator without cancer who received prescriptions for opioids greater than 120mg morphine equivalent dose (MED) for 90 consecutive days or longer, and from four or more prescribers and four or more pharmacies.	1.12
Concurrent Use of Opioids and Benzodiazepines [PQA]	Percentage of beneficiaries age 18 and older with concurrent use of prescription opioids and benzodiazepines. Patients with a cancer diagnosis or in hospice are excluded.	17.08%
Continuity of Pharmacotherapy for Opioid Use Disorder [RAND; NQF #3175]	Percentage of adults in the denominator with pharmacotherapy for OUD who have at least 180 days of continuous treatment	17.44%
Follow-up after Discharge from the Emergency Department for Mental Health or Alcohol or Other Drug Dependences [NCQA; NQF #2605; Medicaid Adult Core Set]	Percentage of ED visits for mental illness for which the beneficiary received follow-up within 7 days of the ED visit (8 total days).	40.33%
	Percentage of ED visits for mental illness for which the beneficiary received follow-up within 30 days of the ED visit (31 total days).	54.37%

Section 7: Financing

Please refer to the attached documentation prepared by the State's actuary for a detailed analysis of the budget neutrality impact.

Section 8: Interim Evaluation Report

An Interim Evaluation of the SUD portion of the waiver was completed by Burns and Associates. As the IMD waiver for acute psychiatric stays was implemented on January 1, 2020, evaluation findings are not yet available. The evaluation plan, and subsequent Summative Evaluation Report, will be updated to incorporate the SMI IMD components of the waiver and submitted for CMS review and approval in accordance with the State's special terms and conditions (STCs).

The SUD Interim Evaluation explored the hypotheses and research questions outlined in Table 5, in accordance with the CMS-approved evaluation plan.

Table 5: SUD Waiver Hypotheses and Research Questions

Hypothesis	Research Questions
Aims and Primary Drivers	
Key health outcomes improve in the SUD population in the post-waiver period.	Does the level and trend of initiation and engagement in treatment increase in the SUD population in the post waiver period?
	Does the level and trend of follow-up after discharge from the Emergency Department (ED) for SUD increase among the SUD population in the post waiver period?
	Does the level and trend in continuity of pharmacotherapy for opioid use disorder increase among the OUD population in the post waiver period?
	Does the level and trend in concurrent use of opioids and benzodiazepines decrease in the OUD population in the post waiver period?
	Does the level and trend in the rate of use of opioids at high dosage in persons without cancer decrease in the post waiver period?
Costs of care decreases in the SUD population in the post waiver period.	Does the level and trend in overall spending for the SUD population decrease in the post waiver period?
	Does the level and trend in SUD service spending for the SUD population increase in the post waiver period?
	Does the level and trend in acute utilization for SUD, potentially preventable emergency department or potentially preventable hospital readmissions decrease in the SUD population in the post waiver period?
Secondary Drivers	
Access to care improved in the SUD population in	Does the level and trend in the number of SUD and primary care providers and the number of providers per capita in the SUD population increase in the post waiver period for each ASAM level of care?

Hypothesis	Research Questions
the post-waiver period	Does the utilization per 1,000 of SUD services and primary care in the SUD population increase in the post waiver period for each ASAM level of care?
Prior authorization (PA) requirements do not negatively impact access to residential or inpatient services (ASAM 3.1, 3.5 and 4.0).	Are the rates of prior authorizations (PAs) submitted and PA requests that are denied in the SUD population, controlling for volume, relatively consistent by MCE and over time?
	Are prior authorization (PA) denials predominately for reasons directly related to not meeting clinical criteria as opposed to administrative reasons such as lack of information submitted?

The full report is provided as a separate attachment to this extension application.

8.1 Evaluation Plan for Extension Period

The State requests no modifications to the evaluation plan during the extension period. Given no waiver modifications are proposed through this extension request, and the IMD waivers have been in effect for a relatively short time, FSSA will continue to study the previously approved hypotheses and research questions. All evaluation activities will be conducted in accordance with the STCs, including continued use of an independent evaluator.

Section 9: Public and Tribal Comment

In accordance with 42 CFR §431.408, the public had an opportunity to comment on this waiver extension application through a public notice and comment period that ran from November 6, 2019 through December 6, 2019. The public notice and all waiver documents were posted on the FSSA website and made available for review at the FSSA offices. An abbreviated notice was also published on November 6, 2019 in the State's administrative record, the Indiana Register. Additionally, FSSA sent email notification to approximately 1,600 stakeholders. Finally, the State held two public hearings on November 19, 2019 (Medical Care Advisory Committee that operates in accordance with 42 CFR §431.12) and November 20, 2019 (open forum for interested parties to learn about the contents of the application and to comment on its content). Statewide accessibility was assured through web conference capabilities.

9.1 Summary of Public Comments

Of the 32 total comments received on the HIP waiver extension, six addressed the SUD/SMI components of the waiver. All were in support of continuation of the waiver and included feedback from the State's MCEs, as well as Covering Kids and Families, the Indiana State Medical Association and Indiana Hospital Association. Commenters noted the IMD waiver provides a more robust provider network, expands access to inpatient mental health services and reduces barriers to accessing behavioral health treatment. Further, commenters noted the importance of the waiver in assisting the State in addressing the opioid crisis and providing expanded access to evidence-based treatment.

The State appreciates the commenters support. As no requested changes to the SUD/SMI components of the waiver were noted by the commenters, no updates were made to the extension application in response.

9.2 Post Award Forum

In accordance with 42 CFR §431.420(c) and STC 10, the 1115 demonstration waiver post award forum was held on July 30, 2019 during a special meeting of the Medicaid Advisory Committee and was open to the public. Verbal comments provided during the forum were specific to the HIP components of the waiver. Additionally, a written comment was submitted from the National Alliance on Mental Illness Indiana expressing support for the SMI waiver amendment which was submitted to CMS on August 30, 2019.

9.3 Tribal Notice

In accordance with 42 CFR §431.408, notice of the waiver amendment was provided to Indiana's federally recognized tribe, the Pokagon Band of Potawatomi Indians, on November 1, 2019. The State received no comment in response.

Appendix 1: Public Notice

OFFICE OF THE SECRETARY OF FAMILY AND SOCIAL SERVICES ADMINISTRATION
NOTICE OF PUBLIC COMMENT PERIOD TO EXTEND THE HEALTHY INDIANA PLAN 1115 DEMONSTRATION

Pursuant to 42 CFR § 431.408(a), notice is hereby given that the Indiana Family and Social Services Administration (FSSA) will provide the public the opportunity to review and provide input on a proposed extension of the Healthy Indiana Plan Section 1115 demonstration waiver (HIP Waiver). This notice provides details about the waiver amendment submission and serves to open the 30-day public comment period, which closes on December 6, 2019.

In addition to the 30 day public comment period in which the public will be able to provide written comments to the FSSA via US postal service or electronic mail, the FSSA will host two public hearings in which the public may provide verbal comments. Hearings will be held at the following dates, times, and locations:

1) Tuesday, November 19th at 2:00 pm at the Indiana State Library, History Reference Room 211, 315 W. Ohio St., Indianapolis, IN 46202. This hearing will be a special session of the Medical Advisory Commission.
2) Wednesday, November 20th at 10:00 am at the Indiana Government Center South, Conference Room 18, 302 W. Washington St., Indianapolis, IN 46204. This hearing will be also be accessible via web conference at https://Indiana.AdobeConnect.com/indiana.

Prior to finalizing the proposed HIP Waiver extension, the FSSA will consider all the written and verbal public comments received. The comments will be summarized and addressed in the final version to be submitted to the Centers for Medicare and Medicaid Services (CMS).

EXTENSION PROPOSAL SUMMARY AND OBJECTIVES

The Healthy Indiana Plan (HIP) has been a feature of Indiana's Medicaid program since 2008. The current approval to operate HIP expires December 31, 2020. Based on the long-tenure and demonstrated success of HIP, FSSA is seeking a ten year extension of the HIP Waiver with no substantive changes. The extension request includes incorporation of the HIP Bridge Account amendment, which was submitted to CMS on July 25, 2019. FSSA will be requesting the following non-substantive, technical changes through the extension request:

- Flexibility to modify the POWER Account contribution tiers below average limit of three percent of member income, with appropriate notice to members, stakeholders and CMS, but without requiring the submission of a waiver amendment. Modifications are not currently proposed but could, for example, include increasing or decreasing the amounts of the POWER Account base contribution or the tobacco surcharge.
- Flexibility to modify the HIP Basic copayment amounts within the Medicaid allowable limits, with appropriate notice to members, stakeholders and CMS, but without requiring the submission of a waiver amendment. Modifications are not currently proposed but these modifications may include increases in copayment amounts within limits allowed for cost of

living increases, decreases in copayment amounts, or implementation of copayment waivers on target services.

Additionally, through this waiver extension application, FSSA is seeking federal approval for a five-year extension of the approved substance use disorder (SUD) and requested serious mental illness (SMI) components of the HIP Waiver. This includes authority to reimburse institutions for mental disease (IMDs) for short term stays for individuals diagnosed with SMI or SUD.

BENEFICIARIES & ELIGIBILITY

All current HIP eligibility limits and requirements will remain unchanged. HIP continues to target non-disabled adults between the ages of 19 and 64 with a household income less than less than 133 percent of the federal poverty level (FPL) with a 5 percent of income disregard, including individuals eligible for the adult group, including individuals eligible for the adult group, low- income parents and caretakers eligible under Section 1931 of the Social Security Act (Section 1931), pregnant women with income within the HIP limit, and individuals eligible for transitional medical assistance.

HIP includes Gateway to Work a community engagement initiative that connects HIP members with ways to look for work, train for jobs, finish school and volunteer. While eligibility suspensions for not completing Gateway to Work are on hold, this HIP Waiver extension requests the ability to continue the Gateway to Work program.

Additionally, all Medicaid enrollees ages 21-64, eligible for full Medicaid benefits, and with a SMI or SUD diagnosis would be eligible for short term stays in an IMD under the SUD and requested SMI component of the waiver extension.

The HIP Waiver extension includes incorporation of the HIP Bridge Account amendment, currently under review by CMS, under which Indiana proposes to adopt limited coverage for target individuals eligible in the group of adults who have income over the income eligibility level for the new adult group identified in § 1902(a)(10)(A)(ii)(XX) of the Social Security Act and in 42 CFR § 435.218. Individuals with MAGI-based income above 133% of the federal poverty level (FPL) who have lost HIP coverage solely due to an increase in income will be eligible for the defined benefit HIP Bridge Account for 12-months following HIP disenrollment. There will be no income limits on eligibility for the account.

ENROLLMENT & FISCAL PROJECTIONS

The HIP Waiver extension will have no impact on expected annual Medicaid enrollment as HIP is requested to be continued with no substantial changes. Further, it is expected to be budget neutral as outlined in the table below.

Without-Waiver Total Expenditures

	DEMONSTRATION YEARS (DY)					TOTAL
	2021	2022	2023	2024	2025	
IMD Services MEG 1 (Fee-for-Service Inpatient)	$16,033,187	$16,987,010	$17,997,573	$19,068,244	$20,202,611	$90,288,625
IMD Services MEG 2 (Fee-for-Service Residential)	$5,130,495	$5,435,710	$5,759,076	$6,101,687	$6,464,681	$28,891,648
IMD Services MEG 3 (Managed Care)	$8,752,467	$9,273,174	$9,824,822	$10,409,288	$11,028,510	$49,288,261
TOTAL	$29,916,150	$31,695,893	$33,581,470	$35,579,219	$37,695,802	$168,468,534

With-Waiver Total Expenditures

	DEMONSTRATION YEARS (DY)					TOTAL
	2021	2022	2023	2024	2025	
IMD Services MEG 1 (Fee-for-Service Inpatient)	$16,033,187	$16,987,010	$17,997,573	$19,068,244	$20,202,611	$90,288,625
IMD Services MEG 2 (Fee-for-Service Residential)	$5,130,495	$5,435,710	$5,759,076	$6,101,687	$6,464,681	$28,891,648
IMD Services MEG 3 (Managed Care)	$8,752,467	$9,273,174	$9,824,822	$10,409,288	$11,028,510	$49,288,261
TOTAL	$29,916,150	$31,695,893	$33,581,470	$35,579,219	$37,695,802	$168,468,534

BENEFITS, COST SHARING, AND DELIVERY SYSTEM

The HIP Waiver extension does not propose any changes to benefits, cost sharing, or delivery system. However, it does incorporate the changes requested specific to the HIP Bridge Account amendment, currently under review by CMS, under which HIP members who qualify for the HIP Bridge Account will receive the benefits and cost sharing applicable to the HIP Bridge Account.

All HIP members will continue to receive a comprehensive benefit package, consistent with private market plans and compliant with all mandated essential health benefits as required by the Patient Protection and Affordable Care Act (ACA). The HIP benefit package does not include non-emergency transportation. Notwithstanding the foregoing, low-income parents and caretakers eligible under Section 1931, pregnant women, low-income 19 and 20-year-old dependents, individuals eligible for transitional medical assistance, and individuals identified as medically frail receive the same benefits as the Medicaid State Plan, including non-emergency transportation and other services not otherwise available to HIP members. Except for members receiving these HIP State Plan benefits, vision and dental services are only available through the HIP Plus plan. Participation in HIP Plus requires members to regularly contribute to their POWER account. The HIP Basic plan is only available to members below the federal poverty level who fail to make their monthly POWER account contributions. The HIP Basic plan does not cover vision and dental services and includes Medicaid allowable copayment amounts.

For all plans, preventive services, such as annual examinations, smoking cessation programs, and mammograms, are covered without charge to the members and are not included in the deductible amount. After the plan deductible is met by way of the $2,500 POWER account, the HIP program includes a comprehensive health plan benefits package.

All HIP medical benefits are currently provided through four (4) MCEs: Anthem, MDwise, Managed Health Services (MHS), and CareSource. Once an MCE has been selected, the member must remain in the MCE for 12 months, with limited exceptions. Members who do not select an MCE will be auto-assigned to an MCE have the opportunity to change the assigned MCE before the first POWER account contribution is made.

Enrollees receiving services under the SUD and requested SMI component of the waiver extension will continue to receive services through their current delivery system.

HYPOTHESES & EVALUATION

The HIP Waiver extension will not propose any changes to the evaluation design or hypotheses. Enhanced program goals, which include the below and will be incorporated into the existing evaluation design posted with the extension documentation, are proposed in the extension request. The enhanced program goals for the HIP extension include period the following:

- Provide timely and geographically appropriate access to healthcare services.
- Promote appropriate utilization of healthcare by maintaining low inappropriate use of the emergency department and supporting utilization of needed services from qualified non-emergency providers.
- Promote control of chronic conditions, delivery of needed care, and increase in member health and wellbeing.
- Increase community engagement leading to increased educational attainment, sustainable employment and member self-sufficiency.
- Reduce the number of uninsured Hoosiers, decrease gaps in coverage, and promote uptake of commercial insurance when leaving HIP.
- Meaningfully increase use of tobacco cessation services and meaningfully decrease tobacco use status for HIP members.

- Encourage healthy behaviors and appropriate care, including early intervention, prevention, and wellness.
- Leverage HIP policies to support the goals of HIP by promoting continuous coverage and improved health outcomes.
- Generate actionable information on social determinants of health.

WAIVER & EXPENDITURE AUTHORITY

FSSA requests an extension of all currently approved waivers and the waiver authority currently under review with CMS for the HIP Workforce Bridge amendment. As specified in the HIP Waiver extension, the requested waivers include:

1. **Premiums Section 1902(a)(14) insofar as it incorporates Section 1916 and 1916A**
   To enable the State to charge monthly contributions for HIP Plus at a minimum amount of one-dollar per month and not to exceed a maximum amount of three-percent of member income.

2. **Reasonable Promptness Section 1902(a)(8)**
   To the extent necessary to enable enrollment in HIP Plus on the first day of the month in which an individual makes their initial contribution to the POWER Account, or, for individuals with incomes at or below 100 percent FPL who fail to make an initial POWER Account payment within 60 days following the date of invoice, the first day of the month in which the 60-day payment period expires, except for individuals who are found eligible through presumptive eligibility.

3. **Provision of Medical Assistance Sections 1902(a)(8) and 1902(a)(10)**
   To the extent necessary to enable Indiana to suspend eligibility for, and not make medical assistance available to, beneficiaries who fail to comply with community engagement requirements, unless the beneficiary is exempted.

4. **Eligibility Sections 1902(a)(10) and 1902(a)(52)**
   To the extent necessary to enable Indiana to make a determination of ineligibility, and terminate eligibility for, beneficiaries who are in a suspension of coverage for failure to meet the approved community engagement requirements, unless the beneficiary meets the requirement or is exempted as described in the STCs.

   To the extent necessary to enable Indiana to prohibit reenrollment, and deny eligibility, for up to six months, for individuals with income over 100 percent of the FPL who are disenrolled for failure to make POWER Account premium contributions within 60 days of the date of invoice, subject to the exceptions and qualifying events.

   To the extent necessary to enable Indiana to prohibit reenrollment, and deny eligibility, for up to three months following the end of the 90-day reconsideration period for individuals who are disenrolled for failure to provide the necessary information for the state to complete an annual redetermination, subject to the exceptions and qualifying events.

5. **Methods of Administration Section 1902(a)(4) insofar as it incorporates 42 CFR 431.53**

To the extent necessary to relieve Indiana of the requirement to assure transportation to and from medical providers for HIP demonstration populations. No waiver of methods of administration is authorized for pregnant women, individuals determined to be medically frail, and section 1931 parents and caretaker relatives.

6. **Comparability and Amount, Duration and Scope of Services Sections 1902(a)(17) and 1902(a)(10)(B)**
   To the extent necessary to enable the State to vary cost sharing requirements for beneficiaries for cost sharing to which they otherwise would be subject under the state plan, such that beneficiaries who are in HIP Plus will be charged only one copayment (for non-emergency use of the emergency department) and individuals who are in HIP Basic will be subject to copayments within Medicaid permissible levels.

   To the extent necessary to enable Indiana to vary contribution requirements, for different HIP Plus program beneficiaries based on income and on tobacco use, and in a manner consistent with all otherwise applicable law. To allow for variations or waivers of POWER Account contribution requirements, within established limits, based on target initiatives such as encouraging uptake of employer insurance.

   To allow the HIP Workforce Bridge Account to be available solely to defined eligible individuals that are disenrolled from HIP due to an increase in income.

   To allow the State to provide only a limited defined benefit via the HIP Bridge Account, that is limited to cost sharing assistance up to an amount of $1,000, regardless of health care costs incurred by the member. To allow any balance payable in excess of $1,000, to be assigned to member responsibility without regard to cost-sharing limitations.

7. **Retroactivity Section 1902(a)(34)**

   To enable the State not to provide three months of retroactive eligibility for beneficiaries receiving coverage through the HIP program as described in the STCs, except for pregnant women.

FSSA also requests extension of the following expenditure authorities that are currently approved or pending approval by CMS:

1. Expenditures under contracts with managed care entities that do not meet the requirements in section 1903(m)(2)(A) of the Act specified below. Indiana's managed care organizations (MCO) participating in the demonstration will have to meet all the requirements of section 1903(m) except the following:

   a. Section 1903(m)(2)(A)(vi) of the Act insofar as it requires compliance with requirements in section 1932(a)(4) of the Act and 42 CFR 438.56(c)(2)(i) that enrollees be permitted an initial period to disenroll without cause, except as described in the terms and conditions.
   b. Section 1903(m)(2)(A)(vi) of the Act insofar as it requires compliance with requirements

in section 1932(a)(4) of the Act and 42 CFR 438.56(g) that automatic MCO reenrollment occur only if the beneficiary's disenrollment was due to a Medicaid eligibility lapse of two months or less, as described in the terms and conditions.

2. Expenditures for otherwise covered services furnished to otherwise eligible individuals who are primarily receiving treatment and withdrawal management services for substance use disorder (SUD) who are short-term residents in facilities that meet the definition of an institution for mental disease (IMD) and expenditures for otherwise covered services furnished to otherwise eligible individuals for short term stays for acute care in a psychiatric hospital that qualifies as an IMD.

REVIEW OF DOCUMENTS & SUBMISSION OF COMMENTS

All information regarding the submission, including the public notice, the HIP Waiver extension, and other documentation regarding the proposal are available for public review at the FSSA, Office of General Counsel, 402 W. Washington Street, Room W451, Indianapolis, Indiana 46204. The full Public Notice and HIP Waiver documents are also available to be viewed online at https://www.in.gov/fssa/hip/.

Written comments may be sent to the FSSA via mail at 402 West Washington Street, Room W374, Indianapolis, Indiana 46204, Attention: Natalie Angel or via electronic mail at hip@fssa.in.gov through **December 6, 2019**.

Appendix 2: Abbreviated Public Notice

OFFICE OF THE SECRETARY OF FAMILY AND SOCIAL SERVICES ADMINISTRATION
NOTICE OF PUBLIC HEARING

In accordance with 42 CFR §431.408(a)(2)(ii), the Indiana Family and Social Services Administration (FSSA) will be holding public hearings on a proposed extension of the Healthy Indiana Plan Section 1115 demonstration waiver (HIP Waiver) that will be submitted to the Centers for Medicare and Medicaid Services (CMS). The Healthy Indiana Plan (HIP) has been a feature of Indiana's Medicaid program since 2008. The current approval to operate HIP expires December 31, 2020. Through this submission, FSSA is seeking a ten year extension of the HIP Waiver with no substantive changes. The extension request includes incorporation of the HIP Bridge Account amendment, which was submitted to CMS on July 25, 2019. FSSA will be requesting the following non-substantive, technical changes through the extension request:

- Flexibility to modify the POWER Account contribution tiers below average limit of three percent of member income, with appropriate notice to members, stakeholders and CMS, but without requiring the submission of a waiver amendment. Modifications are not currently proposed but could, for example, include increasing or decreasing the amounts of the POWER Account base contribution or the tobacco surcharge.
- Flexibility to modify the HIP Basic copayment amounts within the Medicaid allowable limits, with appropriate notice to members, stakeholders and CMS, but without requiring the submission of a waiver amendment. Modifications are not currently proposed but these modifications may include increases in copayment amounts within limits allowed for cost of living increases, decreases in copayment amounts, or implementation of copayment waivers on target services.

Additionally, through this waiver extension application, FSSA is seeking federal approval for a five-year extension of the substance use disorder (SUD) and requested serious mental illness (SMI) components of the HIP Waiver. This includes authority to reimburse institutions for mental disease (IMDs) for short term stays for individuals diagnosed with SMI or SUD.

Hearings will be held as follows:

3) Tuesday November 19th at 2:00 pm at the Indiana State Library, History Reference Room 211, 315 W. Ohio St., Indianapolis, IN 46202. This hearing will be a special session of the Medical Advisory Commission.
4) Wednesday November 20th at 10:00 am at the Indiana Government Center South, Conference Room 18, 302 W. Washington St, Indianapolis, IN 46204. This hearing will be also be accessible via web conference at https://Indiana.AdobeConnect.com/indiana.

All information regarding the submission, including the public notice, the HIP Waiver extension, and other documentation regarding the proposal are available for public review at the FSSA, Office of General Counsel, 402 W. Washington Street, Room W451, Indianapolis, Indiana 46204. The full Public Notice and HIP Waiver documents are also available to be viewed online at https://www.in.gov/fssa/hip/.

Written comments may be sent to the FSSA via mail at 402 West Washington Street, Room W374, Indianapolis, Indiana 46204, Attention: Natalie Angel or via electronic mail at hip@fssa.in.gov through **December 6th, 2019 at 5:00 pm**.

Appendix 3: Tribal Notice

INDIANA FAMILY AND SOCIAL SERVICES ADMINISTRATION
NOTICE OF TRIBAL COMMENT PERIOD FOR §1115 WAIVER EXTENSION

In accordance with 42 CFR § 431.408(b), notice is hereby given to the Pokagon Band of the Potawatomi that the Indiana Family and Social Services Administration (FSSA) will be seeking renewal of its Healthy Indiana Plan Section 1115 demonstration waiver (HIP Waiver) to the Centers for Medicare and Medicaid Services (CMS).

This notice also serves to open the **30-day tribal comment period, which closes December 1st at 5:00 pm.**

RENEWAL REQUEST SUMMARY

The Healthy Indiana Plan (HIP) has been a feature of Indiana's Medicaid program since 2008. The current approval to operate HIP expires December 31, 2020. Based on the long-tenure and demonstrated success of HIP, FSSA is seeking a ten year extension of the HIP Waiver with no substantive changes. The extension request includes incorporation of the HIP Workforce Bridge amendment, for which tribal notice was provided on May 15, 2019. FSSA will be requesting the following non-substantive, technical changes through the extension request:

- Flexibility to modify the POWER Account contribution tiers below average limit of three percent of member income, with appropriate notice to members, stakeholders and CMS, but without requiring the submission of a waiver amendment. Modifications are not currently proposed but could for example include increasing or decreasing the amounts of the POWER Account base contribution or the tobacco surcharge.
- Flexibility to modify the HIP Basic copayment amounts within the Medicaid allowable limits, with appropriate notice to members, stakeholders and CMS, but without requiring the submission of a waiver amendment. Modifications are not currently proposed but these modifications may include increases in copayment amounts within limits allowed for cost of living increases, decreases in copayment amounts, or implementation of copayment waivers on target services.

Additionally, through this waiver extension application, FSSA is seeking federal approval for a five-year extension of its substance use disorder (SUD) and requested serious mental illness (SMI) components of the HIP Waiver. This includes authority to reimburse institutions for mental disease (IMDs) for short term stays for individuals diagnosed with SMI or SUD.

TRIBAL IMPACT

As only technical changes related to POWER Account and cost sharing are proposed through this extension application, there will be no impact to tribal enrollees. Members of the Pokagon Band of the Potawatomi located in Indiana will continue to be eligible to obtain coverage under HIP when they meet the current criteria for eligibility. All eligible tribal members will also continue to receive HIP services in a manner consistent with federal regulations, including the American Recovery and Reinvestment Act of 2009, which in relevant part precludes states from imposing

Medicaid premiums or other cost-sharing on members of federally-recognized Indian tribes. As occurs today, all eligible tribal members who participate in the demonstration will be enrolled in the HIP Plus plan with no POWER Account contribution or cost-sharing requirements. Further, tribal members will continue to have the option to voluntarily participate in HIP. If an enrollment option is not specified, members will be enrolled in a managed care entity (MCE) by default, and will be given the option to disenroll and receive benefits through the Medicaid fee-for-service program. Pending CMS approval of the HIP Workforce Bridge Amendment, for which tribal notice was provided on May 15, 2019, those who opt to participate will receive an exemption to any active Gateway to Work requirements in place of the current activity credit received for participation in the Pathways program. Exempt members do not have a Gateway to Work requirement when it applies but may still access Gateway to Work resources and participate on a voluntary basis. In addition, tribal members will be eligible to receive the HIP Bridge Account, if applicable.

Additionally, through extension of FSSA's IMD waiver, members of the Pokagon Band of the Potawatomi located in Indiana and enrolled in full Medicaid benefits will continue to have access to: (1) short term stays for acute care in a psychiatric hospital that qualifies as an IMD; and (2) treatment and withdrawal management services for SUD in IMDs.

REVIEW OF DOCUMENTS AND SUBMISSION OF COMMENTS

Written comments may be sent to the FSSA via mail at 402 West Washington Street, Room W374, Indianapolis, Indiana 46204, Attention: Amy Owens or via electronic mail at amy.owens@fssa.in.gov **through December 1st, 2019**. Additionally, we would be happy to schedule a phone or in-person consultation to discuss the program in further detail.

MILLIMAN CLIENT REPORT

1115 Waiver – Healthy Indiana Plan

Second Renewal – Budget Neutrality

Expenditure authority for members with a substance use disorder or serious mental illness

Draft

State of Indiana

Family and Social Services Administration

October 30, 2019

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Renata Ringo, FSA, MAAA
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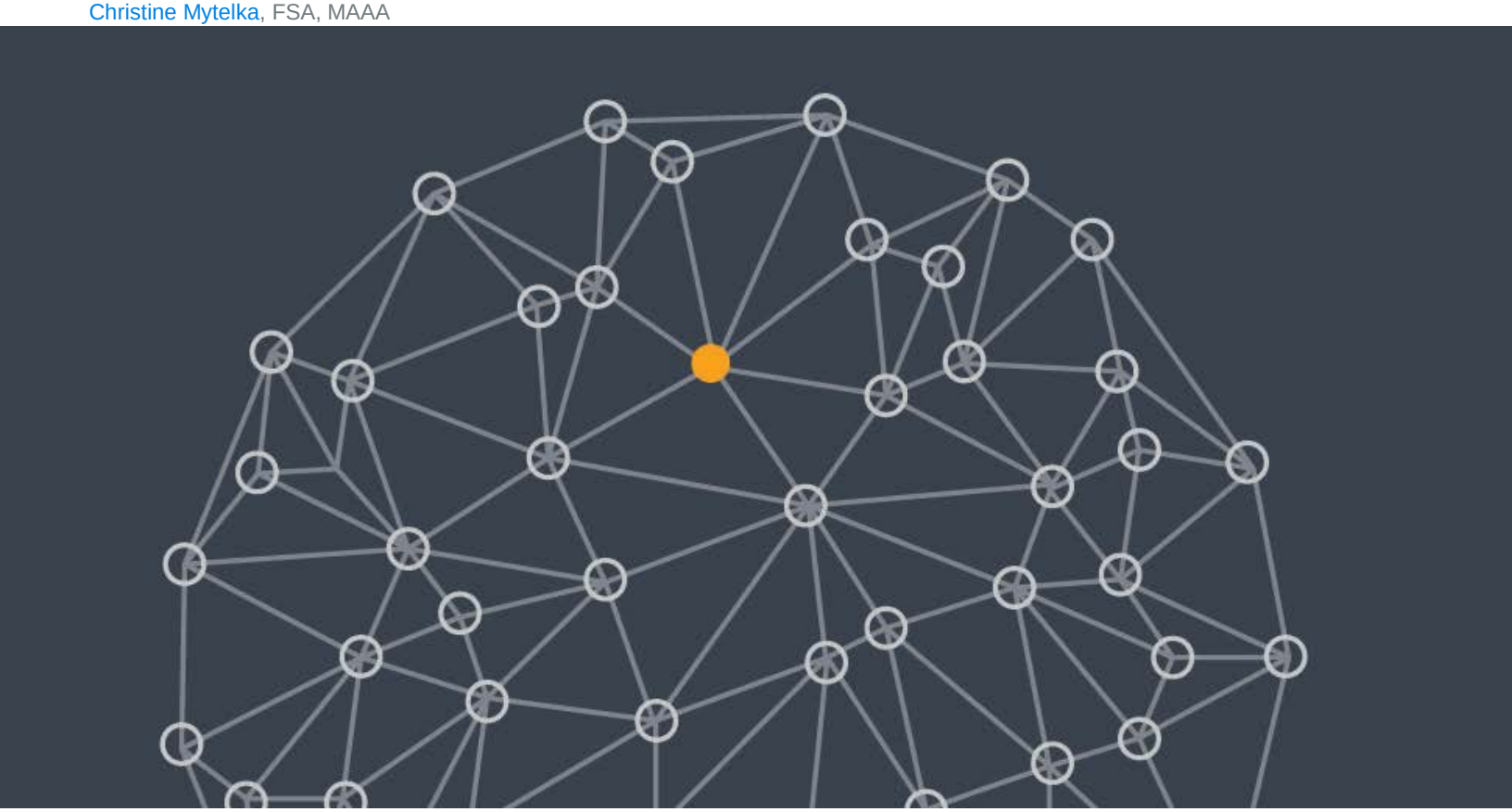

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BACKGROUND

The state of Indiana's current 1115 Healthy Indiana Plan (HIP) waiver, No. 11-W-00296/5, requests expenditure authority for adults who receive Substance Use Disorder (SUD) services delivered in an Institution for Mental Disease (IMD). Budget neutrality documentation for this Medicaid Eligibility Group (MEG) was provided in a report titled "*22-1115 Waiver Renewal – IMD only.pdf*" dated January 21, 2018. The current waiver has been approved for the period February 1, 2018 through December 31, 2020.

Based on the CMS letter[1] to State Medicaid Directors dated November 13, 2018, the state wished to revise the waiver to include Serious Mental Illness (SMI) services as well. The state submitted a waiver amendment reflecting the state's intention to transition from one MEG to three, effective January 1, 2020. Budget neutrality documentation for the waiver amendment was provided in a report titled *"02-1115 SUD SMI Budget Neutrality.docx"* dated July 23, 2019. This amendment is currently pending approval from CMS.

The state wishes to request a five-year waiver renewal for the period January 1, 2021 through December 31, 2025. The remainder of this report details the budget neutrality projections for this proposed waiver renewal.

EXECUTIVE SUMMARY

This report has been developed for the state of Indiana, Family and Social Services Association (FSSA) to document budget neutrality projections for the HIP 1115 waiver renewal. These projections reflect the MEGs proposed in the state's recently submitted waiver amendment, described in the "Background" section above.

For reference, the proposed MEGs are:

1. **Fee-for-service (FFS) intensive inpatient** – FFS member months for an adult aged 21-64 with a SUD or SMI intensive inpatient stay (ASAM level 4.0)
2. **FFS residential treatment** – FFS member months for an individual of any age with a SUD or SMI residential treatment (ASAM level 3.1 to 3.5)
3. **Managed care** – managed care member months for an adult aged 21-64 with a SUD or SMI intensive inpatient stay or an individual with a SUD or SMI residential treatment (ASAM level 3.1 to 4.0)

We estimated calendar year (CY) 2019 expenditures for each proposed population described above, including all Medicaid-funded expenses. For the managed care group, this includes capitation payments plus any carved out services administered under the FFS delivery system. We used CY 2019 estimated experience based on guidance communicated by CMS in a technical assistance call on October 7, 2019. Effective January 1, 2019, the hospital presumptive eligibility (PE) population, previously covered under managed care, transitioned to FFS. Due to this transition, it was decided that emerging 2019 experience would be more representative of the waiver renewal period than the most recently completed calendar year. Further details of the transition and the methodology used to estimate representative experience for the entire CY 2019 period are provided later in the "Hospital presumptive eligibility" section of this report.

For purposes of completing the budget neutrality template provided by CMS, we populated a placeholder assumption of 4.9% for the president's budget trend and a 1.0% enrollment trend rate for each MEG. However, it is our understanding that since the "IMD Without Waiver" and "IMD With Waiver" calculations are the same in the template, the CY 2019 PMPM values for each MEG are the primary information desired. This is also consistent with guidance communicated by CMS in various phone calls during the waiver amendment process.

Please refer to the Excel file named "*05-SMI IMD Budget Neutrality Template.xlsx*", included with the delivery of this report, to see the completed budget neutrality template. The remainder of this report details the data and methodology used to populate the template.

[1] https://www.medicaid.gov/federal-policy-guidance/downloads/smd18011.pdf

DATA, ASSUMPTIONS, AND METHODOLOGY

DATA

CY 2019 member months and expenditures were estimated based on enrollment, capitation payment, and claims data reported through the state of Indiana's Enterprise Data Warehouse (EDW), and originally provided by the fiscal agent. FFS enrollment and expenditure data reflect services reported as of September 30, 2019. Managed care enrollment and capitation data reflect information incurred through June 30, 2019 and reported as of July 31, 2019.

METHODOLOGY AND ASSUMPTIONS

The methodology used to determine the CY 2019 member months and expenditures is described below:

Fee-for-service methodology

FFS member months represent those individuals receiving residential treatment or intensive inpatient services in an IMD. Residential treatment was determined by procedure code, either H0010 or H2034. Intensive inpatient recipients were identified according to the IMD provider IDs included in Figure 1 below, and limited to adults ages 21-64. Individuals were accordingly assigned to either the residential treatment or intensive inpatient MEG. In the case where a recipient had both types of services in the same month, they were assigned to the intensive inpatient MEG.

FIGURE 1: INSTITUTIONS FOR MENTAL DISEASE (IMD) – INDIANA HEALTH COVERAGE PROGRAM

Billing Provider ID*	Provider Name
100273400	Valle Vista Health System
100273450	Fairbanks Hospital
100273680	Bloomington Meadows Hospital
200029610	Northern Indiana Hospital, Plymouth
200240620	Deaconess Cross Pointe, Evansville
200484350	Michiana Behavioral Health
200813230	Wellstone Regional Hospital
200903750	Harsha Behavioral Center Inc
200968000	Brentwood Meadows LLC
201050770	Options Behavioral Health System
201110540	Sycamore Springs LLC
201292260	Assurance Health Psychiatric Hospital

*AIM billing provider ID. In CORE, a location code may be appended.

Once the eligible recipient-months were identified as described above, we summarized all FFS expenditures for those months in which they received residential treatment or intensive inpatient services. We included all expenditures, not just the applicable SUD/SMI expenditures, because without the waiver these members would not be eligible for Medicaid during months in which they received treatment in an IMD.

Managed care methodology

Managed care member months were identified in the same manner as FFS. The only distinction is that there is only one managed care MEG for residential treatment and intensive inpatient services combined.

Once the eligible recipient-months were identified as described above, we summarized all expenditures for those months in which they received residential treatment or intensive inpatient services. Again, we included all expenditures, not just the applicable SUD/SMI expenditures, because without the waiver these members would not be eligible.

The expenditures for the managed care recipients consist of two components: capitation payments and services administered under the FFS delivery system.

Capitation payments

Capitation payments were calculated for each member based on their managed care rate cell. The capitation rates currently included in the EDW do not correspond to the latest CY 2019 capitation rates that will ultimately be paid. As such, we adjusted the capitation payments to include the impact of CY 2019 rates that are not yet reflected in the EDW.

Services administered under FFS

While capitation payments represent the bulk of expenditures for the managed care population, there are some services carved out of managed care that are administered via the FFS delivery system that also must be included. Examples of these carve-outs include some high-cost drugs, such as Hepatitis C therapies, and Medicaid Rehabilitation Option (MRO). The carved out claims expenditures for the applicable member months were added to the capitation payments to reflect the comprehensive total cost for this MEG.

Hospital presumptive eligibility

As of January 1, 2019, PE members began enrolling in FFS, rather than managed care. Due to this program change, there was a significant shift in enrollment and expenditures from the managed care MEG to FFS in CY 2019. Based on CMS guidance, we have reviewed and extrapolated emerging 2019 experience to develop the CY 2019 starting point for the budget neutrality projections.

CY 2019 projection

The FFS and managed care data described above was summarized by MEG, month, and Medicaid/Medicare dual eligibility status. Dual eligibility status was considered because the PE population is primarily non-dual, in contrast to most other members receiving IMD services through the state's FFS delivery system, who are predominantly dual eligible. The influx of non-dual IMD members into FFS is expected to increase average PMPM expenses since their costs are not shared with Medicare.

The monthly data was reviewed to identify the impact of the PE transition and select appropriate stable time periods to project the partial year emerging experience to a full calendar year. The different population stratifications were extrapolated as follows:

1. **FFS duals** – This population is not expected to change significantly as a result of the transition. Therefore, the average enrollment and PMPM expenditures from the first six months of 2019 were assumed to be representative of the entire CY 2019.
2. **FFS non-duals** – Effective May 1, 2019, the state changed the IMD reimbursement policy for PE individuals[2], producing a subsequent increase in enrollment and expenditures over the first four months of the year. The following four months, May through August, are more indicative of the expected ultimate levels of enrollment and expenditures. Therefore, we developed CY 2019 projections as if this policy were in force all year to more accurately represent renewal year experience.
3. **Managed care** – The managed care data is from an earlier time period than the FFS data and also appears to be incomplete in the later months. Consequently, the average member months and PMPM expenditures from the first three months of 2019 were assumed to be representative of the entire CY 2019.

Figure 2 below shows the calculation of the CY 2019 estimated values. The significant differences compared to CY 2018 experience underscore the need to use this alternative basis for budget neutrality projections. The decision to use FFS non-dual eligible experience after the May 2019 policy change is also supported by the table.

[2] http://provider.indianamedicaid.com/ihcp/Bulletins/BT201926.pdf

FIGURE 2: CALCULATION OF CY 2019 ESTIMATED EXPERIENCE

		FFS INTENSIVE INPATIENT								
		TOTAL			DUAL ELIGIBLE			NON-DUAL ELIGIBLE		
	TIME PERIOD	EXPENDITURES	MEMBER MONTHS	PMPM	EXPENDITURES	MEMBER MONTHS	PMPM	EXPENDITURES	MEMBER MONTHS	PMPM
	CY 2018	$ 2,461,870	1,085	$ 2,269.00	$ 2,115,531	1,043	$ 2,028.31	$ 346,339	42	$ 8,246.17
(a)	201901-201904	2,200,801	380	5,791.58				2,200,801	380	5,791.58
(b)	201905-201908	4,119,097	621	6,633.01				4,119,097	621	6,633.01
(c)	201901-201906	962,969	463	2,079.85	962,969	463	2,079.85			
	Estimated CY 2019	**$ 14,283,229**	**2,789**	**$ 5,121.27**	**$ 1,925,938**	**926**	**$ 2,079.85**	**$ 12,357,290**	**1,863**	**$ 6,633.01**
	Extrapolation Formula				*(c) * 2*	*(c) * 2*		*(b) * 3*	*(b) * 3*	

		FFS RESIDENTIAL TREATMENT								
		TOTAL			DUAL ELIGIBLE			NON-DUAL ELIGIBLE		
	TIME PERIOD	EXPENDITURES	MEMBER MONTHS	PMPM	EXPENDITURES	MEMBER MONTHS	PMPM	EXPENDITURES	MEMBER MONTHS	PMPM
	CY 2018	$ 288,642	72	$ 4,008.92	$ 160,220	50	$ 3,204.40	$ 128,422	22	$ 5,837.37
(a)	201901-201904	1,612,605	352	4,581.26				1,612,605	352	4,581.26
(b)	201905-201908	1,371,923	293	4,682.33				1,371,923	293	4,682.33
(c)	201901-201906	227,378	56	4,060.32	227,378	56	4,060.32			
	Estimated CY 2019	**$ 4,570,523**	**991**	**$ 4,612.03**	**$ 454,755**	**112**	**$ 4,060.32**	**$ 4,115,768**	**879**	**$ 4,682.33**
	Extrapolation Formula				*(c) * 2*	*(c) * 2*		*(b) * 3*	*(b) * 3*	

		MANAGED CARE								
		TOTAL			DUAL ELIGIBLE			NON-DUAL ELIGIBLE		
	TIME PERIOD	EXPENDITURES	MEMBER MONTHS	PMPM	EXPENDITURES	MEMBER MONTHS	PMPM	EXPENDITURES	MEMBER MONTHS	PMPM
	CY 2018	$ 10,025,712	9,480	$ 1,057.56	$ 54,418	47	$ 1,157.83	$ 9,971,294	9,433	$ 1,057.07
(a)	201901-201903	1,949,299	1,863	1,046.32	6,936	6	1,155.96	1,942,363	1,857	1,045.97
	Estimated CY 2019	**$ 7,797,196**	**7,452**	**$ 1,046.32**	**$ 27,743**	**24**	**$ 1,155.96**	**$ 7,769,453**	**7,428**	**$ 1,045.97**
	Extrapolation Formula				*(a) * 4*	*(a) * 4*		*(a) * 4*	*(a) * 4*	

Note that the managed care member months and expenditures for CY 2018 are higher than what was shown in the recently submitted waiver amendment due to a change in the HIP monitoring logic; however, the PMPMs remain similar.

Limitations

The information contained in this report has been prepared for the state of Indiana, Family and Social Services Administration (FSSA) to assist with the development of budget neutrality for the HIP 1115 waiver renewal to be submitted to the Centers for Medicaid and Medicare Services (CMS). The data and information presented may not be appropriate for any other purpose.

It is our understanding that the information contained in this report may be utilized in a public document. To the extent that the information contained in this correspondence is provided to any third parties, the correspondence should be distributed in its entirety. Any user of the data must possess a certain level of expertise in actuarial science and healthcare modeling so as not to misinterpret the information presented.

Milliman makes no representations or warranties regarding the contents of this correspondence to third parties. Likewise, third parties are instructed that they are to place no reliance upon this correspondence prepared for FSSA by Milliman that would result in the creation of any duty or liability under any theory of law by Milliman or its employees to third parties.

Milliman has relied upon certain data and information provided by the state of Indiana, Family and Social Services Administration and their vendors. The values presented in this letter are dependent upon this reliance. To the extent that the data was not complete or was inaccurate, the values presented in our report will need to be reviewed for consistency and revised to meet any revised data.

The services provided for this project were performed under the signed Consulting Services Agreement between Milliman and FSSA approved December 5, 2018.

Guidelines issued by the American Academy of Actuaries require actuaries to include their professional qualifications in all actuarial communications. The authors of this report are members of the American Academy of Actuaries, and meet the qualification standards for performing the analyses in this report.

Milliman is among the world's largest providers of actuarial and related products and services. The firm has consulting practices in life insurance and financial services, property & casualty insurance, healthcare, and employee benefits. Founded in 1947, Milliman is an independent firm with offices in major cities around the globe.

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Healthy Indiana Plan Interim Evaluation Report

Final for CMS Review

HEALTH CARE AND HUMAN SERVICES POLICY, RESEARCH, AND ANALYTICS—WITH REAL-WORLD PERSPECTIVE.

Prepared for: **Indiana Family and Social Services Administration**

Submitted by: **The Lewin Group, Inc.**

December 18, 2019

Healthy Indiana Plan
Interim Evaluation Report

Prepared for: Indiana Family and Social Services Administration

Submitted by: The Lewin Group, Inc.

December 18, 2019

Final for CMS Review

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Table of Exhibits

A. Executive Summary

The Centers for Medicare & Medicaid Services (CMS) renewed the Indiana Family and Social Services Administration's (FSSA) Healthy Indiana Plan (HIP) Section 1115(a) demonstration waiver for three years from February 1, 2018 through December 31, 2020. First passed by the Indiana General Assembly in 2007, and implemented in 2008, HIP represents the nation's first consumer-driven health plan for Medicaid beneficiaries, and in 2015, became an alternative to traditional Medicaid expansion under the Patient Protection and Affordable Care Act.

HIP provides health care coverage for qualified low-income, non-disabled adults ages 19 to 64 up to 138% of the federal poverty level (FPL). From February 2015 to December 2018, HIP served approximately 814,600 unique members.[1] The number of unique members covered annually increased from 390,000 in 2015 to 570,000 in 2018. HIP covered an average of 390,650 unique members every month in 2018.

HIP seeks to engage members and empower them to become active consumers of health care services. Building on the original HIP design (referred to as the Original HIP in this report), FSSA implemented HIP 2.0 in 2015. HIP 2.0 continued the use of the Personal Wellness and Responsibility (POWER) Account, a health savings-like account members use to pay for health care, and POWER Account Contributions, a monthly amount paid by HIP Plus members into their POWER Account. HIP 2.0 also included a voluntary Gateway to Work program to connect members to job training and job search resources, and HIP Link, which provided enrolled individuals with a defined contribution to help pay for the costs of employer-sponsored insurance.

Exhibit A.1: HIP Changes Under Review for the Current Evaluation

- Modification of POWER Account Contributions from a flat 2% of income to a tiered structure.
- Expansion of the Gateway to Work program that added a community engagement reporting requirement for non-disabled working-age members beginning in 2019.
- Addition of a tobacco use surcharge that increases users' POWER Account Contributions by 50% beginning in their second year of continuous enrollment.

The State used the current HIP demonstration, referred to as "HIP" throughout this report, to continue or expand many of the HIP 2.0 policies (**Exhibit A.1**). Most notably, the State simplified the payment tiers for member POWER Account Contributions, included community engagement reporting requirements in the Gateway to Work program, and added a POWER Account Contribution surcharge for members using tobacco for longer than one year. HIP Link did not continue into the waiver renewal period due to limited participation. The State submitted a waiver amendment to CMS in July 2019 to implement HIP Workforce Bridge, which serves a similar goal as HIP Link in supporting the transition to non-HIP coverage. If approved, HIP Bridge will provide financial support to members transitioning from HIP to another coverage option (e.g., employer-sponsored coverage or the federal marketplace) through a special health savings-like account that covers health care costs incurred during their coverage transition up to $1,000. **Section B: Summary of HIP Demonstration** provides additional detail on current HIP policies.

[1] Members with enrollment status values of Regular Basic (RB), Regular Plus (RP), State Basic (SB), State Plus (SP), pregnant (MA), and HIP Plus Copay (PC). We did not include months when an individual had conditional eligibility or presumptive eligibility status, or members that were eligible for Emergency Room services only (Emergency Room services flag of "Y").

The State contracted with The Lewin Group ("Lewin") to conduct the federally-mandated evaluation of HIP for the waiver renewal period (February 2018 to December 2020).[2] This evaluation includes two reports:

- **Interim Evaluation Report** – This report reflects the first 17 months of the HIP waiver renewal (February 2018 to June 2019) and the first six months of the phase-in of the new community engagement reporting requirements (voluntary reporting from January 2019 to June 2019). As appropriate, we have included data from 2015 to 2018 for comparative purposes. As required by CMS as part of the waiver renewal's Specific Terms and Conditions (STCs) and Section 1115 rules, this report must accompany the State's waiver renewal application due to CMS by December 31, 2019 (including a 30-day public comment period).
- **Summative Evaluation Report** – This report will provide a comprehensive evaluation of the full three-year demonstration period from February 2018 to December 2020; the State will submit Lewin's Summative Evaluation Report to CMS in 2022.

This Interim Evaluation Report provides observations to date on the HIP policies under the waiver renewal. These observations will inform the State's continued implementation of these policies, and help inform and guide the development of analyses conducted for the Summative Evaluation Report.

Summary of the Goals of the Demonstration

Building on the successes and lessons learned from Original HIP and HIP 2.0, the State used the 2018 HIP waiver renewal to test new approaches and flexibilities in Indiana's Medicaid program to provide incentives for members to take personal responsibility for their health (Refer to **Section B: Summary of HIP Demonstration**). Over the current demonstration period (February 2018 to December 2020), the State seeks to achieve several demonstration goals relating to tobacco cessation, community engagement, and other policies. These goals inform the State's evaluation of the HIP program, and include, but are not limited to, the following:

1. Improve health care access, appropriate utilization, and health outcomes among HIP members.
2. Increase community engagement leading to sustainable employment and improved health outcomes among HIP members.
3. Discourage tobacco use among HIP members through a premium surcharge and the utilization of tobacco cessation benefits.
4. Promote member understanding and increase compliance with payment requirements by changing the monthly POWER Account payment requirement to a tiered structure.
5. Ensure HIP program policies align with commercial policies, encourage member understanding, promote positive member experience, and minimize gaps in coverage.
6. Assess the costs to implement and operate HIP and other non-cost outcomes of the demonstration.

[2] The Lewin Group's team includes AIRvan Consulting, Engaging Solutions, Indiana University, and McCarty Research. AIRvan Consulting is certified as an Indiana Women's Business Enterprise, Engaging Solutions is certified as an Indiana Minority Business Enterprise, and McCarty Research is certified as an Indiana Veteran's Business Enterprise.

Summary of Evaluation Methodology

The methodology follows the federally required evaluation plan that covers analyses for both the Interim and the Summative Evaluation Reports. **Attachment I: Evaluation Plan** provides the most recent version of this plan.[3] The evaluation methodology relies on a mixed-methods approach employing both qualitative and quantitative analyses to provide preliminary observations for the hypotheses and research questions corresponding to each goal of the demonstration (Refer to **Section D: Methodology**).

The analyses reflect qualitative sources (e.g., key informant interviews with State officials, managed care entity [MCE] executives, providers, and members), and quantitative sources (e.g., enrollment data, encounter data, and other State administrative data). Lewin and its partners conducted key informant interviews between July and September 2019. Data sources for the Interim Evaluation Report included February 2015 to March 2019 monthly enrollment and disenrollment files, 2015 to 2018 annual POWER Account Reconciliation files, February 2015 to December 2018 encounter data, and January 2019 to June 2019 Gateway to Work reporting data.

Due to data availability and the required timeline for submission, this Interim Evaluation Report primarily offers preliminary observations for a subset of the hypotheses and research questions based on HIP metrics. The Summative Evaluation Report, scheduled for 2022, will provide a more comprehensive examination of HIP, including outcomes and cross-state comparisons. Evaluating impacts of individual HIP policies presents a challenge due to their interdependent nature. Additionally, the time period used for analysis and trending encompasses a variety of waiver and non-waiver developments. These include the maturation of the HIP program since 2015, recent improvement in the state economy, case-mix changes over time, implementation of a new Medicaid Management Information System, removal of a graduated Emergency Department (ED) copayment, updates to HIP verification processes, and new processes for reporting and tracking community engagement activities.

Interim Evaluation Report Observations to Date

Indiana's HIP program functions within Medicaid regulations and operational constraints to provide health care coverage that resembles commercial coverage and ties health care benefits to member community engagement reporting requirements. The resulting policies produce a multifaceted set of outcomes and require a high degree of collaboration between the State and the contracted MCEs, and between State agencies. This collaboration includes a range of data sharing (e.g., related to tracking member enrollment in HIP benefit plans, community engagement reporting and member POWER Account Contribution payments) and intensive, targeted member communications that must distill multifaceted HIP policies into key takeaways.

HIP enrollment has grown from 389,984 unique members in 2015 (February to December) to 569,971 unique members in 2018.[4] While the number of unique HIP members has increased from 2015 to 2018, the annual rate of increase in unique members decreased over the same period (33% increase from 2015 to 2016, 7% increase from 2016 to 2017, and 2% increase from 2017 to 2018). The number of

[3] As of December 18, 2019, CMS was still in the process of reviewing Indiana's Evaluation Plan.

[4] Members with enrollment status values of Regular Basic (RB), Regular Plus (RP), State Basic (SB), State Plus (SP), pregnant (MA), and HIP Plus Copay (PC). We did not include months when an individual had conditional eligibility or presumptive eligibility status, or members that were eligible for Emergency Room services only (Emergency Room services flag of "Y").

unique individuals newly enrolled in HIP per year decreased by 16% from 2016 to 2017 (178,258 to 149,483) and then stayed approximately the same in 2018 (149,747). These decreases in new enrollment in HIP occurred alongside a decrease in Indiana's unemployment rate (4.8% in June 2015 as compared to 3.5% in June 2018), as well as a decrease in the estimated number of potentially HIP eligible individuals (838,047 in 2015 as compared to 773,990 in 2017).[5,6]

HIP members were more likely to be female and less likely to be non-Hispanic White compared to the general population of Indiana. The average income of HIP members increased from 2015 to 2018 with the proportion of members with income over 100% of the FPL increasing from 11% to 17%. Black HIP members disproportionately disenrolled regardless of the disenrollment reason compared to their race category counterparts during this same period. **Section B: Summary of HIP Demonstration** and **Attachment II: HIP Sociodemographic Statistics** contains more detailed sociodemographic analyses.

Overall, the complexity of HIP creates challenges for the State and MCEs to support member and provider understanding of key policies, in particular, POWER Accounts and community engagement reporting requirements. Although the State and MCEs have dedicated resources to communicating key policies and related changes, information gathered during key informant interviews with State officials, MCE executives, members, and providers suggest opportunities for improvement in member and provider understanding of HIP policies. Additionally, maintaining current and accurate member contact information has been a long-standing challenge for the State and MCEs, presenting a barrier to member communications. As such, we recommend the following areas of focus for the State going forward:

- Identify new opportunities to update member contact information, for example, through increased public outreach and support for MCEs in establishing member incentive programs to update contact information to help members understand the steps or pathway to updating their contact information.
- Continue to work with MCEs to carefully test and further streamline communications to support member understanding of POWER Account policies and community engagement reporting requirements, along with other HIP policies such as rollover, Fast Track, and presumptive eligibility, including continuing a layered communication approach (e.g., social media, text message, email, mail) and multiple communication releases reframing the same message to reinforce the policies; and
- Explore additional opportunities to increase engagement of providers, community organizations, and certified navigators in communications about HIP policies.

The remainder of this section summarizes preliminary observations and recommendations by demonstration goal. **Section G: Conclusions** provides a more detailed description of these observations. **Section F: Results by Demonstration Goal** provides the results by hypothesis and research question.

[5] Bureau of Labor Statistics (2019, September 10). Local Area Unemployment Statistics. Retrieved from https://data.bls.gov/pdq/SurveyOutputServlet.

[6] American Community Survey Data (2015 – 2017), IPUMS Online Data Analysis System (2019). IPUMS USA. Retrieved from https://usa.ipums.org/usa/sda/.

Goal 1 – Improve health care access, appropriate utilization, and health outcomes among HIP members

Overall, members, providers, MCE executives, and State officials report that HIP has improved health care access, particularly for people previously uninsured. Analyses of 2015 to 2018 data indicate that utilization of primary, urgent, and Centers for Disease Control and Prevention (CDC)-defined preventive care services increased while specialty care and avoidable ED utilization decreased. Use of dental and vision services decreased from 2015 to 2018, and prescription drug adherence remained approximately the same. A higher proportion of continuously enrolled HIP Plus members used one or more services compared to HIP Basic members. Additionally, HIP Plus members were more likely to use primary, urgent, specialty, and preventive care services than HIP Basic members. Enrollment in MCE disease management and pregnancy management programs increased from 2015 to 2018. While enrollment via Fast Track and presumptive eligibility supported additional months of coverage for HIP members, the percentage of new enrollees using these policies decreased.

Lewin recommends the following key areas of focus for the State related to **Goal 1**:

- Collaborate with the MCEs to tailor outreach to engage HIP Basic members in their care as appropriate and support HIP Basic members in understanding how to enroll in HIP Plus and maintain that enrollment.
- Develop policies to further decrease avoidable ED use.
- Conduct analyses and gather additional member and certified navigator feedback to better understand the decrease in the percentage of new enrollees using presumptive eligibility and Fast Track options.
- Explore opportunities to conduct additional outreach with providers and potential enrollees related to Fast Track use and presumptive eligibility enrollment processes.

Goal 2 – Increase community engagement leading to sustainable employment and improved health outcomes among HIP members.

Due to the phase-in of the new reporting requirements under the waiver renewal, the period of analysis for Gateway to Work reflects voluntary reporting of community engagement activities.[7] As of June 2019, nearly 75% of HIP members were exempt from reporting community engagement activities, 18% had a reporting requirement (voluntary basis only), and 7% prequalified due to existing employment. Less than 1% of those required to report (voluntary basis only) actually did so, with most reporting employment, volunteer work, or caregiving as the qualifying community engagement activity. Those members required to report (voluntary basis only) and those not required to report both disenrolled for similar reasons, including increase in income, failure to verify information, or failure to submit paperwork for redetermination.

Overall, members, providers, State officials, and MCE executives agree that HIP members have some level of understanding of their community engagement requirement, including reporting status and consequences of non-compliance. Barriers to compliance include time commitment, paperwork, geographic location, internet access, and the scope of the "good cause" exemption. The State and MCEs perform a range of data matching to proactively identify a member's reporting status, including potential exemptions from reporting.

[7] As such, Lewin will evaluate mandatory reporting only as part of the Summative Evaluation Report.

Lewin recommends the following key areas of focus for the State to consider related to **Goal 2**:

- Increase efforts to obtain updated member contact information (as described above) so that communications regarding how to report community engagement activities can reach all members required to report qualifying activities, but have not yet done so.
- Continue focusing on ongoing, tailored communications for individuals required to report qualifying activities, and work closely with MCEs to ensure similar tailored communications emphasizing the variety of ways that members can report their hours (e.g., online, calling the MCEs, in-person).
- Use the "good cause exemption" category to provide exemptions for members that have encountered barriers to reporting (for example, lack of a reliable street address or email).
- Encourage MCEs to increase efforts to work through community-based organizations to reach members required to report qualifying activities.

Goal 3 – Discourage tobacco use among HIP members through a premium surcharge and the utilization of tobacco cessation benefits.

While the analyses for the evaluation of **Goal 3** will not occur until the Summative Evaluation Report, this Interim Evaluation Report provides baseline analyses of member tobacco use (based on a subset of new enrollees) and member tobacco cessation use, along with themes from key informant interviews with MCE executives, State officials, members, and providers. Preliminary observations include:

- Approximately 29% to 31% of HIP members in the State's smoking indicator file reported using tobacco. The State's smoking indicator file includes new HIP members, members switching MCEs, and members who have self-reported their tobacco use status (reflecting a non-representative subset of 10% to 15% of the overall HIP population). Use of tobacco is highest for non-Hispanic Whites and members living in rural and non-metro areas.
- From 2015 to 2018, an average of 7.3% of HIP members utilized a tobacco cessation service annually, with medications as the most common quit method. Cessation services were most common among members 51 years of age or older, females, non-Hispanic Whites, members living in rural areas.
- MCE executives reported receiving few complaints or disputes related to the new tobacco surcharge.
- Results from the member interviews suggest that HIP members generally know about HIP policies, including the tobacco surcharge and available cessation services. However, only a small portion of interviewees were also tobacco users, and responses may not reflect all members' understanding of the State's tobacco surcharge policy.
- MCEs reported applying the tobacco surcharge to less than 1% of the HIP member population in 2018.

Lewin recommends the following key areas of focus for the State to consider related to **Goal 3**:

- Reevaluate the process used by the MCEs to identify which members the surcharge applies to as MCEs currently base their surcharge decision primarily on inconsistently tracked self-reported tobacco use.

- Consider a regular review of HIP-covered tobacco cessation services to identify whether additional services should be covered, such as group therapy services and newer nicotine patches.
- Consider targeted outreach to HIP members in rural and non-metro areas given the relatively higher prevalence of tobacco use for these members.

Goal 4 – Promote member understanding and increase compliance with payment requirements by changing the monthly POWER Account payment requirement to a tiered structure.

The State's transition from a percent of income POWER Account Contribution structure to a simplified tiered structure in 2018 aimed to reduce administrative burden, support initial and sustained HIP enrollment, and reduce disenrollments related to member understanding of their POWER Account Contribution payment amounts. Lewin's analyses found that MCE executives and State officials agreed that the tiered structure supports sustained member enrollment and reduced MCE administrative burden. According to provider and member interviews, however, some members are unsure of their POWER Account Contribution payment obligations.

Analyses of 2015 to 2018 data did not provide a clear conclusion regarding how the new payment tiers have affected overall enrollment and disenrollment rates. HIP Plus enrollment increased from 2017 to 2018 while the rate of disenrollments with non-payment as a disenrollment reason decreased. However, given that the State implemented the new POWER Account policy in 2018 and disenrollment due to non-payment declined prior to 2018, any impact of the change in payment tiers on HIP Plus disenrollment requires additional analysis over time.

Analyses of data also indicated that Black HIP members had a higher likelihood of disenrollment (overall and with non-payment of the POWER Account as a reason), and a higher likelihood of moving from HIP Plus to HIP Basic, as compared to non-Hispanic White members.

Lewin recommends the following key areas of focus for the State to consider related to **Goal 4**:

- Focus on improving member contact information and supporting additional communications to members, as described earlier in this subsection; and
- Investigate underlying causes of the increased disenrollment rate and movement from HIP Plus to HIP Basic for Black HIP members; consider a targeted and culturally appropriate communication strategy to more fully engage all subpopulations and providers.

Goal 5 – Ensure HIP program policies align with commercial policies, are understood by members, and promote positive member experience and minimize gaps in coverage.

Similar to most commercial insurance plans, the HIP structure follows a cost-sharing model with deductibles, copayments, and monthly contributions or premiums. The State and MCEs work together in distinct capacities to convey information to members. Two major themes emerged from the key informant interviews – the importance of communications and customer service.

Overall, the majority of members expressed satisfaction with the HIP program, especially related to affordability, enrollment processes, including Fast Track and presumptive eligibility, and online options for payments and community engagement reporting. Reasons for dissatisfaction reported by members and providers include loss of coverage from HIP as a result of non-payment, documentation and time required for enrollment, confusing language in outreach materials, and timeliness of communications. Other reasons for dissatisfaction included lack of coverage for some services or medications, poor provider selection in some areas of the State, lack of adequate transportation resources, problems related to switching MCEs, and the misplacement of paperwork between members and the State. Analyses indicated that members' knowledge of different HIP policies varies, particularly related to the POWER Account and rollover.

Lewin recommends the State consider focusing on further developing communications and communication methods with members, with specific attention to POWER Account policies and community engagement requirements.

Goal 6 – Assess the costs to implement and operate HIP and other non-cost outcomes of the demonstration.

The Summative Evaluation Report will address this goal.

B. Summary of HIP Demonstration

CMS renewed the Indiana FSSA's HIP Section 1115(a) demonstration for three years beginning on February 1, 2018. Through the Section 1115(a) demonstrations and waiver authorities in the Social Security Act, states can test and evaluate innovative solutions to improve quality, accessibility, and health outcomes in a budget-neutral manner. Indiana's approved 1115 waiver STCs to implement HIP requires an evaluation of this program's ability to meet its intended goals (Refer to **Attachment I: Evaluation Plan**[8]). **Exhibit B.1** identifies relevant milestones for HIP from 2008 to 2018. This report refers to the different periods of HIP as follows: Original HIP for 2008 to 2014, HIP 2.0 for 2015 to 2017, and HIP or the current HIP demonstration for 2018 to 2020.

Exhibit B.1: Program History

2007: HIP passed in the Indiana General Assembly.
2008: With CMS approval, HIP began enrolling working-age, uninsured adults in coverage (Referred to as Original HIP).
2011: State legislature passed Senate Enrolled Act 461 that called on HIP to be the program used for the eventual expansion of Medicaid through the Patient Protection and Affordable Care Act.
2014: State requested permission from CMS to expand its existing demonstration waiver via HIP 2.0.
2015: CMS approved HIP 2.0, which included Indiana's Medicaid expansion, through a three-year waiver renewal expiring January 2018.
2017: State requested permission from CMS to expand its existing demonstration waiver via HIP.
2018: CMS approved the current HIP through a three-year waiver renewal expiring December 2020.

The extension, granted in February 2018, continues most components of HIP 2.0 and adds some new provisions. Changes for HIP, summarized from the State's amended waiver application, include:[9]

- Adding a tobacco use surcharge by increasing users' POWER Account Contributions by 50% beginning in their second year of continuous enrollment
- Expanding the Gateway to Work program by adding a community engagement reporting requirement for non-disabled working-age members beginning in 2019
- Changing POWER Account Contributions to a tiered structure instead of a flat 2% of income
- Adding a new HIP Plus chiropractic benefit
- Facilitating enrollment in HIP Maternity coverage for pregnant women
- Enhancing the MCE member incentive program by increasing available healthy incentives to a maximum of $200 per initiative
- Reestablishing an open enrollment period
- Waiving the "institution for mental disease" payment exclusion for short-term substance use disorder (SUD) treatment services for all Medicaid adults ages 21 to 64 (**Note:** this provision will be the subject of a separate evaluation)
- Discontinuing the graduated copayments for non-emergency use of the ED and the HIP Link premium assistance program for those with employer-sponsored insurance.

[8] This HIP Evaluation Plan (pending CMS' review) incorporates CMS' March 2019 evaluation design guidance for all states.

[9] Indiana Family and Social Services Administration. (2018). HIP Waiver Application. Retrieved from https://www.in.gov/fssa/hip/files/IN-HIP-1115-Approval-Package_2-1-2018.pdf

Demonstration Goals

This evaluation focuses on the following goals of the HIP renewal waiver:

1. Improve health care access, appropriate utilization, and health outcomes among HIP members.
2. Increase community engagement leading to sustainable employment and improved health outcomes among HIP members.
3. Discourage tobacco use among HIP members through a premium surcharge and the utilization of tobacco cessation benefits.
4. Promote member understanding and increase compliance with payment requirements by changing the monthly POWER Account payment requirement to a tiered structure.
5. Ensure HIP program policies align with commercial policies, encourage member understanding, and promote positive member experience and minimize gaps in coverage.
6. Assess the costs to implement and operate HIP and other non-cost outcomes of the demonstration.

The above goals address objectives of Section 1115(a) demonstrations, including improving access to high-quality services that produce positive health outcomes for individuals; strengthening beneficiary engagement in their personal health care plan, including incentive structures that promote responsible decision-making; and enhancing alignment between Medicaid policies and commercial health insurance products to facilitate smoother beneficiary transition.[10]

Description of the Demonstration and Implementation Plan

First passed by the Indiana General Assembly in 2007, HIP provides Medicaid health insurance coverage for qualified low-income, non-disabled adults ages 19 to 64. HIP offers its members a high-deductible health plan paired with a POWER Account, which operates similarly to a health savings account. The State uses a managed care delivery system for HIP. Four MCEs, contracted under HIP at the time of this report, have responsibilities related to some of the topics covered by this evaluation. Specifically, beyond providing health coverage, MCE responsibilities include:

- Conducting Gateway to Work member assessments
- Providing community engagement reporting assistance to members
- Reporting community engagement hours and exemptions to the State
- Tracking and invoicing for POWER Account Contributions
- Applying the tobacco surcharge
- Providing member incentives
- Reporting key metrics to the State

[10] CMS. About Section 1115 Demonstration Waivers. Accessed March 29, 2018 at https://www.medicaid.gov/medicaid/section-1115-demo/about-1115/index.html

Sample metrics include rate of preventive examinations for HIP members, ED admissions per 1,000 member months, or number of outpatient visits per member months. The State designates staff to work with the MCEs on HIP implementation. In coordination with the State, MCEs also have a critical role in communicating many of the HIP policies outlined in this section.

Healthy Indiana Plan

In 2015, HIP's target population changed to all non-disabled, low-income adults between 19 and 64 years old with household income at or below 138% of the FPL. HIP covers the adult group, low-income parents and caretakers, Transitional Medical Assistance (TMA), and pregnant women. HIP offers distinct benefit packages to its eligible members: HIP Plus, HIP Basic, HIP State Plan Plus, HIP State Plan Basic, HIP Maternity, and HIP Plus Copay.

HIP Benefit Plans

Indiana's current Section 1115(a) demonstration provides authority for the State to continue to offer HIP with different benefit plans:

- **HIP Plus:** HIP members with income at or below 138% of the FPL who make required monthly POWER Account Contributions maintain access to HIP Plus, an enhanced benefit plan that includes additional health care benefits such as coverage for dental, vision, and chiropractic services.[11] HIP Plus members pay a monthly POWER Account Contribution payment based on income tiers but do not pay copayments.
- **HIP Basic***:* HIP members with income at or below 100% of the FPL who do not make monthly POWER Account Contributions for HIP Plus coverage enroll in HIP Basic. This benefit plan provides more limited coverage than HIP Plus (i.e., not covering vision or dental services) and includes copayments for doctor visits, hospital stays, non-emergency ED visits, and prescriptions.[12] These copayments are consistent with traditional Medicaid copayments, and can range from $4 to $8 per doctor visit or prescription filled and can be as high as $75 per hospital stay. Pregnant members have no cost sharing and there is a 5% of income quarterly cost sharing limit for all members. HIP Basic members can enroll in HIP Plus during their annual redetermination if they choose to begin paying their POWER Account Contribution.
- **HIP State Plan Plus:** Members have the same cost-sharing requirements as HIP Plus and do not pay copayments for services. State Plan Plus members, similarly to HIP Plus, make POWER Account Contributions. Enrollment in this plan provides certain members[13] with access to the Medicaid State Plan benefits in place of the approved Alternative Benefit Plan.

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[11] On June 10, 2015, the State submitted an approved copy of the Alternative Benefit Package (ABP) for HIP Plus as a State Plan Amendment to the Centers for Medicare and Medicaid Services. These benefits for the ABP were aligned using Essential Health Benefits. Indiana Family and Social Services Administration. (2014). Alternative Benefit Plan: Healthy Indiana Plan (HIP) 2.0 Plus. Retrieved from https://www.in.gov/fssa/hip/files/DraftPlusABP.pdf

[12] On June 10, 2015, the State submitted an approved copy of the Alternative Benefit Package (ABP) for HIP Basic as a State Plan Amendment to the Centers for Medicare and Medicaid Services. These benefits for the ABP were aligned using Essential Health Benefits. Indiana Family and Social Services Administration. (2014). Alternative Benefit Plan: Healthy Indiana Plan (HIP) 2.0 Basic. Retrieved from https://www.in.gov/fssa/hip/files/DraftBasicABP.pdf

[13] Medically frail, TMA participants, Section 1931 low-income (< 19% of the FPL) parents and caretakers, and low-income (< 19% of the FPL) 19 – 20 year olds.

- **HIP State Plan Basic:** Members have the same cost-sharing requirements and copayments for services as HIP Basic. Enrollment in this plan provides certain members[14] with access to the Medicaid State Plan benefits in place of the approved Alternative Benefit Plan.
- **HIP Maternity:** HIP members who become pregnant while enrolled in a HIP plan transition to HIP Maternity. HIP Maternity (MA) covers HIP members throughout their pregnancy and 60 days postpartum. HIP Maternity enrollees do not have cost-sharing requirements and have access to the Medicaid State Plan benefits.
- **HIP Plus Copay:** HIP members above 100% of the FPL identified as medically frail[15] by the State or an MCE and have not been able to meet their HIP Plus POWER Account Contribution obligations. These members have copayments assigned to them, consistent with the HIP Basic Plan and have access to the HIP Plus benefits.

Members can switch between benefit plans as policies allow. Adults that meet all the eligibility requirements for HIP, but who are not a U.S. citizen and not a lawful permanent resident in the U.S. for at least five years or are not qualified aliens, are entitled to "emergency services only" under HIP. Lewin did not include this enrollment category in this evaluation due to the limited nature of covered services.

HIP Enrollment Over Time

The HIP program has grown from 389,984 unique members in 2015 to 569,971 unique members in 2018, with the largest enrollment increase occurring from 2015 to 2016.[16] During the four-year period from 2015 to 2018, there were 814,571 unique members in the HIP program.

In 2018, approximately 55% of members (313,902) were enrolled only in HIP Plus during the year, 25% (142,310) were enrolled only in HIP Basic, and the remaining 20% (113,759) were either enrolled in HIP Maternity or had otherwise switched HIP enrollment statuses during the year (e.g., from HIP Plus to HIP Basic or vice versa). Generally, HIP Maternity will involve a switch to the maternity enrollment status from HIP Plus or HIP Basic, or vice versa; approximately 38% of members who switched enrollment statuses in 2018 fall into the HIP Maternity category.

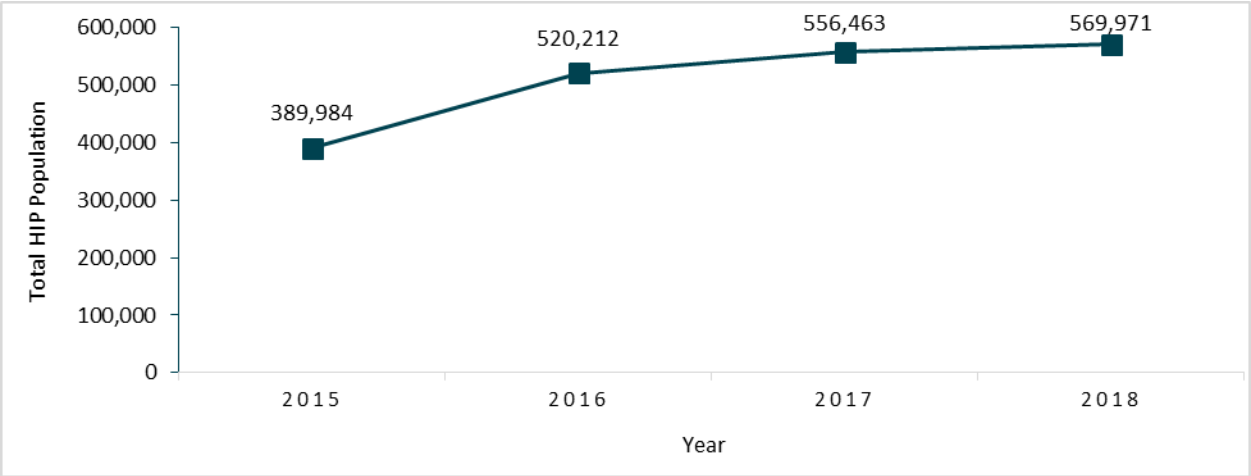
Exhibits B.2 to B.4 summarize HIP enrollment. Sociodemographic information about the HIP population can be found at the end of **Section B: Summary of HIP Demonstration** and in **Attachment II: HIP Sociodemographic Statistics**.

[14] Medically frail, TMA participants, Section 1931 low-income (< 19% of the FPL) parents and caretakers, and low-income (< 19% of the FPL) 19 – 20 year olds.

[15] Medically frail refers to a federally required designation of members who have disabling mental disorders, including serious mental illness; chronic substance use disorders; serious or complex medical conditions; physical, intellectual or developmental disabilities that significantly impair the ability to perform one or more activities of daily living; or a disability determination based on Social Security Administration criteria. These members have a medically frail flag of Y in the monthly enrollment data.

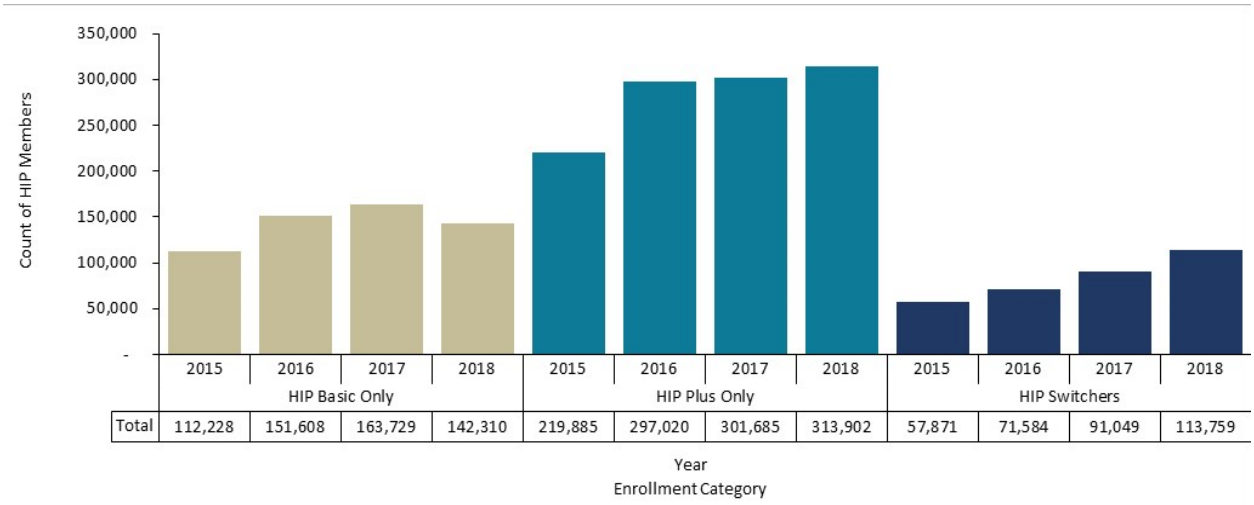
[16] Enrollment status values of Regular Basic (RB), Regular Plus (RP), State Basic (SB), State Plus (SP), pregnant (MA), and HIP Plus Copay (PC). We did not include months when an individual had conditional eligibility, or members that were eligible for Emergency Room services only (Emergency Room services flag of "Y").

Exhibit B.2: Total Unique HIP Members by Year (February 2015 – December 2018)



Source: HIP monthly enrollment files, February 2015 – December 2018.

Exhibit B.3: Total Unique HIP Members by Benefit Plan Type (February 2015 – December 2018)



Source: HIP monthly enrollment files, February 2015 – December 2018.

Exhibit B.4: Number and Percent of Unique HIP Members by Year and Benefit Plan Type (February 2015 – December 2018)

Benefit Plan	2015		2016		2017		2018	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent
HIP Basic Only	112,228	29%	151,608	29%	163,729	29%	142,310	25%
HIP Plus Only	219,885	56%	297,020	57%	301,685	54%	313,902	55%
HIP Switcher	57,871	15%	71,584	14%	91,049	16%	113,759	20%
Total	**389,984**	**100%**	**520,212**	**100%**	**556,463**	**100%**	**569,971**	**100%**

Source: HIP monthly enrollment files, February 2015 – December 2018.

Eligibility Determination Process

Individuals apply for HIP services through the Division of Family Resources, which determines eligibility for Indiana Health Coverage Programs. Members can also complete a presumptive eligibility application with qualified providers to receive temporary health coverage.

To start coverage, HIP members must wait 60 days or make an initial Fast Track or POWER Account Contribution payment. Individuals with income greater than 100% FPL must make a payment within 60 days to obtain coverage. New HIP members in the waiting period who have not made a Fast Track payment are determined conditionally eligible by the Division of Family Resources. Conditionally eligible members do not receive full eligibility and cannot enroll as members until one of the following occurs within the 60-day payment period:

- Enrollee makes a payment of their first POWER Account Contribution for HIP Plus
- Enrollee makes a Fast Track $10 prepayment for HIP Plus
- Enrollee at or below 100% of the FPL does not make a first payment before the 60-day payment period expires and, therefore, enrolls in HIP Basic

Members have the opportunity to select an MCE on their application. However, if an individual determined to be conditionally eligible for HIP by the Division of Family Resources does not select an MCE, the State auto-assigns the member to an MCE. Member eligibility is effective the first day of the month; coverage end dates fall on the last day of a month unless a member dies.

Presumptive Eligibility

With HIP 2.0, the State introduced a Fast Track prepayment option for POWER Account Contributions and enhancements to the presumptive eligibility process. The presumptive eligibility process allows qualified providers to determine eligibility for certain groups to receive temporary health coverage under the Indiana Health Coverage Programs, which includes HIP. As of April 1, 2015, the State expanded qualified presumptive eligibility providers to include Federally Qualified Health Centers (FQHCs), Rural Health Centers (RHCs), Community Mental Health Centers, and local County Health Departments. Qualified providers work with individuals to complete a presumptive eligibility application. Using an online system and member self-reported responses, qualified providers receive real-time presumptive eligibility determinations for individuals seeking health care services. An individual can receive presumptive eligibility coverage only once during a 12-month rolling period, and only once per pregnancy.[17]

Individuals determined presumptively eligible can receive temporary coverage and receive services immediately until the end of the following month. Members must complete the full application by the last day of the next month to maintain presumptive eligibility coverage. Before January 1, 2019, members determined presumptively eligible received coverage under the managed care delivery system. State applicants determined presumptively eligible for the adult category (PE Adult) before 2019 enrolled with a MCE and received coverage similar to HIP Basic with copayment obligations. As of January 1, 2019, applicants determined presumptively eligible receive coverage under a fee-for-service delivery system.[18]

[17] Indiana Health Coverage Programs. (2019). Presumptive Eligibility Provider Reference Model. Retrieved from https://www.in.gov/medicaid/files/presumptive%20eligibility.pdf

[18] Ibid.

Starting in 2018, presumptive eligibility members determined to be conditionally eligible for HIP move directly to HIP Basic with an opportunity to pay for HIP Plus. The State refers to this population as "Potential Plus." This extension allows members to avoid a gap in coverage as long as they meet the required application and payment deadlines. Applicants have 60 days to pay any required POWER Account Contribution to be eligible for HIP Plus.[19]

Fast Track

The Fast Track option expedites HIP enrollment by allowing applicants to make a prepayment of $10 towards their POWER Account Contribution. Using Fast Track, applicants can pay a POWER Account Contribution at the time of application or any time before the State's eligibility determination. Once the State determines an applicant eligible for Medicaid, the individual's Medicaid eligibility dates back to the first day of the month in which the member made the Fast Track payment. Individuals approved for HIP with income less than 100% of the FPL who do not make a POWER Account Contribution within the 60 days enroll in HIP Basic. Individuals with income over 100% of the FPL who do not make a POWER Account payment or Fast Track pre-payment in the required 60-day period do not receive coverage and must reapply.[20]

POWER Accounts

To help members prepare for participation in the commercial marketplace, the State offers all HIP members a POWER Account, similar to a health savings account. POWER Accounts provide incentives for members to stay healthy, be value and cost conscious, and use services in a cost-efficient manner. HIP Plus, HIP Basic, or HIP State Plan members use their POWER Accounts to pay for covered services up to their $2,500 deductible. MCEs establish and administer each member's POWER Account and pay the claims for all covered services when a member exhausts their POWER Account.

POWER Account Contributions

While all members have a POWER Account, HIP Plus members have a POWER Account Contribution. The State funds POWER Accounts up to a ceiling of $2,500 per year, contributing an amount annually for each member that is equal to the difference between the required member contribution and the $2,500 ceiling. For HIP Plus members, this monthly amount represents a combination of member, employer or not-for-profit, or State contributions. Members may also apply earned MCE incentives as offered by their plan. For HIP Basic members, the State fully funds the POWER Accounts and covers the member's $2,500 annual deductible. All HIP members pay $8 for a non-emergency ED visit.

MCEs bill for and collect HIP Plus POWER Account Contributions and send monthly statements to members. HIP Basic members also receive monthly account statements to assist them in managing the POWER Account and copayments and to increase awareness of the cost of the health care services received.

Determination of POWER Account Contribution Amounts

Effective with CMS' waiver approval in 2018, the State changed the determination of member POWER Account Contribution amounts from 2% of income to a tiered structure based on income level (**Exhibit B.5**). The previous monthly POWER Account Contribution amounts ranged from a maximum amount of

[19] Ibid.

[20] Indiana Family & Social Services Administration. (2019). MCE Reporting Manual HIP 2.0, Office of Medicaid Policy and Planning Version 4.0

$4.28 for members with incomes less than 22% of the FPL to a maximum amount of $27.17 for those at 100% of the FPL or higher. Fluctuations in a member's income required a recalculation of the member's 2% of income and changed the monthly amount due. This change could happen as frequently as every month for members with monthly income fluctuations. This ongoing variability of the POWER Account Contribution amounts created confusion among members regarding the amount owed and increased the overall administrative burden for the State and MCEs related to these tiers.

The new tiered monthly contribution amounts range from $1.00 for members with income less than 22% of the FPL and $20.00 for those at 100% of the FPL or higher. The State anticipates that moving to this simplified tiered structure will result in greater member understanding, increased member compliance with payments, and will minimize gaps in coverage.

The State calculates the household's POWER Account Contribution based on a tiered contribution structure for individuals. For two HIP-eligible married adults, the State divides the monthly contribution, and each member pays half of the calculated amount on a monthly basis. Married members with household income less than 22% both pay a $1 POWER Account Contribution. Other income tiers split the amount; for example, two married adults with household income of 51% to 75% FPL each pay $5.00. Beginning in January 2019, members may pay a 50% tobacco use surcharge in addition to the POWER Account tier amounts.

Exhibit B.5: Comparison of HIP Plus Previous and Current POWER Account Contribution Amounts for Single Members (2015 and 2018)

	HIP 2.0 POWER Account Contribution (Previous)[a]		HIP POWER Account Contribution (Current)[b]		
FPL	2015 Monthly Income, Single Individual	Maximum Monthly POWER Account Contribution, Single Individual	2018 Monthly Income, Single Individual	Monthly POWER Account Contribution, Single Individual	Tobacco Use Surcharge
<22%	**Less than $214**	$4.28	**Less than $222**	$1.00	$1.50
23-50%	**$214.01 to $487**	$9.74	**$222.01 to $505**	$5.00	$7.50
51-75%	**$487.01 to $730**	$14.60	**$505.01 to $758**	$10.00	$15.00
76-100%	**$730.01 to $973**	$19.46	**$758.01 to $1,011**	$15.00	$22.50
101-138%	**$973.01 to $1,358**	$27.17	**$1,011.01 to $1,396**	$20.00	$30.00

[a] FSSA. HIP 2.0 Introduction, Plan options, Cost sharing, and Benefits. Accessed May 6, 2019 at https://www.in.gov/idoi/files/HIP_2_0_Training_-_Introduction_Plans_Cost-Sharing_Benefits_-_1_21_15.pdf

[b] FSSA. POWER Accounts. Accessed May 6, 2019 at https://www.in.gov/fssa/hip/2590.htm

Note: For HIP 2.0, the monthly income amounts shown here reflect 2015 FPL and the monthly POWER Account Contribution amounts represent a percentage of income. For current HIP, the POWER Account Contribution amounts reflect the tiered contribution structure.

Loss of Coverage Due to Non-Payment of POWER Account Contributions

HIP Plus members with incomes from 101% to 138% of the FPL that do not make monthly POWER Account Contribution payments are disenrolled from HIP and are not allowed to re-enroll for six months (also referred to as the six-month lockout or non-eligibility period). The State exempts members determined medically frail from non-payment penalties regardless of income; these members do not lose benefits due to non-payment of POWER Account Contributions. The enrollment lockout period also does not apply for members residing in a domestic violence shelter or in a state-declared disaster area. Members subject to a lockout period can request a waiver to reenter the program.

Tobacco Cessation Initiative

As indicated previously, all HIP members must contribute to their POWER Account to maintain access to the enhanced HIP Plus benefit plan. To discourage tobacco use and to align with commercial market coverage policies, HIP includes a surcharge on top of the POWER Account Contribution for HIP Plus members who self-identify as tobacco users.[21] Tobacco use means the use of tobacco four or more times a week in the last six months, including use of chewing tobacco, cigarettes, electronic cigarettes (including vaping), cigars, pipes, hookah, and snuff. The HIP tobacco initiative began in January 2018, with surcharges taking effect in January 2019.

The State assesses a surcharge on top of the POWER Account Contribution for members who continuously enroll for 12 months with the same MCE and self-identify as tobacco users during this period. If the member continues to self-identify as using tobacco, the State increases their monthly contributions by 50% beginning in the first month of their new benefit period. For example, the POWER Account Contribution for an individual with income less than 22% of the FPL would increase from $1.00 to $1.50 per month with the application of the tobacco surcharge. For married HIP members, only the tobacco user receives the tobacco surcharge. When both married members have the surcharge, they split the surcharge. MCEs reported applying the tobacco surcharge to 2,662 members in 2019, representing <1% of the 569,971 HIP members in 2018.[22]

MCEs separate the surcharge on the monthly POWER Account statements to highlight the additional cost due to tobacco use for members. Some MCEs offer members MCE-specific incentives to participate in tobacco cessation services. Two of these tobacco cessation services include:

- **Indiana Tobacco Quitline:** Free phone-based counseling service administered by the State. Users can access services every day of the week in over 170 languages. The Quitline includes access to one-on-one coaching, resources for health care providers, and tools for other stakeholders to use for smoke-free and other smoking cessation programming.[23]
- **Baby and Me Tobacco Free:** Smoking cessation program for pregnant and postpartum women (up until 12 months postpartum). This program includes individualized education sessions, biochemical testing at visits, and several diaper vouchers.[24]

Approximately 29% to 31% of HIP members in the State's October 2017 – March 2019 smoking indicator file reported using tobacco. The State's smoking indicator file includes new HIP members, members switching MCEs, and members who have self-reported their tobacco use status (reflects a non-representative subset of approximately 10% to 15% of all HIP members). This percentage range is lower than low income/Medicaid estimates for Indiana from other sources, which are in the 35% to 37% range.[25]

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[21] Members may self-identify as tobacco users during their initial application, during MCE selection, or when a member notifies their MCE.

[22] Members with enrollment status values of Regular Basic (RB), Regular Plus (RP), State Basic (SB), State Plus (SP), pregnant (MA), and HIP Plus Copay (PC). We did not include months when an individual had conditional eligibility or presumptive eligibility status, or members that were eligible for Emergency Room services only (Emergency Room services flag of "Y").

[23] Indiana.gov Quitline. (2019). Indiana's Tobacco Quitline. Retrieved from https://www.in.gov/quitline/.

[24] Indiana State Department of Health: Maternal and Child Health Epidemiology Division. (2016). Infant Mortality: Year in Review. Retrieved from https://www.in.gov/fssa/files/Medicaid%20Advisory%20Board%208.16.pdf.

[25] Ku, L., Bruen, B., Steinmetz, E., & Bysshe, T. (2016). Medicaid Tobacco Cessation: Big Gaps Remain In Efforts To Get Smokers To Quit. Health Affairs. Retrieved from https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2015.0756#EX4FN1;

The State collects information on HIP member tobacco use during the HIP enrollment process (i.e., initial enrollment and when changing plans during open enrollment); members can also report changes in their tobacco use by calling their MCE or the State. While there are questions about tobacco use on the health needs assessment performed by the MCEs, these responses are not used to determine the tobacco surcharge due to concerns about members underreporting tobacco use during an assessment performed for clinical purposes. When a member changes MCEs during the MCE selection period or the middle of the year, the tobacco indicator passes to the new MCE. However, the surcharge is based on 12 months of full eligibility and tracking of tobacco use, so the new MCE will not know the member's previous tobacco use indicator or be expected to apply a surcharge.

Preventive Service Incentive and Rollover

The State provides all HIP members with incentives to receive preventive services and to manage their POWER Accounts via direct financial investment. Members have an opportunity to rollover any funds remaining in their POWER Account and apply the rollover as a credit toward their POWER Account Contribution in the next benefit period. For members that contribute to a POWER Account and use services, claims are paid from the account proportionally from State and member funds. If the member contributes $240 over the year out of the $2,500 limit, then 9.6% of every claim paid by the account is paid with member dollars; the rest is covered with State dollars. If the entire account is not spent, then the member's remaining dollars can be rolled over to the next year or refunded if the member leaves the program.

The amount rolled over or discounted depends on whether the member received preventive care services and what program the member enrolled in on the last day of the benefit period:

- If HIP Plus members have funds remaining at year-end and received preventive services, the State matches the members rollover amount and provides extra funds to their POWER Account. These funds further reduce the amount owed for the current benefit period, but only after members use rollover funds.
- If HIP Basic members receive preventive services, they can offset the required contribution for HIP Plus by up to 50% the following year. However, members may not double their rollover as in HIP Plus. Members who choose to remain in HIP Basic will incur a penalty on any unused member rollover funds. HIP Basic members who do not receive preventive services will not earn the rollover discount. Members who choose to remain in HIP Basic will incur a penalty on any unused member rollover funds.

Exhibits B.6 and B.7 illustrate the rollover for HIP Plus and HIP Basic.

Exhibit B.6: HIP Rollover for HIP Plus Members

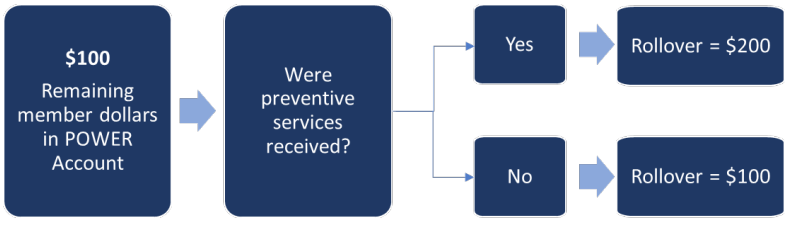
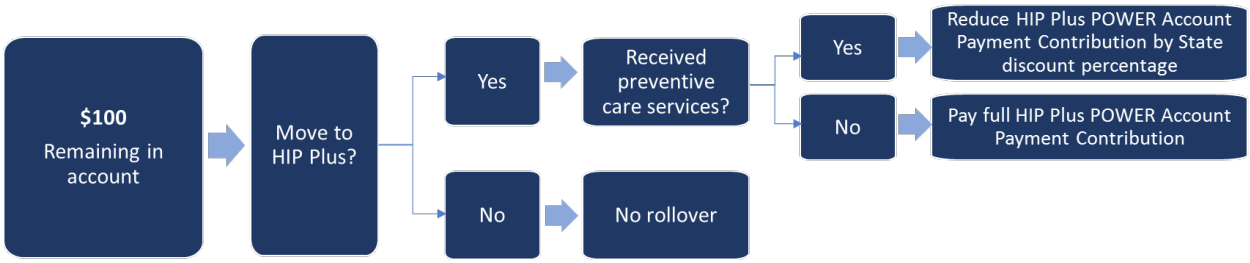


Exhibit B.7: HIP Rollover for HIP Basic Members



The MCEs calculate the rollover 121 calendar days after the end of the benefit period to allow for a claims run-out period. The MCEs then submit this information to the State. For member rollover, members can reuse these funds to reduce the amount owed for their current benefit period. HIP members who leave the program remain eligible to receive a refund for the unused portion of their contributions and rollover following the reconciliation of their POWER Account. State rollover funds never pay tobacco surcharge amounts, and unused funds return to the State at the end of the current benefit period.

Employment, Education, and Gateway to Work Policy

Indiana's community engagement reporting requirement went into effect in 2019 with a six-month voluntary reporting period. This policy evolved from Indiana's existing HIP 2.0 voluntary Gateway to Work program and provides an incentive for HIP members to attain employment or engage in other community activities correlated with improved health and wellness (e.g., employment, volunteer work, education, and training). Under this new policy, all able-bodied HIP participants, not otherwise meeting an exemption, or already working at least 20 hours per week, must engage in and report on qualifying activities monthly.

The Gateway to Work program provides three possible reporting statuses for members, reflecting that some members may already work a substantial amount, and others may encounter circumstances that create significant barriers to participation. **Exhibit B.8** provides a summary of each status.

Exhibit B.8: Gateway to Work Reporting Status and Number and Percent of HIP Members (June 2019)

Reporting Status	Definition	Number	Percent
Exempt	Member has an exemption from reporting requirements and does not have to report qualifying activities during exemption months. The member still has the option of using Gateway to Work resources.	286,107	74.6%
Reporting Met (i.e., pre-qualified)	Member already works at least 20 hours per week. The member can still use Gateway to Work resources.	28,496	7.4%
Required to Report (i.e., non-exempt)	Member needs to report qualifying activities for a certain number of hours each month (e.g., FSSA Benefits portal or by calling the MCE). ***Note**: January to June 2019 reporting is on a voluntary basis only.*	68,952	18.0%

Sources: June 2019 State administrative data; Indiana FSSA. Learn About Gateway to Work. Retrieved from https://www.in.gov/fssa/hip/2592.htm

Exhibit B.9 provides a summary of qualifying activities and exempt populations. The list of possible exemptions includes a "good cause" exemption, which members report to their MCE for further review by the State and which does not specify any one circumstance or condition. The good cause exemption applies to individuals who do not fit into the other designated exemption categories that may affect their ability to meet reporting hours (e.g., restrictions due to religious affiliations or having a degenerative disease that does not yet meet the medically frail definition). MCEs submit good cause exemption requests to a State Good Cause Panel that includes a lawyer, doctor, HIP policy staff member, and a Gateway to Work analyst. Based on the good cause exemption request, this panel will determine whether to issue a good cause exemption and for how many months this exemption applies. If the good cause exemption is denied, the Good Cause Panel will issue the reason why, and if there are any hours that could be logged for credit in a qualifying activity category.

Exhibit B.9: Gateway to Work Qualifying Activities and Exempt Populations

Gateway to Work Qualifying Activities	Exempt Populations

Employment
• Employment (subsidized or unsubsidized)
• Health plan employment programs
• Job search activities
• Education related to employment (on-the-job training)
• Caregiving
• Homeschooling
• Members of the Pokagon Band of Potawatomi participating in the Pathways program
Education
• General Education:
  ○ High School Equivalency
  ○ Adult education
  ○ Post-secondary education
• Job skills training (e.g., Next Level Jobs)
• Vocation education or training
• English as a second language education
Community Service
• Community service/public service
• Volunteer work
• Gateway to Work community work experience
Other
• Qualifying activities based on State or MCE review
• MCE Qualifying Activities (MCE specific programs)
• Attending Alcoholic Anonymous or Narcotics Anonymous meetings
• Completing pre-suspension courses
	• Age 60 years or older
	• Temporary Assistance for Needy Families (TANF)/ Supplemental Nutrition Assistance Program (SNAP) recipients
	• Medically frail
	• Pregnant women
	• Homeless individuals
	• Recently Incarcerated (up to 6 months from release)
	• Certified illness or incapacity (temporary)
	• SUD treatment
	• Student (full or half time)
	• Primary caregiver:
	  ○ Dependent child below the compulsory age (seven and under prior to October 1, 2019; changed to under 13 years of age effective October 1, 2019)
	  ○ Disabled dependent
	  ○ Kinship caregiver of abused or neglected children
	• Good cause exemption (e.g., hospitalization, domestic violence, or the death of a family member)

The State began to phase-in the reporting requirements in 2019 with a member grace period of six months of voluntary reporting only to allow for operational readiness and promote member awareness. Members required to report qualifying activities had to start reporting a minimum of five hours per week beginning on July 1, 2019, increasing over time to 20 hours per week by July 1, 2020. **Exhibit B.10** outlines this phase-in period.

Exhibit B.10: Gateway to Work Phase In Hours

HIP Eligibility Period	Required Participation Hour Reporting
January 2019 – June 2019	0 hours per week
July 2019 – September 2019	5 hours per week
October 2019 – December 2019	10 hours per week
January 2020 – June 2020	15 hours per week
July 2020 – Ongoing	20 hours per week

The State assesses member compliance with the Gateway to Work reporting requirement in December of each year; at least eight months of compliance during a calendar year results in continued enrollment. Effective October 31, 2019, the State temporarily removed the enrollment suspension for members who do not meet their reporting requirements pending the results of the federal lawsuit regarding CMS approval of HIP.

Other State Policies

HIP Workforce Bridge

The State anticipates that the implementation of the Gateway to Work requirement will yield higher rates of employment among HIP members. As members gain employment, their eligibility in HIP may change; members who earn income over the HIP income limit may lose their HIP coverage and potentially transition to commercial coverage. The State developed the HIP Workforce Bridge program to support individuals making the transition, submitting the *HIP Workforce Bridge Amendment* to CMS in July 2019 for approval.[26]

The HIP Workforce Bridge account seeks to alleviate the potential gap in coverage between the time a member leaves HIP and transitions to their commercial plan. Under HIP Workforce Bridge, members transitioning from HIP to employer-sponsored coverage or the federal marketplace have access to a special health account that covers direct health care costs incurred during their coverage transition up to $1,000. Individuals can use this account to pay for premiums, deductibles, copayments, and coinsurance incurred while in commercial insurance. The HIP Workforce Bridge Account eligibility period covers 12 months from an individual's disenrollment from HIP, or until the member uses the full account balance (whichever comes first).

The HIP Workforce Bridge account, funded from aggregate remaining balances of the POWER Account, entitles members to the full $1,000 Bridge account amount regardless of their POWER Account balance upon disenrollment from HIP. The State anticipates the HIP Workforce Bridge account will:

[26] Indiana FSSA. (2019). Workforce Bridge Account Amendment. Retrieved from https://www.in.gov/fssa/hip/files/BridgeAmendmentRequest2019_SubmissionFINAL.PDF

- Reduce the amount of out-of-pocket costs for members transitioning to commercial plans and support members who face a coverage gap.
- Increase the number of successful enrollments in marketplace and employer-sponsored insurance from HIP coverage.
- Reduce the number of individuals who leave HIP due to increased earnings and end up uninsured following disenrollment.
- Reduce churn back to HIP among eligible individuals.

Workforce Training Initiative

Created under Governor Holcomb's Next Level Indiana agenda, Next Level Jobs focuses on connecting Indiana residents with jobs and other employment enrichment opportunities.[27] This program provides free trainings to individuals and reimbursements for Indiana employers when they train employees in high-demand fields. For individuals searching for jobs that have completed trainings, Next Level Jobs also connects them to the Indiana Career Ready IN Demand Jobs tool to search for high-demand jobs.

State officials interviewed for this evaluation indicated that the Gateway to Work program, Next Level Jobs, and the pending HIP Workforce Bridge program work in concert to strengthen workforce participation throughout Indiana. HIP members can leverage participation in Next Level Jobs training to satisfy HIP community engagement reporting requirements, and HIP Workforce Bridge would help individuals make the transition from HIP to commercial coverage when appropriate.

HIP Member Sociodemographics

An analysis of monthly HIP enrollment data indicates that HIP members had the following sociodemographic characteristics in 2018:

- 80% of HIP members were between the ages of 19 and 49.
- 63% of HIP members were female.
- 70% of HIP members identified as non-Hispanic White, as compared to 19% Black, 5% Hispanic, and 2% Asian or Pacific Islander.
- 78% of HIP members lived in metro areas (greater than 250,000 population) and 22% lived in non-metro areas. In addition, 7% of HIP members lived in non-metro communities with a population of 20,000 or more, 14% lived in non-metro areas with a population of 2,500 to 19,999, and 1% lived in non-metro areas with a population of less than 2,500.
- 84% of HIP members were at or below 100% of the FPL as compared to 17% at 101% of the FPL or higher; 48% of HIP members had no income.
- 15% of HIP members were medically frail.[28]

[27] State of Indiana. (2019). Next Level Jobs Indiana. Retrieved from https://www.nextleveljobs.org/

[28] Medically frail refers to a federally required designation of members who have disabling mental disorders, including serious mental illness; chronic substance use disorders; serious or complex medical conditions; physical, intellectual or developmental disabilities that significantly impair the ability to perform one or more activities of daily living; or a disability determination based on Social Security Administration criteria. These members have a medically frail flag of Y in the monthly enrollment data.

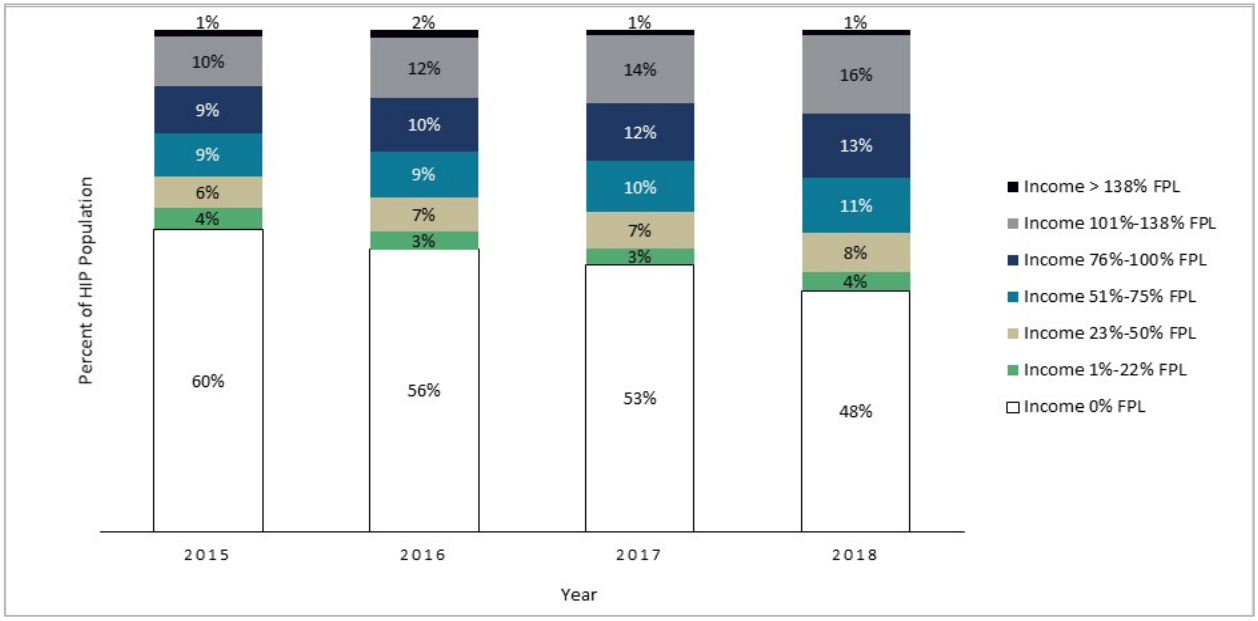
The distribution of gender, race/ethnicity, and geographic location of the HIP population has generally remained unchanged since 2015, while the distribution of income level has changed. The proportion of HIP members at higher levels of income has increased from 2015 to 2018, specifically:[29]

- The percentage of members with zero income has decreased from 60% in 2015 to 48% in 2018.
- The percentage of members with income between 51% and 100% of the FPL has increased from 18% to 24% from 2015 to 2018.
- The percentage of members with income above 100% FPL has increased from 11% to 17% from 2015 to 2018.

This change in the proportion of HIP members at higher income levels corresponds to a reduction in the statewide Indiana unemployment rate over the same period (5.4% in January 2015 compared to 3.3% in January 2018).[30] **Exhibits B.11 and B.12** summarizes the HIP population by income range.

This section includes select sociodemographic descriptions along with comparisons of sociodemographic characteristics between members with only HIP Plus coverage (HIP Plus Only), members with only HIP Basic coverage (HIP Basic Only) and members that switched between coverage types during the calendar year (HIP Switcher). **Attachment II: HIP Sociodemographic Statistics** provides additional detail by these benefit plan categories, along with methodological explanations.

Exhibit B.11: HIP Population by Income Range (February 2015 – December 2018)



Source: HIP monthly enrollment files, February 2015 – December 2018.

[29] Analysis relied on the first observed FPL from the start of the calendar year.

[30] Bureau of Labor Statistics (2019, September 10). Local Area Unemployment Statistics. Retrieved from https://data.bls.gov/pdq/SurveyOutputServlet

Exhibit B.12: Number and Percent of HIP Members by Income Range for All Members (February 2015 – December 2018)

	2015		2016		2017		2018	
Income Range	Number	Percent	Number	Percent	Number	Percent	Number	Percent
0% FPL	234,805	60%	292,672	56%	296,201	53%	273,248	48%
1% - 22% FPL	16,169	4%	17,995	3%	17,425	3%	20,850	4%
23% - 50% FPL	24,798	6%	35,252	7%	40,194	7%	45,196	8%
51% - 75% FPL	33,643	9%	48,373	9%	56,546	10%	62,268	11%
76% - 100% FPL	37,007	9%	54,611	10%	64,761	12%	72,829	13%
101% - 138% FPL	37,997	10%	63,072	12%	75,894	14%	88,879	16%
> 138% FPL	5,565	1%	8,237	2%	5,442	1%	6,701	1%
Total	**389,984**	**100%**	**520,212**	**100%**	**556,463**	**100%**	**569,971**	**100%**

Source: HIP monthly enrollment files, February 2015 – December 2018.

Gender

The majority of HIP members are female (overall and by benefit plan type). HIP Plus Only members are more likely to be female as compared to HIP Basic Only members (60% in 2018 as compared to 56%). From 2015 to 2018, the percentage of HIP Basic Only male members increased from 31% to 44% while the percentage of HIP Plus Only male members stayed approximately the same (38% in 2016 and 40% in 2017 and 2018). HIP Switcher members were much more likely to be female (80% in 2018) as this population included pregnant women. **Exhibit B.13** summarizes the HIP gender composition by HIP plan.

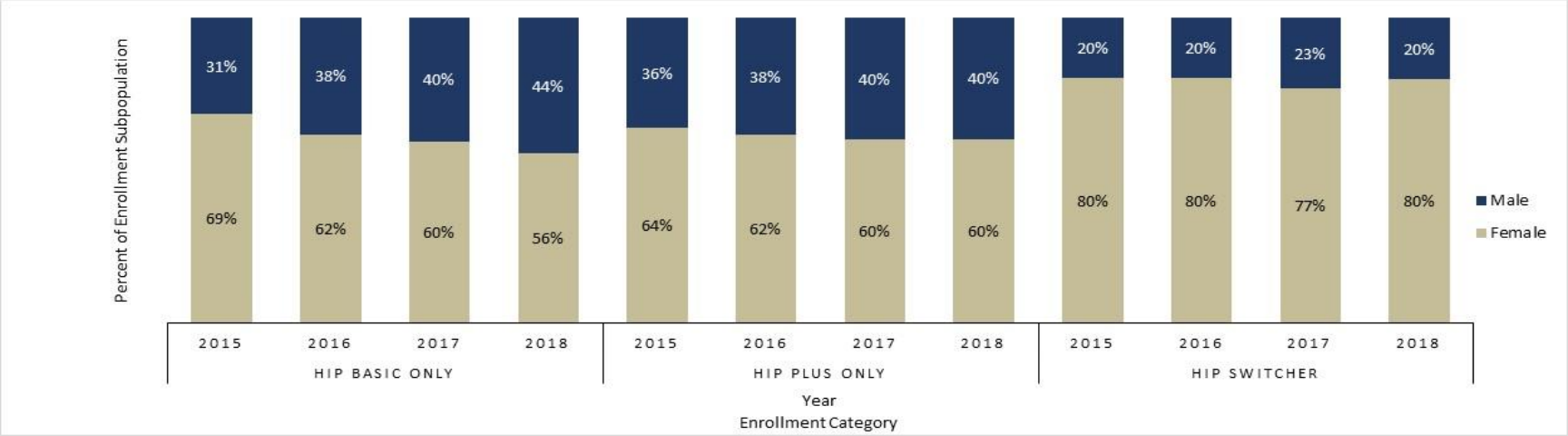
Health Status

The proportion of medically frail HIP members has increased over time from 10% in 2015 to 15% in 2018. HIP Plus Only members were more likely to be medically frail than HIP Basic Only members by five to seven percentage points from 2015 to 2018, specifically:

- Between 7% and 10% of members with only HIP Basic coverage were medically frail per year from 2015 to 2018.
- Between 12% and 17% of members with only HIP Plus coverage were medically frail per year from 2015 to 2018.

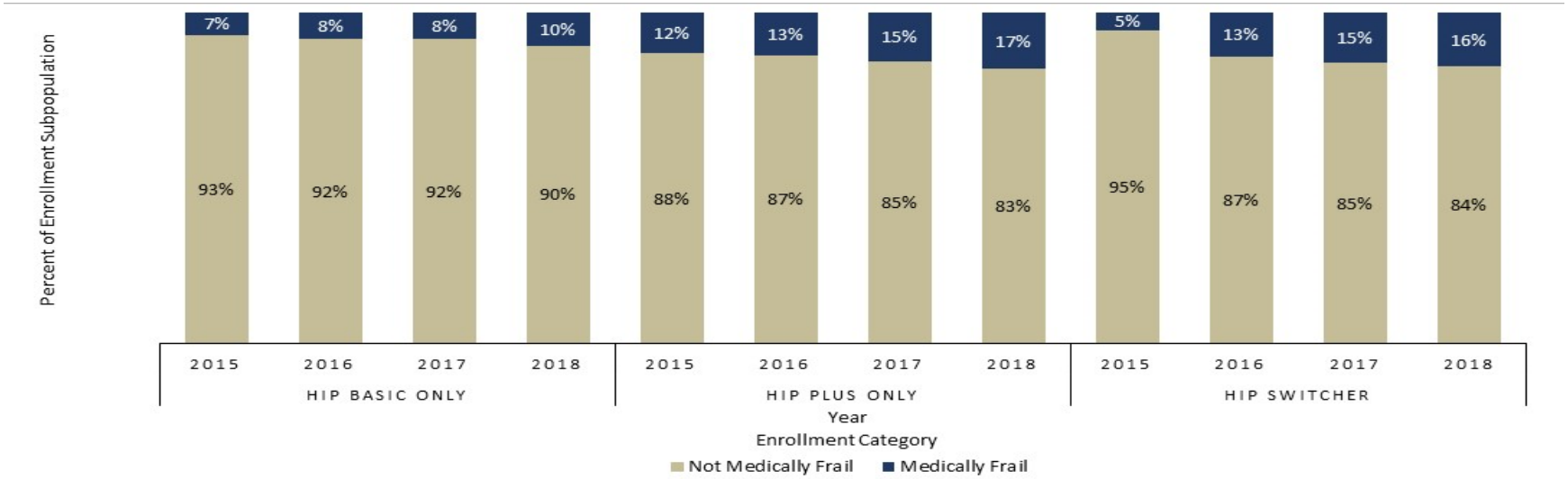
Exhibit B.14 summarizes the HIP population by medically frail status.

Exhibit B.13: Composition of HIP Population by Gender and Benefit Plan (February 2015 – December 2018)



Source: HIP monthly enrollment files, February 2015 – December 2018.

Exhibit B.14: Composition of HIP Population by Enrollment Category and Health Status (February 2015 – December 2018)



Source: HIP monthly enrollment files, February 2015 – December 2018.

Race/Ethnicity

The composition of the overall HIP population in terms of race and ethnicity remained consistent across time, with non-Hispanic White members comprising approximately 71% of the overall HIP population, Black members approximately 20%, Hispanic members approximately 5%, and Asian or Pacific Islander members approximately 2%. The composition of race and ethnicity by HIP benefit plan category was also consistent across time.

HIP Basic Only members were more likely to be Black and less likely to be non-Hispanic White than HIP Plus Only members (by approximately 12 and 9 percentage points in 2018, respectively). HIP Switcher members included a slightly smaller proportion of Black HIP members as compared to the HIP Basic Only members. Hispanic members and Asian and Pacific Islander members comprised similar proportions of the HIP Basic Only, HIP Plus Only, and HIP Switchers subpopulations at 1% to 3% of members each.

A 2015 to 2017 comparison of race and ethnicity of HIP members to the overall Indiana population and the potentially eligible HIP population[31] indicates that HIP members are more likely to be Black. Additionally, HIP members are less likely to be Hispanic as compared to the potentially eligible HIP population. This comparison used HIP monthly enrollment data and the most recently available American Community Survey (ACS) data.[32]

In comparison to the overall Indiana population:

- HIP members are less likely to be non-Hispanic White (71% of HIP members as compared to approximately 80% of Indiana residents each year).
- HIP members are approximately twice as likely to be Black (20% of HIP members as compared to 9% of Indiana residents each year).
- The percentages of Asian and Hispanic members in the HIP population are similar (2% and 5% to 6%, respectively each year).

In comparison to potentially eligible HIP members:

- HIP members are approximately as likely to be non-Hispanic White (71% of HIP members as compared to approximately 69% of potentially eligible HIP members).
- HIP members are more likely to be Black (20% of HIP members compared to approximately 15% of potentially eligible HIP members).
- HIP members are less likely to be Hispanic (5% of HIP members compared to approximately 9% of potentially eligible HIP members).

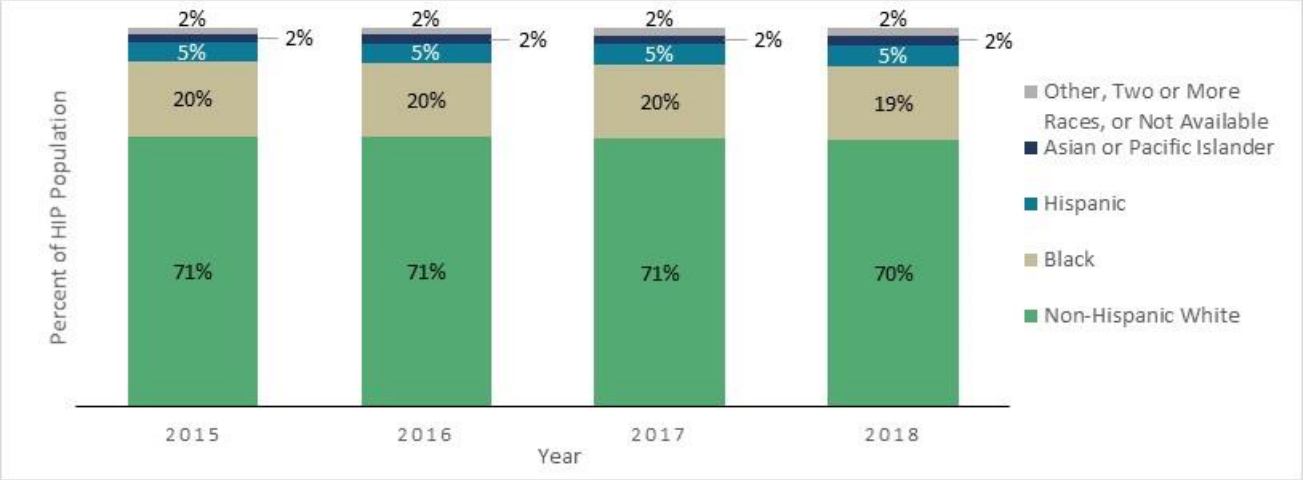
Exhibits B.15 to **B.19** summarize the HIP population by race and provide comparisons to the general Indiana population and potentially eligible HIP members.

[31] Defined as those with income below 150% FPL, between the ages of 19 and 64, without Medicare coverage and without Supplemental Security Income

[32] IPUMS Online Data Analysis System (2019). IPUMS USA. Retrieved from https://usa.ipums.org/usa/sda/

Attachment II: HIP Sociodemographic Statistics provides a complete summary of enrollment by sociodemographic characteristics for all HIP members, as well as by the HIP Plus Only, HIP Basic Only, and HIP Switcher subpopulations.

Exhibit B.15: HIP Population by Race/Hispanic Origin (February 2015 – December 2018)



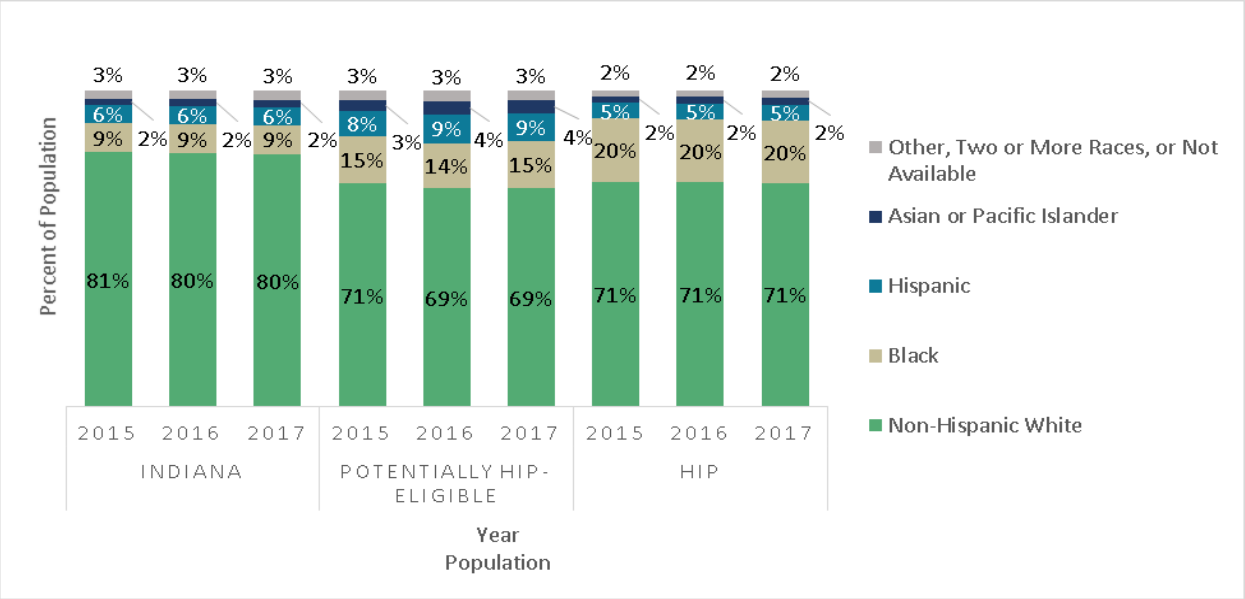
Source: HIP monthly enrollment files, February 2015 – December 2018.

Exhibit B.16: Number and Percent of HIP Members by Race for All Members (February 2015 – December 2018)

Race	2015		2016		2017		2018	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent
Non-Hispanic White	277,789	71%	369,662	71%	394,323	71%	401,517	70%
Black	77,757	20%	102,827	20%	108,864	20%	111,119	19%
Hispanic	19,247	5%	26,272	5%	28,782	5%	31,105	5%
Asian or Pacific Islander	8,087	2%	11,218	2%	12,692	2%	13,662	2%
Other or Not Available	7,104	2%	10,233	2%	11,802	2%	12,568	2%
Total	**389,984**	**100%**	**520,212**	**100%**	**556,463**	**100%**	**569,971**	**100%**

Source: HIP monthly enrollment files, February 2015 – December 2018.

Exhibit B.17: Indiana Population, Potentially Eligible HIP Population and HIP Population by Race (2015 – 2017)



Sources: HIP monthly enrollment files, February 2015 – December 2018; Integrated Public Use Microdata Series (IPUMS) Online Data Analysis System (2019). IPUMS USA. Retrieved from https://usa.ipums.org/usa/sda/

Exhibit B.18: Number and Percent of Indiana Population by Race (2015 – 2017)

Race	2015		2016		2017	
	Number	Percent	Number	Percent	Number	Percent
Non-Hispanic White	5,335,580	81%	5,318,291	80%	5,329,064	80%
Black	606,803	9%	611,187	9%	613,320	9%
Hispanic	368,065	6%	373,972	6%	384,393	6%
Asian or Pacific Islander	141,365	2%	145,813	2%	146,800	2%
Other or Unknown	167,867	3%	183,790	3%	193,241	3%
Total	**6,619,680**	**100%**	**6,633,053**	**100%**	**6,666,818**	**100%**

Source: IPUMS Online Data Analysis System (2019). IPUMS USA. Retrieved from https://usa.ipums.org/usa/sda/

Exhibit B.19: Number and Percent of Potentially Eligible HIP Population by Race (February 2015 – December 2017)

Race	2015		2016		2017	
	Number	Percent	Number	Percent	Number	Percent
Non-Hispanic White	591,701	71%	551,577	69%	535,140	69%
Black	126,476	15%	114,326	14%	114,707	15%
Hispanic	67,297	8%	72,818	9%	68,682	9%
Asian or Pacific Islander	28,451	3%	32,662	4%	31,542	4%
Other or Unknown	24,122	3%	26,775	3%	23,919	3%
Total	**838,047**	**100%**	**798,158**	**100%**	**773,990**	**100%**

Source: IPUMS Online Data Analysis System (2019). IPUMS USA. Retrieved from https://usa.ipums.org/usa/sda/

C. Evaluation Questions and Hypotheses

The following goals and hypotheses guide the evaluation of HIP and are based on the approved STCs and CMS evaluation guidance documents. **Exhibit C.1** details the hypotheses listed by program goal. **Section F: Results by Demonstration Goal** and **Attachment I: Evaluation Plan** provides the research questions corresponding to each hypothesis.

Exhibit C.1: HIP Evaluation Goals and Hypotheses

Goal	Hypothesis
Goal 1 – Improve health care access, appropriate utilization, and health outcomes among HIP members.	• **Hypothesis 1** – Enrollment in HIP will promote member use of preventive care, primary care, chronic disease management care, and urgent care, and needed prescription drugs. • **Hypothesis 2** – Unnecessary ED services will not rise over time for HIP members. • **Hypothesis 3** – HIP members will report positive health outcomes. • **Hypothesis 4** – HIP members will report satisfaction with health care access. • **Hypothesis 5** – The Indiana Medicaid enrollment rate will be comparable to other Medicaid expansion states.
Goal 2 – Increase community engagement leading to sustainable employment and improved health outcomes among HIP members.	• **Hypothesis 1** – Medicaid beneficiaries subject to community engagement requirements will have higher employment levels than Medicaid beneficiaries not subject to the requirements. • **Hypothesis 2** – Community engagement requirements will increase the average income of Medicaid beneficiaries subject to the requirements compared to Medicaid beneficiaries not subject to the requirements. • **Hypothesis 3** – Community engagement requirements will improve the health outcomes of current and former Medicaid beneficiaries subject to the requirements, compared to Medicaid beneficiaries not subject to the requirements. • **Hypothesis 4** – HIP policies, including community engagement and required payment policies, increase the likelihood that Medicaid beneficiaries transition to commercial health insurance after separating from Medicaid, compared to Medicaid beneficiaries not subject to the requirements. • **Implementation Questions**
Goal 3 – Discourage tobacco use among HIP members through a premium surcharge and the utilization of tobacco cessation benefits.	• **Hypothesis 1** – The tobacco premium surcharge will increase use of tobacco cessation services among HIP members. • **Hypothesis 2** – The tobacco premium surcharge and availability of tobacco cessation benefits will decrease tobacco use.
Goal 4 – Promote member understanding and increase compliance with payment requirements by changing the monthly POWER Account payment requirement to a tiered structure.[33]	• **Hypothesis 1** – HIP's new income tier structure for POWER Account Contributions will be clear to HIP members. • **Hypothesis 2** – Enrollment and enrollment continuity will vary for the POWER Account payment tiers.

[33] Previous versions of this goal included a reference to "efficient use of services" consistent with the STCs. This wording is no longer included as efficient use of services is addressed under Goal 1.

Goal	Hypothesis
Goal 5 – Ensure HIP program policies align with commercial policies, are understood by members, and promote positive member experience and minimize coverage gaps.	• **Hypothesis 1** – Beneficiaries who are required to participate in HIP policies will understand program policies. • **Hypothesis 2** – Beneficiaries will be satisfied with the HIP program. • **Hypothesis 3** – Individuals subject to the non-eligibility/"lockout" periods (payment and redetermination) are no different from commercial market populations.
Goal 6 – Assess the costs to implement and operate HIP and other non-cost outcomes of the demonstration.	**Implementation Questions**

D. Methodology

This Interim Evaluation Report reflects the first 17 months of the current waiver period (February 2018 to June 2019). This period includes the first six months of the phase-in of the new community engagement reporting requirements during which member reporting of activities was voluntary. Some analyses only go through March 2019, or before, due to data availability. Lewin includes data from February 2015 to December 2017 as a point of reference and context for analyses, but we do not evaluate this period.

The methodology follows the State's HIP Evaluation Plan that describes analyses for both the Interim and the Summative Evaluation Reports (**Attachment I: Evaluation Plan**).[34] This methodology relies on a mixed-methods approach employing both qualitative and quantitative analyses to provide preliminary observations for the hypotheses and research questions corresponding to each goal of the demonstration.

Under the mixed-methods approach, qualitative analyses support an understanding of stakeholders' perspectives about implementation and outcomes and identify contextual factors that help to explain outcomes. Quantitative analyses examine changes in outcomes and estimate the impact of policy changes, as demonstration design and data permit. As such, qualitative data and analysis informs the collection, analysis, and interpretation of quantitative data, and quantitative data and analysis informs the collection, analysis, and interpretation of qualitative data. For example, interviews with HIP members provide important contextual information to help explain the results of analyses of encounter data; these analyses may inform the development of survey and interview protocols for the Summative Evaluation Report. Triangulated quantitative and qualitative analyses contribute to understanding context, impact, and variation in program implementation and outcomes. **Attachment I: Evaluation Plan** provides the State's HIP Evaluation Plan, including a description of the overall evaluation approach, related data sources, and which analyses Lewin will perform for the Interim Evaluation Report versus the Summative Evaluation Report.

Lewin compiled a variety of data for the Interim Evaluation Report to evaluate outcomes related to each goal, including HIP monthly enrollment data, encounter data,[35] Gateway to Work program data, and POWER Account reconciliation files (**Attachment III** provides detailed descriptions of the quantitative data). We also conducted key informant interviews to capture member, provider, State official, and MCE executive experience. Between June and September 2019, Lewin conducted key informant interviews with nine FSSA officials, four MCEs, four provider associations, 36 providers, and 27 members. Lewin reviewed information gathered from these interviews to address relevant research questions and identify common themes. We assured interviewees that they would remain anonymous.

Exhibit D.1 provides a summary of the qualitative data sources, including information about how we identified interviewees, who interviewed them, and interview topics. Since we used a similar methodology to conduct and analyze the qualitative key informant interviews, we only describe the methodology in this section. Lewin conducted all interviews over the phone and each interview lasted from 15 to 60 minutes depending on the interview type.

[34] This HIP Evaluation Plan is currently pending CMS' review.

[35] Data that MCEs provide to the Medicaid agency that detail specific services provided to a member by a provider.

Exhibit D.2 provides a summary of the quantitative data sources and key analyses by goal along with the target population used for the analysis. This target population varied by goal and sometimes by specific research question. We excluded individuals eligible for only ED services under HIP from this evaluation given the short-term nature of this enrollment and limited service coverage.

When developing analyses by benefit plan type, we included State Plan Basic and State Plan Plus members. While the State provides these members with a specific set of State Plan services due to their qualifying health condition or eligibility category,[36] the HIP Plus and HIP Basic member cost-sharing requirements still apply. As such, they do not experience the same choices between the HIP Plus and HIP Basic benefit plans, but do experience similar tradeoffs in cost-sharing in terms of paying copayments under HIP Basic versus the monthly POWER Account Contribution amount under HIP Plus.

Exhibit D.1: Summary of Qualitative Data Sources

Interview Type	Description	Relevant Goals
FSSA State Officials *Total: 9*	• The Indiana FSSA evaluation contract officer identified State interviewees representing several roles within FSSA. • Some interview questions were specific to each official's role. Common questions across officials covered the following topics: overall HIP experience, rollout of community engagement reporting requirements, POWER Accounts, communication strategies, and perceptions of member understanding of HIP policies and satisfaction with HIP.	Goal 1 Goal 2 Goal 3 Goal 4 Goal 5
MCEs *Total: 8 (4 General, 4 Tobacco)*	• The Indiana FSSA evaluation contract officer identified MCE interviewees. Interviews included key individuals from each of the four MCEs. Each MCE participated in two separate calls, one for a general interview and another for a tobacco cessation interview. • Lewin conducted general interviews with executives and key team members from each of the four MCEs. • For the general interview, Lewin asked executives and team members a standardized set of questions related to overall HIP experience, rollout of community engagement reporting requirements, POWER Accounts, communication strategies, and perceptions of member understanding of HIP policies and satisfaction with HIP. • Lewin's partner, Indiana University, conducted tobacco cessation-specific interviews with key executives from each MCE. These interviews informed the evaluation of **Goal 3** (tobacco cessation services and tobacco surcharge).	MCE General Interviews: Goal 1, Goal 2, Goal 3, Goal 4, Goal 5 MCE Tobacco Interviews: Goal 3

[36] Medically frail, TMA participants, Section 1931 low-income (< 19% of the FPL) parents and caretakers, and low-income (< 19% of the FPL) 19 – 20 year olds.

Interview Type	Description	Relevant Goals
Providers *Total: 36 providers, 4 provider associations*	• Lewin identified initial provider interviewees based on MCE provider lists and the State navigator list. Due to a low response rate, Lewin worked with four Indiana provider associations to identify additional interviewees. Lewin also conducted individual interviews with the four Indiana provider associations. • Lewin's partner, McCarty Research, conducted the provider interviews, which yielded responses from 36 unique providers. • Providers included three physicians, five nurses, 13 administrators, and 15 certified navigators. • McCarty Research asked providers a standardized set of questions related to HIP member satisfaction, community engagement reporting requirements, POWER Accounts, presumptive eligibility and Fast Track processes, member enrollment experience, tobacco cessation services, and successes and challenges of HIP implementation. • McCarty Research compiled the data from these phone calls with providers and conducted qualitative analyses based on interviewees' responses.	Goal 2 Goal 3 Goal 4 Goal 5
Members *Total: 27*	• Lewin identified a list of potential member interviewees based on HIP enrollment files. Lewin's partner, Engaging Solutions, called members on this list to reach a target number of 25 interviews. Members had the option to participate or decline to participate. • Lewin's partner, Engaging Solutions, conducted 27 unique member interviews. • Engaging Solutions asked members a standardized set of questions related to members understanding of their HIP plan, the community engagement reporting requirement, the POWER Account, and member satisfaction. • Engaging Solutions compiled the data from these phone calls with members and conducted qualitative analyses based on interviewees' responses. • The number of responses varied for each question as members could refuse to answer and the survey included skip logic so that members were only asked questions that applied to them.	Goal 2 Goal 3 Goal 4 Goal 5
State 2019 Email Survey (separate from Lewin Evaluation)	• In 2019, the State conducted an email survey, which yielded a 2.2% response rate (883 responses). The contractor conducting the survey indicated that this response was a statistically significant representation of the approximately 400,000 HIP members within ±3% and reflected a "good representation" across all 10 districts of the State. The State shared results from this survey to inform several research questions. Lewin notes that the survey's function was limited to informing the State's communications strategy, and that its reliance on email to distribute the survey introduced notable selection bias inconsistent with surveys conducted for quantitative evaluation purposes.	Goal 2 Goal 4 Goal 5

Exhibit D.2: Summary of Quantitative Data Sources and Populations by Goal

Goal	Populations Used for Analysis	General Analytic Approach	Data Sources
Goal 1 – Service Utilization	HIP Basic (State Plan and Regular), HIP Plus (State Plan and Regular), pregnant (MA), and HIP Plus Copay (PC) members *569,971 enrollees in 2018*	• Analysis of: Preventive care services, primary care visits, specialty care services, ED visits, urgent care center visits • Analysis of MCE disease management program enrollment • Analysis of MCE Healthcare Effectiveness Data & Information Set (HEDIS®) measures	MCE encounter data, February 2015 – December 2018 Enrollment data, February 2015 – December 2018 MCE quarterly reports, 2015 – 2018
Goal 1 – Fast Track	HIP Plus (State Plan and Regular) members, including those that subsequently move to Basic *5,094 members enrolled using Fast Track in 2018*	• Use of Fast Track by new enrollees and related covered months of services	Enrollment data, 2017 – 2018 Fast Track administrative data, 2017 – 2018
Goal 1 – Presumptive Eligibility	Basic (State Plan and Regular) Plus (State Plan and Regular) *21,529 members enrolled using presumptive eligibility in 2018*	• Use of presumptive eligibility processes by new enrollees and related covered months of services	Enrollment data, February 2015 – December 2018 Presumptive eligibility administrative data, February 2015 – December 2018
Goal 2 – Community Engagement	HIP Basic (State Plan and Regular), HIP Plus (State Plan and Regular), pregnant (MA) and HIP Plus Copay (PC) *383,554 enrollees in June 2019 Gateway to Work administrative file*	• Analysis of community engagement reporting status • Frequency of qualifying activities • Frequency of exemption types • Disenrollment rates of individuals that are required to report qualifying activities	Gateway to Work administrative files, January 2019 – June 2019 Enrollment and disenrollment data, December 2018 – April 2019
Goal 3 – Tobacco Surcharge	All HIP members *569,971 enrollees in 2018*	• Tobacco cessation service use • Member tobacco use	MCE encounter data, February 2015 – December 2018 Tobacco use data collected by the State from new HIP applications (new enrollees or enrollees switching MCEs) and self-reported member tobacco use during enrollment, October 2017 – March 2018
Goal 4 – POWER Account Contribution Payment Tiers	HIP Basic (State Plan and Regular) and HIP Plus (State Plan and Regular) ***Note**: The population Lewin used within this goal varies by research question; we include the definition of each research question's population by research question.*	• Enrollment and disenrollment rate analyses, in particular, related to non-payment or POWER Account Contributions • Analyses of members moving from HIP Plus to HIP Basic and from HIP Basic to HIP Plus	Enrollment and disenrollment data, February 2015 – December 2018

Goal	Populations Used for Analysis	General Analytic Approach	Data Sources
Goal 5 – Member Satisfaction & Understanding	Quantitative analysis will not be performed until the Summative Evaluation Report	n.a.	n.a.
Goal 6 – Cost Outcomes	Analysis will be included in Summative Evaluation Report	n.a.	n.a.

Lewin cannot offer preliminary observations for all hypotheses and research questions listed in the HIP Evaluation Plan as the required timeline for the Interim Evaluation Report submission (as expressed in the HIP STCs) does not allow for the collection of data for the full waiver renewal period. We also note that we based this Interim Evaluation Report on HIP metrics and do not compare HIP outcomes to those in other states. We will include cross-state comparisons in the Summative Evaluation Report as specified by the HIP Evaluation Plan.

The Summative Evaluation Report will reflect additional qualitative analysis relying on information collected via member focus groups and additional key informant interviews with State officials, MCE executives, providers, and members. In addition to the qualitative analysis, the Summative Evaluation Report will also expand quantitative analysis to include more current enrollment data, encounter data, and other State administrative data, as well as ACS data, Behavioral Risk Factor Surveillance System data, and 2020 and 2021 HIP member surveys.

E. Methodological Limitations

Exhibit E.1 describes the known limitations of the evaluation for the Interim Evaluation Report and approaches used to minimize those limitations and/or acknowledgment of where limitations might preclude causal inferences about the effects of demonstration policies. The Evaluation Plan (**Attachment I: Evaluation Plan**) describes the limitations of the overall evaluation including data and methodological challenges of the analyses for the Summative Evaluation Report.

Exhibit E.1: Summary of Interim Evaluation Report Methodological Limitations and Approach(es) Used to Minimize Limitations

Area	Issue	Description	Approach(es) Used to Address Limitation
Overall issues	Distinguishing the impacts of overlapping initiatives	Multiple policy changes have been implemented under the renewal. As such, distinguishing the impacts of the individual initiatives becomes challenging. In addition to the HIP waiver policies, non-waiver operational items have overlapping impacts, for example: • Implementation of a new Medicaid Management Information System in 2017 • Updates to verification policies over time • New processes for reporting and tracking community engagement activities	Provided context for interpretation of results.
	Impact of changes in case mix over time	Changes in HIP case mix over time may have an impact on a variety of areas of this evaluation, including service utilization, prevalence of medical frailty exemptions for the Gateway to Work program, and member preference for the HIP Plus versus HIP Basic benefit plan. Case mix analyses were not included the Evaluation Plan.	Provided context for interpretation of results.
	Quality of provider contact information for key informant interviews	Provider contact information reliability made completing provider key informant interviews challenging. For example, provider email addresses and phone numbers listed in the MCE provider list often provided only generic office email addresses.	• Performed outreach and follow-up via phone calls. • Adjusted outreach strategy to work directly through provider associations.
	Quality of MCE encounter data	MCE encounter data is self-reported and the procedure codes and units recorded in the encounter data analyzed for the evaluation of the 2015 to 2017 demonstration period appeared incomplete and/or inaccurate.	• Performed data checks on key variables (e.g., expected versus populated values).

Area	Issue	Description	Approach(es) Used to Address Limitation
Overall issues, continued	Identification of unique HIP members	We based the identification of unique members on the recipient identification number for each member provided in the State administrative files and the MCE encounter data. Recipient identification numbers can change over time and the State performs on-going adjustments to data so that each member has only one active recipient identification number. The State indicated at the end of the Interim Evaluation Report analysis period that there is the possibility that encounter data for some members in Quarter 4, 2018 may reflect more than one recipient identification number per member. As such, unique member counts for 2018 may be slightly overstated.	The State has indicated that they will provide a mapping of duplicate recipient identification numbers for purposes of the Summative Evaluation Report.
	Identification of member FPL	Member income can change throughout the year and as often as monthly. We defined member FPL based on the first enrollment month in the calendar year under analysis (based on analyses of the income in enrollment data and feedback from the State). In some instances we observed FPL amounts that appeared inconsistent with HIP policies (for example, a small number of HIP Plus members with income at or less than 100% had disenrollments with non-payment as a reason). Based on discussions with the State, there are several possible reasons for these inconsistencies, for example: • The member changed income after the first HIP Plus enrollment month in the calendar year under analysis • Interplay between the required member notification for coverage changes (e.g., HIP Plus to HIP Basic) and when the State/MCE received and updates data, in conjunction with member changes in FPL across months • Inconsistencies in FPL data transfer between eligibility and the Medicaid Management Information System that resulted in null FPL values on disenrollment which appear as zero in the provided enrollment data and in some cases in the application of updated FPL numbers to prior months. The State has indicated that this data issue is resolved but on a minority of historical records included in this analyses these data artifacts remain.	• Did not place restrictions on FPL when identifying HIP Plus members for analysis in **Goal 4**. • Provided context for interpretation of results.

Area	Issue	Description	Approach(es) Used to Address Limitation
Overall issues, continued	Identification of new enrollees	The identification of new enrollees is likely overstated as data were not available from the State to identify which individuals were coming into HIP from a separate Medicaid program for the Interim Evaluation Report.	Described limitation in the relevant goals. The State will provide additional data indicating members transitioning into HIP from a separate Medicaid program for purposes of the Summative Evaluation Report.
	Self-reported qualitative data	Key informant interviews represent qualitative feedback from multiple stakeholders including State officials, MCE executives, providers and provider association representatives, and members. This self-reported information requires participants to recall information at a point in time (July 2019) and may not capture all experiences.	• Identified MCE and FSSA participants that represented multiple roles and organizations. • Identified members randomly. • Identified providers and navigators through multiple outreach strategies (e.g., State navigator list, MCE contact lists, and conversations with provider associations) in an effort to represent multiple viewpoints. • Tailored interview questions based on role and type of interview.
	Limited information from members about POWER Account Contribution payments	Few HIP members interviewed needed to make payments and many expressed reluctance to speak about payments in detail, which resulted in limited data collection for this topic.	Described this limited response when summarizing member feedback; Lewin will consider this issue when developing key informant interview questions for the Summative Evaluation Report.
Goal 1: Improve health care access, appropriate utilization, and health outcomes among HIP members	Variations in health care utilization based on time of enrollment	Members may experience higher utilization of service when first enrolled in Medicaid based on previously unmet health care needs. This higher utilization may make identification of trends in the use of preventative, primary, urgent, and specialty care challenging.	Only used members continuously enrolled for at least one year to calculate the participation rate for each service type.

Area	Issue	Description	Approach(es) Used to Address Limitation
Goal 2: Increase community engagement leading to sustainable employment and improved health outcomes among HIP members	Gradual phase-in of community engagement requirements	The State is phasing-in the community engagement reporting requirements during 2019 and the first six months of 2020, with members required to report hours for the first time starting in July 2019 (**Exhibit B.10**). As we conducted member key informant interviews for the Interim Evaluation Report during July 2019, member experiences with, understanding of, or compliance with these requirements do not reflect full implementation. Additionally, as members voluntarily reported qualifying activities during the first six months of 2019, we expect the frequency of member reporting of qualifying activities during this period to be much lower than after July 1, 2019 once reporting becomes mandatory.	Included a description in the evaluation narrative of how this gradual phase-in might affect results.
	Compliance with community engagement reporting	Some members may gain employment, but will not report it to the State as their closure reason(s) fall under other categories (e.g., POWER Account Contribution non-payment, failure to verify information, failure to complete redetermination). This may underestimate the number of members who close due to increased income, and may overestimate the number of members who close due to non-compliance or other reasons.	Provided context in the evaluation narrative for this issue.
Goal 3: Discourage tobacco use among HIP members, through a premium surcharge and the utilization of tobacco cessation benefits	Surcharge only assessed on members who self-report tobacco use via defined channels	The tobacco surcharge determination relies on reporting of tobacco use by members during the MCE selection period, when changing MCEs, or if members otherwise voluntarily contact the MCE to report their tobacco use status. This underestimates the number of members who continue to use tobacco.	Provided context in the evaluation narrative for this issue.
	Members may under-report tobacco use	Members may have an incentive to refrain from reporting tobacco use if they want to avoid the related premium surcharge increase.	Provided context in the evaluation narrative for this issue.
	Medicaid encounter data may not fully reflect the use of tobacco cessation services	Encounter data will not have codes for all tobacco cessation services since some programs will not be reimbursable by the provider.	• Included questions on use of tobacco cessation services for purposes of the member key informant interviews. • Conducted MCE interviews specific to MCE tobacco cessation initiatives.

Area	Issue	Description	Approach(es) Used to Address Limitation
Goal 4: Promote member understanding and increase compliance with payment requirements by changing the monthly POWER Account payment requirement to a tiered structure	Variability in FPL amounts	Discussed as an overall methodological limitation above	Refer to description above
	Limited time following the enactment of the payment tier policy.	Available data spans calendar years 2015 to 2018, allowing three years prior to the enactment of the payment tier POWER Account Contribution structure and one year following its enactment. This limits the ability to interpret the effect of the policy, as additional time periods are necessary to assess time trends in enrollment. In particular, additional time periods are necessary to assess changes in the length of continuous enrollment periods given that many HIP members maintain continuous enrollment for multiple years.	We will conduct additional analyses using 2019 and 2020 data for purposes of the Summative Evaluation Report.
	Change in rollover policy	Starting in 2018, the State made all member benefit periods equal to the calendar year. Prior to 2017, members enrolling multiple times within a year had multiple POWER Accounts and the State applied rollover based on the individual member benefit period (based on the dates the member enrolled).	For consistency, we identified rollover according to successive calendar years and regard findings as nominal.
	Exclusion of special enrollment status	We removed members with TMA, pregnancy, or medically frail enrollment status for the specific month that the member had one of these statuses. Thus, counts of HIP member months do not reflect all HIP members.	It is necessary to remove these members so that the **Goal 4** analyses can focus solely on members that have POWER Account Contribution payment obligations.
	Member coverage span	Members may have coverage for more or less than one calendar year. Counts of enrollment within a calendar year will not reflect the length of coverage a member may receive.	We performed specific analyses to examine length of coverage.
Goal 5: Ensure that HIP policies promote a positive member experience for all HIP members and minimize coverage gaps	None noted	n.a.	n.a.
Goal 6: Assess the costs to implement and operate HIP and other non-cost outcomes of the demonstration	Related analyses conducted by Indiana's actuary, Milliman, Inc., are performed for Summative Evaluation Report only	n.a.	n.a.

F. Results by Demonstration Goal

This section provides detailed observations by research question, organized by the six evaluation goals and related hypotheses. A combination of qualitative and quantitative analyses informed these observations and address trends related to health care access, utilization, outcomes, community engagement, tobacco use, and POWER Accounts. Due to data availability and the required timeline for submission, this Interim Evaluation Report primarily offers preliminary observations for a subset of the hypotheses and research questions. The Summative Evaluation Report, scheduled for 2022, will provide a more comprehensive examination, including outcomes and cross-state comparisons. As such, we indicate which research questions we will address only in the Summative Evaluation Report and not in this Interim Evaluation Report. For ease of reference, we have summarized key observations by hypothesis or research question using a blue bolded text box. **Section G: Conclusions** provides a summary of our observations by goal.

For Goals 1, 2 and 3, we included members from the monthly HIP enrollment files with enrollment statuses of Regular Basic (RB), Regular Plus (RP), State Basic (SB), State Plus (SP), pregnant (MA), and HIP Plus Copay (PC) in the quantitative analyses. We did not include months when an individual had conditional eligibility or presumptive eligibility status, or members that were eligible for Emergency Room services only (Emergency Room services flag of "Y"). We categorized HIP members into three main benefit plan categories as part of our analysis for Goals 1 and 2:

- **HIP Basic Only:** Members enrolled exclusively in HIP Basic, either the State Basic or Regular Basic plans during the calendar year under analysis.
- **HIP Plus Only:** Members enrolled exclusively in HIP Plus, either the State Plus or Regular Plus plans during the calendar year under analysis.
- **HIP Switchers:** Members that moved between HIP Basic and HIP Plus (either direction, State Plan or regular benefits) during the calendar year under analysis, and/or pregnant (MA or pregnancy flag of Y) or HIP Plus Copay (PC). Pregnant members switch from either HIP Plus or HIP Basic to the MA category, and then from MA to HIP Basic or HIP Plus following the conclusion of the pregnancy. HIP Plus Copay members have switched from HIP Plus to the HIP Plus Copay category and are afforded the opportunity at least annually to return to HIP Plus.

Exhibit F.1.1 provides a summary of the number of members by the benefit plan categories described above. HIP Plus Only members represent just over half of the HIP population with approximately a quarter of remaining members falling exclusively under HIP Basic in 2018. The number of HIP Switcher members increased between 2017 and 2018 in part because of the addition of the MA category in 2018. Prior to 2018, pregnant members would have moved out of HIP to pregnancy Medicaid.

Exhibit F.1.1: HIP Population by Benefit Plan Type (February 2015 – December 2018)

Enrollment Category	2015		2016		2017		2018	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent
HIP Basic Only	112,228	28.8%	151,608	29.1%	163,729	29.4%	142,310	25.0%
HIP Plus Only	219,885	56.4%	297,020	57.1%	301,685	54.2%	313,902	55.1%
HIP Switchers	57,871	14.8%	71,584	13.8%	91,049	16.4%	113,759	20.0%
Total	**389,984**	**100%**	**520,212**	**100%**	**556,463**	**100%**	**569,971**	**100%**

Source: HIP monthly enrollment files, February 2015 – December 2018.

Goal 1 – Improve health care access, appropriate utilization, and health outcomes among HIP members

This goal evaluates the HIP program's progress in improving health care access, utilization of health care services, and improved health outcomes. The hypotheses associated with this goal examine whether HIP enrollment supports member use of key services (including appropriate use of ED services), positive health outcomes, and member satisfaction with access to services. A final hypothesis examines whether the Indiana HIP enrollment rate is comparable to other Medicaid expansion states, and whether HIP coverage results in positive health outcomes and member satisfaction with access to care. We describe each of these hypotheses below and the relevant Interim Evaluation Report analyses, if applicable.

Hypothesis 1 – Enrollment in HIP will promote member use of preventive care, primary care, needed prescription drugs, chronic disease care management, and urgent care.

This hypothesis examines whether HIP enrollment supports member use of preventive services, primary and specialty care, needed prescription drugs, chronic disease management, ED, and urgent care.[37] Access to and appropriate use of these services supports positive health outcomes and members' ability to engage in key community activities such as employment, education, and caregiving, among others.

We used monthly enrollment data from February 2015 to December 2018 along with encounter data provided to Indiana FSSA from the four MCEs (Anthem, Managed Health Services [MHS], MDWise, and CareSource) to develop the service utilization analyses related to this hypothesis. The encounter data included services with dates of service from February 2015 to December 2018 and paid through April 30, 2019. We used MCE quarterly reports to gather data regarding MCE's disease management programs and HEDIS® measure results. The beginning of **Section F: Results by Demonstration Goal** provides a description of the HIP member population used for analysis.

Exhibit F.1.2 summarizes the population used for this analysis by benefit plan type. **Exhibit F.1.3** provides the total number of visits by service type for all members. We do not list the number of visits for continuously enrolled members in **Exhibit F.1.3,** as those visits are not used in the participation or utilization rate calculations (described in detail below). The analyses related to disease management and HEDIS® reflects the overall MCE enrolled HIP population as MCE reporting of the related data does not allow for distinguishing by HIP enrollment status.

[37] Results in this report will vary from the 2016 Interim Evaluation Report due to differences in time period evaluated and timing of the receipt of encounter data from the MCEs. Additionally, we have updated the specification and definition of the measures to align more closely with national metric standards when standards are available (i.e., CDC definition of preventive care).

Exhibit F.1.2: HIP Members in Service Utilization Analysis by Benefit Plan (February 2015 – December 2018)

Benefit Plan	Total Members				Continuously Enrolled Members[a]			
	2015	2016	2017	2018	2015	2016	2017	2018
HIP Basic Only	112,228	151,608	163,729	142,310	39,448	55,143	60,990	39,445
HIP Plus Only	219,885	297,020	301,685	313,902	72,700	150,343	161,805	154,874
HIP Switchers	57,871	71,584	91,049	113,759	34,166	41,839	54,036	55,429
Total	**389,984**	**520,212**	**556,463**	**569,971**	**146,314**	**247,325**	**276,831**	**249,748**

[a] Members enrolled for 11 or 12 months in 2016, 2017, and 2018. In 2015, since only 11 months of enrollment data were available, continuous enrollment counts members enrolled for 10 or 11 months.
Source: HIP monthly enrollment files, February 2015 – December 2018.

Exhibit F.1.3: Total Visits by Service Type for All HIP Members (February 2015 – December 2018)

Service Type	Total Visits/Services Count			
	2015	2016	2017	2018
Preventive Care	328,377	508,234	543,618	545,398
Primary Care	482,726	715,844	734,120	787,612
Specialty Care	621,465	999,963	805,473	889,008
Urgent Care	29,519	61,369	71,867	66,771
ED Care	289,183	451,909	473,319	428,150

Source: HIP encounter data and monthly enrollment files, February 2015 – December 2018.

Service utilization over the time period analyzed for the Interim Evaluation Report encompasses a variety of waiver and non-waiver developments. These include the maturation of the HIP program since 2015, recent improvement in the state economy, case-mix changes over time, implementation of a new Medicaid Management Information System, removal of a graduated ED copayment, updates to HIP verification processes, and new processes for reporting and tracking community engagement activities. Lewin will continue the analysis of service utilization using 2019 and 2020 data to fully evaluate the impact of programmatic and policy changes included under the waiver renewal for purposes of the Summative Evaluation Report.

For preventive care, primary care, urgent care, specialty care, and ED, we used HIP enrollment and encounter data to calculate two key metrics—the participation rate and utilization rate—by benefit plan type from 2015 to 2018. These two metrics convey two important aspects of utilization – what proportion of continuously enrolled members access a specific service (participation rate), and how often a particular population accesses the same service (utilization rate). We used different metrics for prescription drug adherence, disease management enrollment, and HEDIS® measures, as described in the relevant subsections.

Participation Rate

The participation rate is the proportion of continuously enrolled members that receive a specific service at least once in the year. For example, of the 249,748 HIP members enrolled for 11 or 12 months in 2018, 102,731 members had a visit to the ED during the year, resulting in a participation rate of 41.1%. This metric only reflects that a member participated in a type of care; it does not reflect how often the member did so. We restricted the calculation of this rate to members with enrollment of at least 11

months in a year (allowing a gap in coverage of up to 30 days) so that the utilization experience of individuals enrolled for only a short amount of time during the year does not influence the rate. We restricted the calculation of the 2015 participation rate to members with enrollment of at least 10 or more months as the 2015 encounter data only included 11 months (February 2015 – December 2015).

Utilization Rate

The utilization rate is the count of services or visits per 1,000 member years, which reflects the frequency at which members access the service regardless of their length of enrollment. For example, from February 2015 to 2018, HIP members' utilization rate for preventive care services increased from 1,366 visits per 1,000 member years to 1,392 visits per 1,000 member years, indicating that members were utilizing preventive care services more frequently in 2018 than in 2015.

The use of "member years" in the utilization rate reflects the number of services used per 1,000 members during a year and reflects the number of months of enrollment by members. The formula for the utilization rate is:

$$\frac{(\#\ of\ services\ or\ visits)}{(member\ months)}\ x\ 1{,}000\ x\ 12\ months$$

While the formula uses member months, a member year is a more tangible concept for the reader to understand and is a commonly used concept in health care utilization metrics. For example, in 2018 HIP members had 428,150 ED visits. The 569,971 unique HIP members enrolled in 2018 had 4,700,243 enrolled member months in that year. Using the above formula, the 2018 ED visit participation rate is 1,093 visits per 1,000 member years.

Primary Research Question 1.1 – How have the following changed over time for HIP members: preventive, primary, urgent, and specialty care; prescription drug use; and chronic care management?

This research question assesses member use over time of preventive, primary, urgent and specialty care; prescription drug adherence; chronic disease management; and ED usage. Tracking trends in service utilization over time can help the State determine if HIP is supporting appropriate service utilization and the efficient use of services.

Brief Summary: Both MCE executives and FSSA officials provided feedback during key informant interviews that HIP improved health outcomes overall, resulting in lower ED use, and increased utilization of preventive care services. The analysis of MCE encounter data, disease management program enrollment, and HEDIS® results provides additional context:

- Based on findings from member key informant interviews, 23 of 27 respondents received needed health care services through HIP. MCE executives, providers, and State officials conveyed that provider network and member access to services continue to improve.
- An analysis of the use of any HIP-covered service from February 2015 to December 2018 indicated that the majority of continuously enrolled HIP members received one or more HIP-covered services, with HIP Plus and HIP Switcher members more likely to receive one or more services as compared to HIP Basic members.

- Participation and utilization rates (percentage of continuously enrolled members participating in the services and the number of services or visits per 1,000 member years, respectively) for CDC-defined preventive services increased from February 2015 to December 2018 while the rates for dental and vision services decreased.
- The percentage of continuously enrolled members accessing a primary care provider increased from February 2015 to December 2018, while the utilization rate remained approximately the same.
- Participation and utilization rates for specialty care services decreased from February 2015 to December 2018.
- HIP members' adherence to their prescription drug regimens remained relatively the same from 2015 to 2018.
- The percentage of continuously enrolled members accessing health care at urgent care centers increased from 2015 to 2018 while the percent accessing health care at EDs decreased.
- HIP Basic members had lower participation and utilization rates for preventive services, primary care, specialty services, and urgent care centers from 2015 to 2018 as compared to HIP Plus members. Many factors could contribute to this difference between benefit plan groups, including case mix (10% of HIP Basic members are medically frail as compared to 17% of HIP Plus members), health literacy, lack of transportation to providers, among others.
- Overall, HIP enrollment in MCE disease management programs continued to increase from 2015 to 2018. Programs for depression had the highest enrollment and grew the fastest at an average annual growth rate of 62%.
- HIP enrollment in pregnancy management programs increased at an average annual growth rate of 41% from 2015 to 2018.
- MCE performance varied on selected HEDIS® measures for the three MCEs with full National Committee for Quality Assurance (NCQA) accreditation as of 2018. From 2015 to 2017, two of the three MCEs performed lower than the national Medicaid Health Maintenance Organization (HMO) average on two of the six selected measures (controlling high blood pressure and cervical cancer screening). In 2017, the three MCEs performed above the national Medicaid HMO average on at least four of the six selected measures (adult Body Mass Index [BMI] assessment, diabetes care: HbA1c testing, breast cancer screening, and medication management for people with asthma).

An analysis of the use of any HIP-covered service from February 2015 to December 2018 indicated that the majority of continuously enrolled HIP members received one or more HIP-covered services, with HIP Plus and HIP Switcher members more likely to receive one or more services as compared to HIP Basic members, specifically:

- Approximately 90% of continuously enrolled HIP members received one or more HIP-covered services across all four years.

- The percentage of continuously enrolled HIP Basic Only members receiving one or more HIP-covered services decreased from 82% in 2015 to 73% in 2018. There are many factors that may be contributing to this decrease, including pent-up demand occurring upon HIP implementation in 2015 and consistency in coverage for continuously enrolled HIP members.
- Continuously enrolled HIP Plus Only and HIP Switcher members were more likely to receive any type of medical service as compared to HIP Basic Only members. Between 2015 and 2018, approximately 91% to 94% of continuously enrolled HIP Plus Only members and HIP Switcher members received one or more medical services compared to HIP Basic Only members who experienced the decrease noted above from 82% to 73%.

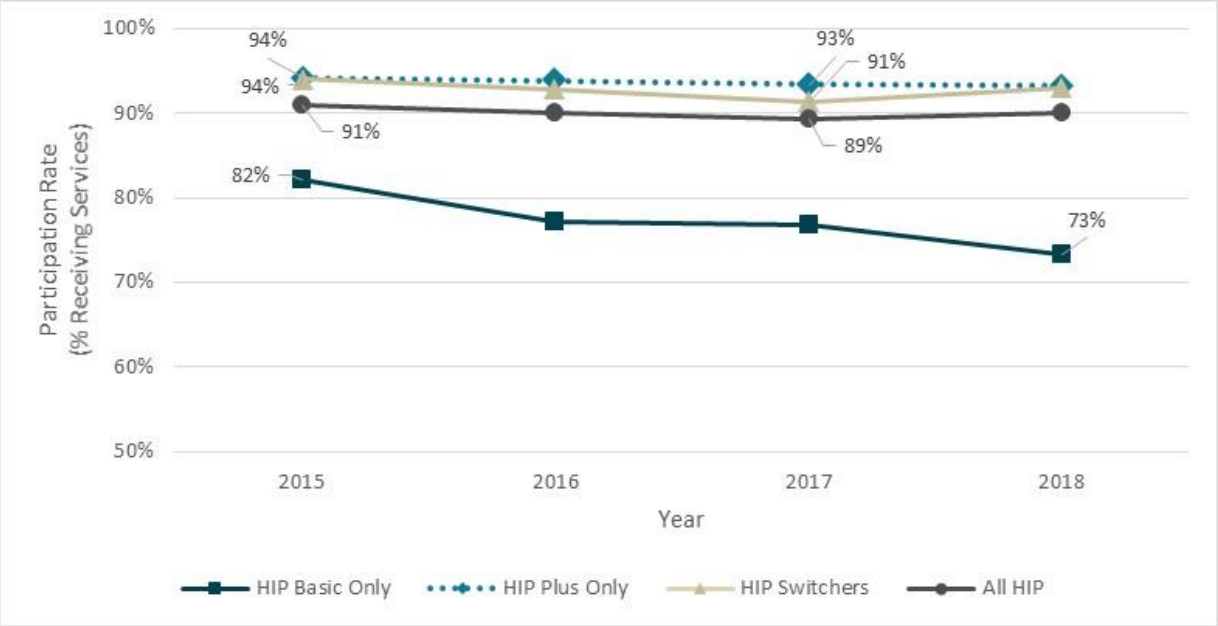
Exhibits F.1.4 to **F.1.5** show participation rates for all members, and members in HIP Basic Only, HIP Plus Only, and HIP Switchers who have received any medical service, including prescriptions, between February 2015 and December 2018. **Attachment IV: Service Utilization Reports (February 2015 – December 2018)** provides additional detail.

Exhibit F.1.4: HIP Member Participation Rates for Any Medical Service, by Benefit Plan (February 2015 – December 2018)

Benefit Plan	Participation Rate			
	2015	2016	2017	2018
HIP Basic Only	82.2%	77.2%	76.8%	73.3%
HIP Plus Only	94.2%	93.8%	93.4%	93.2%
HIP Switchers	94.0%	92.9%	91.3%	93.0%
Total	**90.9%**	**90.0%**	**89.3%**	**90.0%**

Source: HIP encounter data and monthly enrollment files, February 2015 – December 2018.

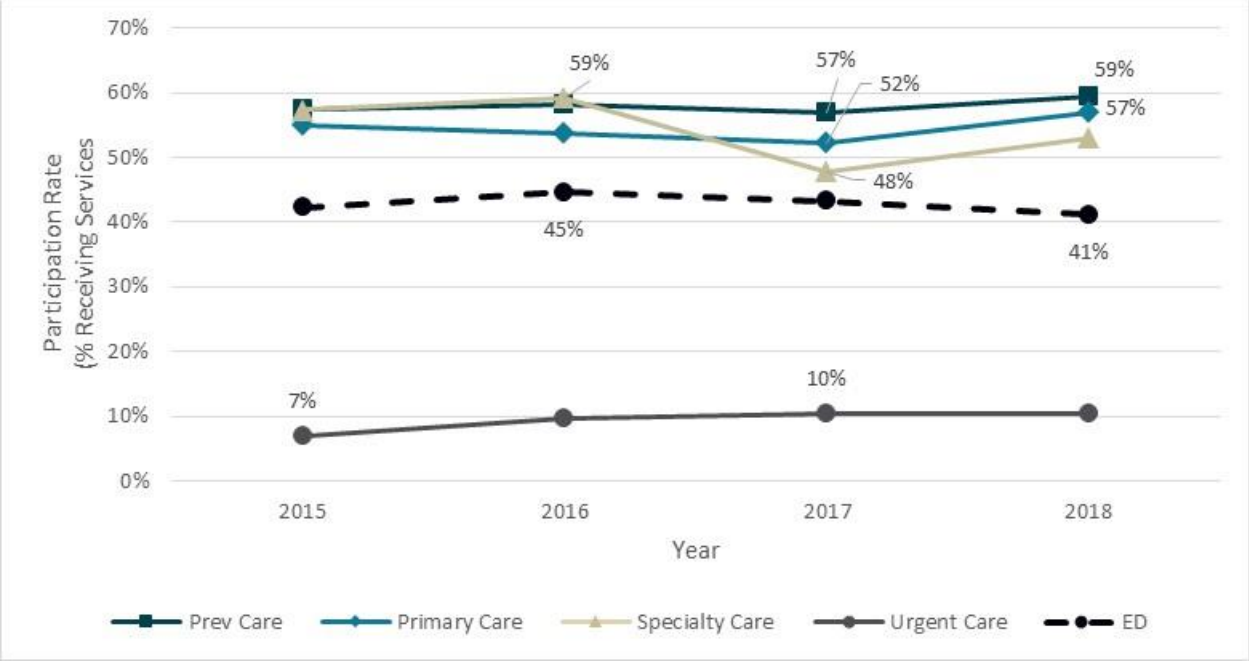
Exhibit F.1.5: HIP Member Participation Rates for Any Medical Service, by Benefit Plan (February 2015 – December 2018)



Source: HIP encounter data and monthly enrollment files, February 2015 – December 2018.

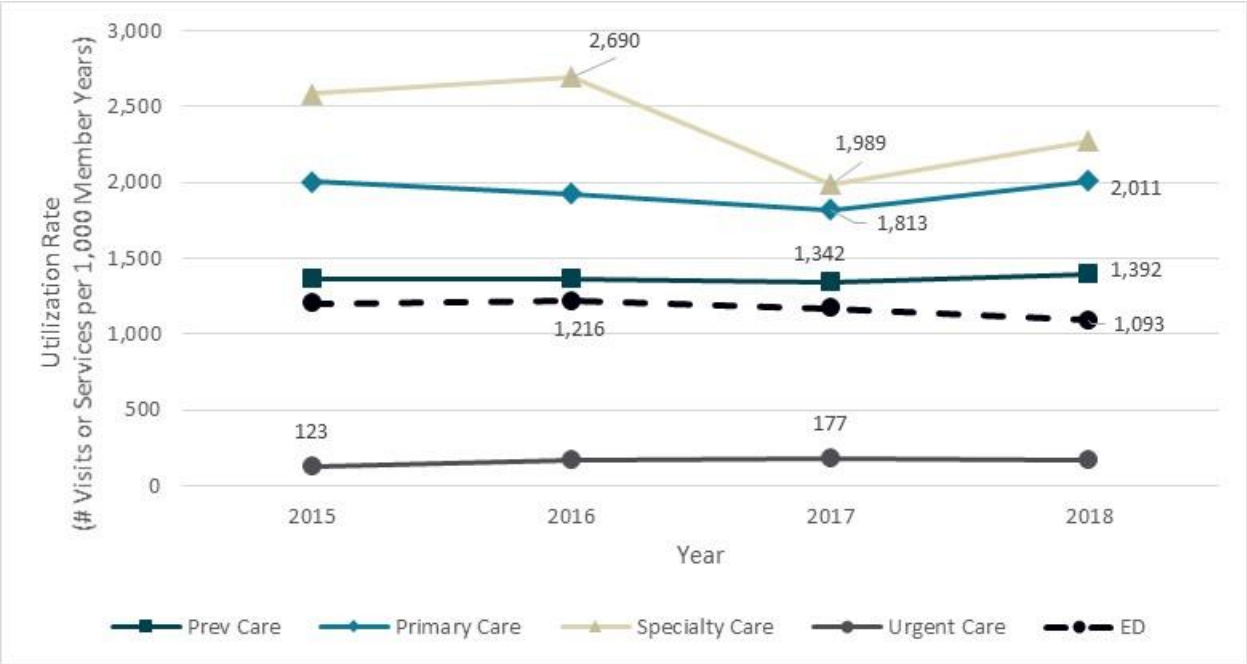
Exhibits F.1.6 and **F.1.7** provide an overview of changes in participation and utilization rates for preventive services, primary care visits, urgent care visits, specialty care services, and ED visits from 2015 to 2018 with additional detail provided by benefit plan category in **Exhibits F.1.8** and **F.1.9.** The remainder of the narrative for this hypothesis provides detailed information by service category (including service category definitions). We report results by benefit plan type where possible using the categories described at the beginning of **Section F: Results by Demonstration Goal**.

Exhibit F.1.6: Participation Rates for All HIP Members by Selected HIP Services (February 2015 – December 2018)



Source: HIP encounter data and monthly enrollment files, February 2015 – December 2018.
Note: Participation rates reflect continuously enrolled members only.

Exhibit F.1.7: Utilization Rates for All HIP Members, by Selected HIP Services (February 2015 – December 2018)



Source: HIP encounter data and monthly enrollment files, February 2015 – December 2018.
Note: Utilization rates include services used by members with any length of enrollment.

Exhibit F.1.8: Summary of Participation Rate by Service, 2015 as Compared to 2018

Service Type		All Members	HIP Plus Only	HIP Basic Only	HIP Switchers
Preventive Care Services	2015	57.4%	63.7%	41.4%	62.8%
	2018	59.4%	62.9%	36.9%	65.7%
	Percentage Point Change	*1.9*	*-0.8*	*-4.4*	*2.9*
Preventive Care (Dental/ Vision)	2015	27.2%	35.8%	12.3%	26.0%
	2018	25.2%	30.8%	7.3%	22.5%
	Percentage Point Change	*-1.9*	*-5.1*	*-5.0*	*-3.5*
Primary Care Visits	2015	55.0%	59.9%	42.1%	59.6%
	2018	56.9%	60.7%	36.7%	60.7%
	Percentage Point Change	*1.9*	*0.7*	*-5.4*	*1.1*
Specialty Care Services	2015	57.4%	62.3%	44.6%	61.5%
	2018	52.9%	57.4%	34.1%	53.7%
	Percentage Point Change	*-4.4*	*-4.9*	*-10.5*	*-7.8*
Urgent Care Center Visits	2015	6.9%	7.9%	4.8%	7.1%
	2018	10.4%	11.1%	7.2%	10.6%
	Percentage Point Change	*3.5*	*3.2*	*2.3*	*3.5*
ED Visits	2015	42.3%	36.0%	48.5%	48.3%
	2018	41.1%	36.5%	42.8%	52.9%
	Percentage Point Change	*-1.1*	*0.5*	*-5.7*	*4.6*

Source: HIP encounter data and monthly enrollment files, February 2015 – December 2018.

Exhibit F.1.9: Summary of Utilization Rate by Service Type, 2015 as Compared to 2018

Utilization Rates reported as "per 1,000" refer to per 1,000 member years, as described in the Utilization Rate explanation.

Service Type		All Members	HIP Plus Only	HIP Basic Only	HIP Switchers
Preventive Care Services	2015	1,366 per 1,000	1,544 per 1,000	774 per 1,000	1,682 per 1,000
	2018	1,392 per 1,000	1,456 per 1,000	689 per 1,000	1,863 per 1,000
	Percent Change	*2.0%*	*-5.7%*	*-10.9%*	*10.7%*
Dental/Vision Services	2015	354 per 1,000	487 per 1,000	114 per 1,000	304 per 1,000
	2018	296 per 1,000	390 per 1,000	71 per 1,000	258 per 1,000
	Percent Change	*-16.4%*	*-19.9%*	*-37.3%*	*-15.2%*
Primary Care Visits	2015	2,008 per 1,000	2,364 per 1000	1,141 per 1000	2,193 per 1000
	2018	2,011 per 1,000	2,315 per 1000	1,040 per 1000	2,105 per 1000
	Percent Change	*-0.2%*	*-2.0%*	*-8.8%*	*-4.0%*
Specialty Care Services	2015	2,584 per 1,000	3,100 per 1,000	1,454 per 1,000	2,679 per 1,000
	2018	2,270 per 1,000	2,750 per 1,000	1,052 per 1,000	2,135 per 1,000
	Percent Change	*-12.2%*	*-11.3%*	*-27.6%*	*-20.3%*
Urgent Care Center Visits	2015	123 per 1,000	147 per 1,000	71 per 1,000	125 per 1,000
	2018	170 per 1,000	190 per 1,000	111 per 1,000	173 per 1,000
	Percent Change	*38.9%*	*29.6%*	*54.9%*	*38.9%*
ED Visits	2015	1,203 per 1,000	1,046 per 1,000	1,345 per 1,000	1,460 per 1,000
	2018	1,093 per 1,000	924 per 1,000	1,126 per 1,000	1,497 per 1,000
	Percent Change	*-9.1%*	*-11.7%*	*-16.3%*	*2.5%*

Source: HIP encounter data and monthly enrollment files, February 2015 – December 2018.

Preventive Care Services

Preventive care services include a variety preventive exams, screenings, immunizations, contraception, and chronic disease services. HIP policies encourage the use of these services; copays do not apply to preventive care and all members may rollover a portion of their unused POWER Account funds to the next benefit year if they received "qualifying preventive services" as defined by the HIP MCE Manual[38] (**Section B: Summary of HIP Demonstration**).

[38] Indiana Family & Social Services Administration. (2019). MCE Reporting Manual HIP 2.0, Office of Medicaid Policy and Planning Version 4.0

Definition of Preventive Care Services

Lewin used the CDC list of preventive care procedures, identified by Current Procedural Terminology (CPT) codes and accompanying diagnosis, to identify preventive care services in the 2015 to 2018 MCE encounter data.[39] The CDC list does not include dental and vision services as identified in the HIP Basic and Plus benefit packages; we have added dental and vision services as a supplemental analysis to this preventive services section.

Analysis Results for Preventive Care Services

The following narrative describes preventive care participation and utilization rate trends by member benefit plan category. **Exhibits F.1.10** to **F.1.17** provide a summary of these rates by benefit plan; **Attachment IV: Service Utilization Reports (February 2015 – December 2018)** provides additional detail.

All HIP Members: The preventive services participation rate for all HIP members increased from 57.4% in 2015 to 59.4% in 2018. The utilization rate for these services increased 2.0% from 2015 to 2018, from 1,366 services per 1,000 to 1,392 services per 1,000. The participation rate for dental/vision services dropped from 27.2% of the HIP members receiving services in 2015 to 25.2% in 2018. The utilization rate for dental/vision services dropped 16.4% from 354 services per 1,000 to 296 per 1,000 in 2018.

HIP Plus Only Members: The preventive services participation rate for HIP Plus Only members dropped from 63.7% in 2015 to 62.9% in 2018. The utilization rate for preventive services dropped each year from 2015 to 2018 for an overall 5.7% drop (1,544 per 1,000 to 1,456 per 1,000). When evaluating dental/vision preventive services, there was a 19.9% drop in the utilization rate from 487 per 1,000 to 390 per 1,000.

HIP Basic Only Members: HIP Basic Only members saw a larger drop in preventive service participation and utilization rates than HIP Plus Only members. HIP Basic Only participation dropped 4.5 percentage points from 41.4% to 36.9%, while utilization dropped 10.9% from 774 services per 1,000 in 2015 to 689 services per 1,000 in 2018. HIP Basic Only members, overall, have much lower preventive services participation and utilization rates than HIP Plus Only members:

- HIP Plus Only members' participation rate averaged 1.5 to 1.7 times that of HIP Basic Only members from 2015 to 2018. For example, in 2018, 36.9% of HIP Basic Only continuously enrolled members received a preventive service, while 62.9% of HIP Plus Only continuously enrolled members received a preventive service.
- The preventive services utilization rate for HIP Plus Only was approximately double the rate for HIP Basic Only from 2015 to 2018.
- The difference in dental/vision preventive services utilization rate for HIP Plus Only grew from 4.3 times that of HIP Basic Only in 2015 to 5.5 times the utilization rate by 2018. As the HIP Plus benefit plan provides more generous coverage of dental and vision services, higher utilization of these services is expected by HIP Plus Only members as compared to HIP Basic Only members.

[39] Centers for Disease Control and Preventions, Office of the Associate Director of Policy-Prevention. (2014). Retrieved from https://www.cdc.gov/prevention/billingcodes.html

HIP Switchers: HIP Switchers' preventive services participation rate aligned more closely with HIP Plus Only members' participation rate, however, HIP Switchers participation increased from 62.8% in 2015 to 65.7% in 2018. HIP Switchers' utilization rate increased from 2015 to 2018 as well. In 2015, HIP Switchers utilized 1,682 preventive services per 1,000, increasing to 1,863 services per 1,000 by 2018. This increase may be, in part, due to the addition of the MA category in 2018.

Exhibit F.1.10: CDC-Defined Preventive Services Utilization, by Benefit Plan (February 2015 – December 2018)

Benefit Plan	Participation Rate				Utilization Rate			
	2015	2016	2017	2018	2015	2016	2017	2018
HIP Basic Only	41.4%	39.2%	39.0%	36.9%	774	726	735	689
HIP Plus Only	63.7%	63.7%	62.5%	62.9%	1,544	1,529	1,505	1,456
HIP Switchers	62.8%	63.6%	61.1%	65.7%	1,682	1,812	1,705	1,863
Total	**57.4%**	**58.2%**	**57.1%**	**59.4%**	**1,366**	**1,367**	**1,342**	**1,392**

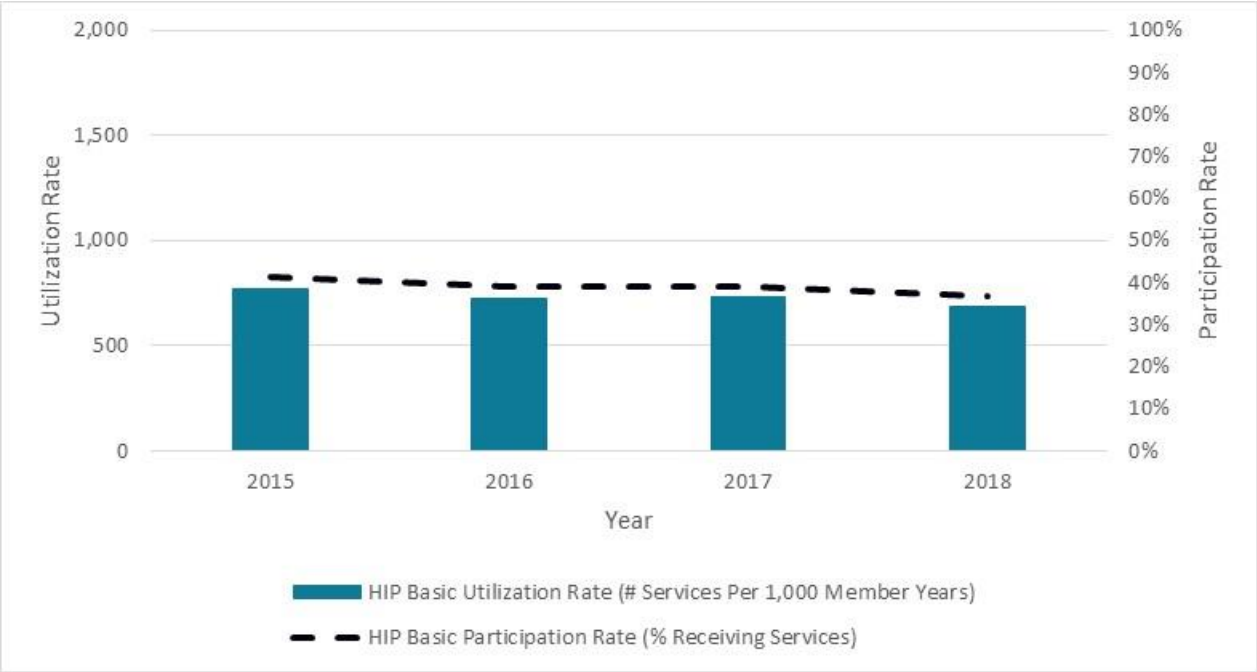
Source: HIP encounter data and monthly enrollment files, February 2015 – December 2018.

Exhibit F.1.11: Dental/Vision Preventive Services Utilization, by Benefit Plan (February 2015 – December 2018)

Benefit Plan	Participation Rate				Utilization Rate			
	2015	2016	2017	2018	2015	2016	2017	2018
HIP Basic Only	12.3%	9.2%	8.8%	7.3%	114	87	85	71
HIP Plus Only	35.8%	32.1%	31.4%	30.8%	487	413	397	390
HIP Switchers	26.0%	22.6%	21.2%	22.5%	304	264	250	258
Total	**27.2%**	**25.4%**	**24.4%**	**25.2%**	**354**	**305**	**288**	**296**

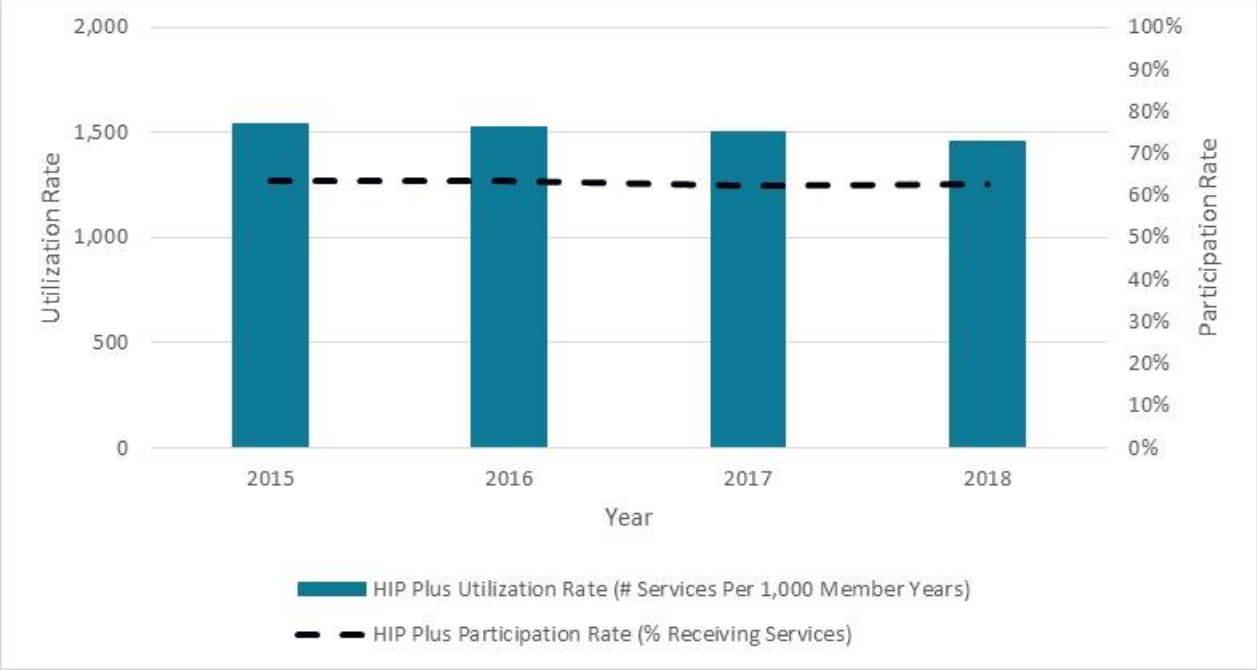
Source: HIP encounter data and monthly enrollment files, February 2015 – December 2018.

Exhibit F.1.12: HIP Basic Only Preventive Services Utilization and Participation Rates (February 2015 – December 2018)



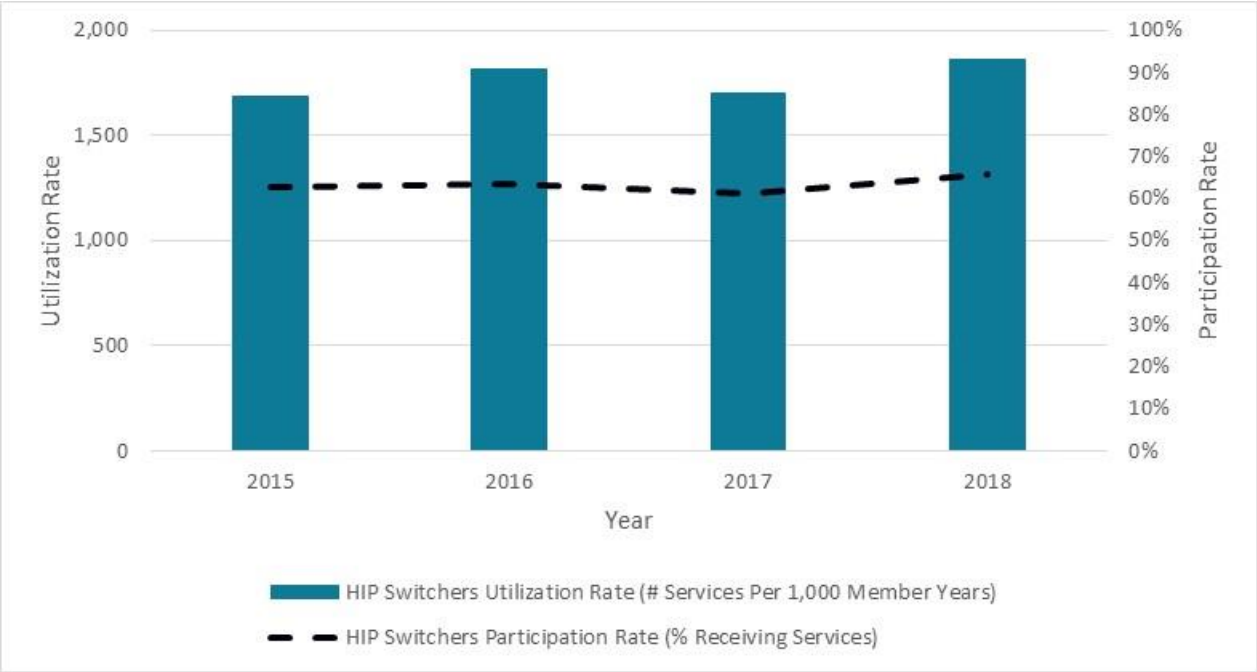
Source: HIP encounter data and monthly enrollment files, February 2015 – December 2018.

Exhibit F.1.13: HIP Plus Only Preventive Services Utilization and Participation Rates (February 2015 – December 2018)



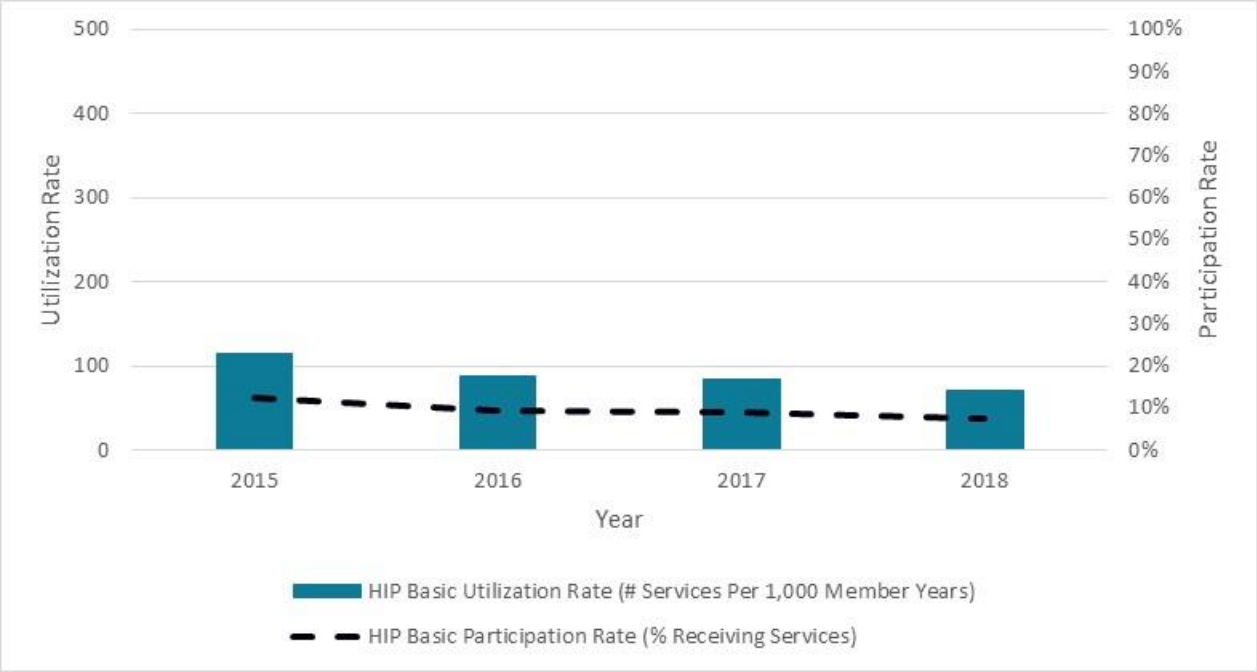
Source: HIP encounter data and monthly enrollment files, February 2015 – December 2018.

Exhibit F.1.14: HIP Switchers Preventive Services Utilization and Participation Rates (February 2015 – December 2018)



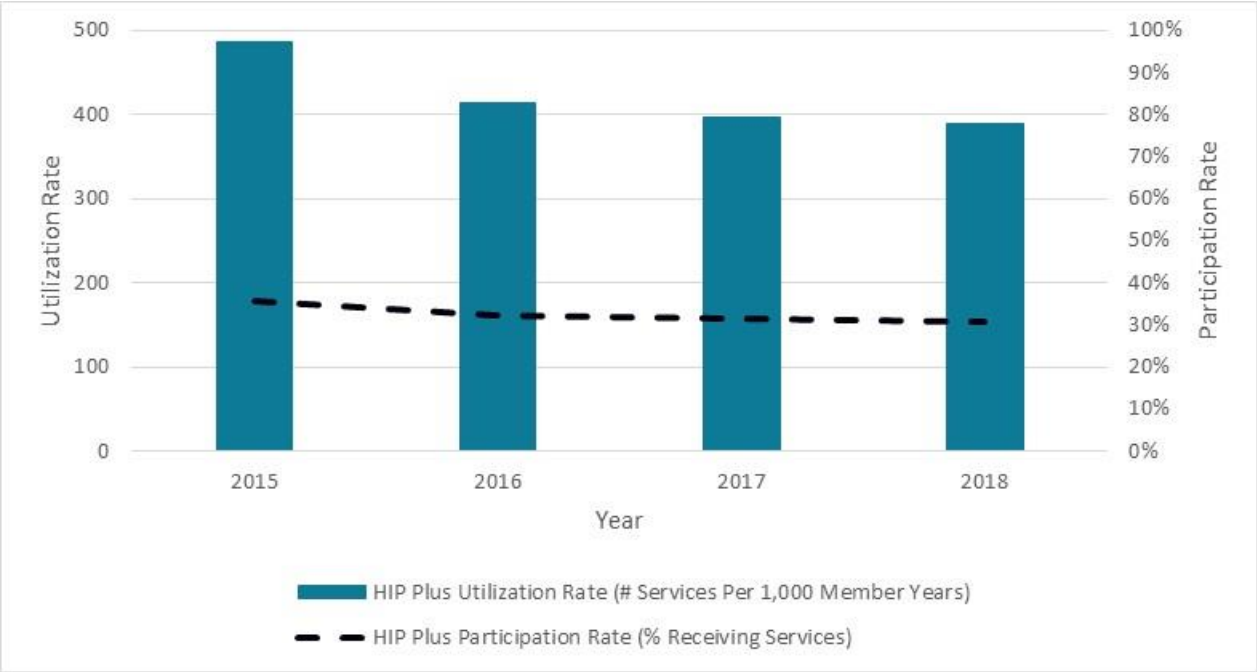
Source: HIP encounter data and monthly enrollment files, February 2015 – December 2018.

Exhibit F.1.15: HIP Basic Only Preventive Dental/Vision Services Utilization and Participation Rates (February 2015 – December 2018)



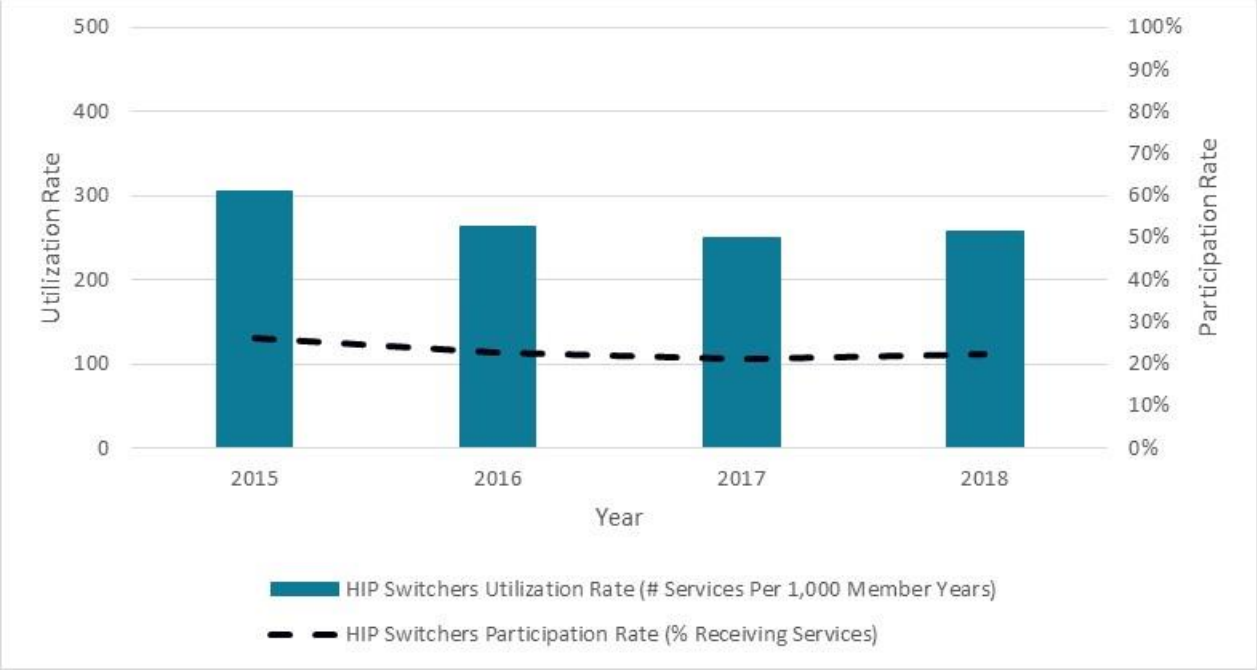
Source: HIP encounter data and monthly enrollment files, February 2015 – December 2018.

Exhibit F.1.16: HIP Plus Only Preventive Dental/Vision Services Utilization and Participation Rates (February 2015 – December 2018)



Source: HIP encounter data and monthly enrollment files, February 2015 – December 2018.

Exhibit F.1.17: HIP Switchers Preventive Dental/Vision Services Utilization and Participation Rates (February 2015 – December 2018)



Source: HIP encounter data and monthly enrollment files, February 2015 – December 2018.

Primary Care Visits

Members who enroll in HIP must choose a primary medical provider (PMP) within their health plan. If the member does not select a PMP, the MCE assists in selecting a PMP for the member. Although members may have a selected PMP, this does not ensure they will regularly access services from their PMP. To gauge members' engagement level with their PMP or other primary care provider, we calculated annual primary care participation rates and annual utilization rates from February 2015 to December 2018 (a description of these rates is available at the beginning of Hypothesis 1).

Definition of Primary Care Visits

We used February 2015 to December 2018 encounter data to identify primary care office and ambulatory care visits using evaluation and management (E&M) procedures, International Classification of Diseases (ICD)-9 and ICD-10 codes, and institutional revenue codes to identify ambulatory visits. We then limited these visits to primary care provider specialties. The PMP specialties include family practice, pediatricians, obstetrician-gynecologist (OB/GYNs), general practitioners, physician assistants, primary care nurse practitioners, internal medicine providers who do not have primary care sub-specialty, and office/ambulatory visits received at FQHCs and RHCs.

Analysis Results for Primary Care Visits

The following narrative describes primary care visit participation and utilization rate trends by member benefit plan category. **Exhibits F.1.18** to **F.1.21** provide a summary of these rates by benefit plan; **Attachment IV: Service Utilization Reports (February 2015 – December 2018)** provides additional detail.

All HIP Members: The participation rate was 55.0% in 2015, followed by two years of decreases to 52.2% in 2017 and then increasing in 2018 to 56.9%. The utilization rate decreased 10% between 2015 and 2017 (2,008 to 1,813 visits per 1,000) then increased 10% approximately back to the 2015 rate (2,011 visits per 1,000) in 2018.

HIP Plus Only Members: The utilization rate for HIP Plus Only members decreased by 2.1% when comparing 2015 and 2018 while the participation rate increased slightly. Both rates decreased from 2016 to 2017. HIP Plus Only members had the highest participation and utilization rates for primary care visits across the benefit plan categories, most notably as compared to HIP Basic Only members. HIP Plus Only members utilized a primary care provider over 2.2 times as frequently as HIP Basic Only members in 2018 (2,315 as compared to 1,040 per 1,000). The HIP Plus member participation rate was 24 percentage points higher than HIP Basic Only in 2018 (60.7% as compared to 36.7%). The gap in both the utilization and participation rates between these two groups of members grew from 2015 to 2018.

HIP Basic Only Members: HIP Basic Only members' participation rate decreased 5.5 percentage points from 42.1% 2015 to 36.7% in 2018. The utilization rate decreased 15% from 2015 to 2016, then increased slightly for an overall 8.9% decrease from 2015 to 2018 (1,141 to 1,040 per 1,000). These members had notably lower participation and utilization rates compared to HIP Plus Only members, as described above.

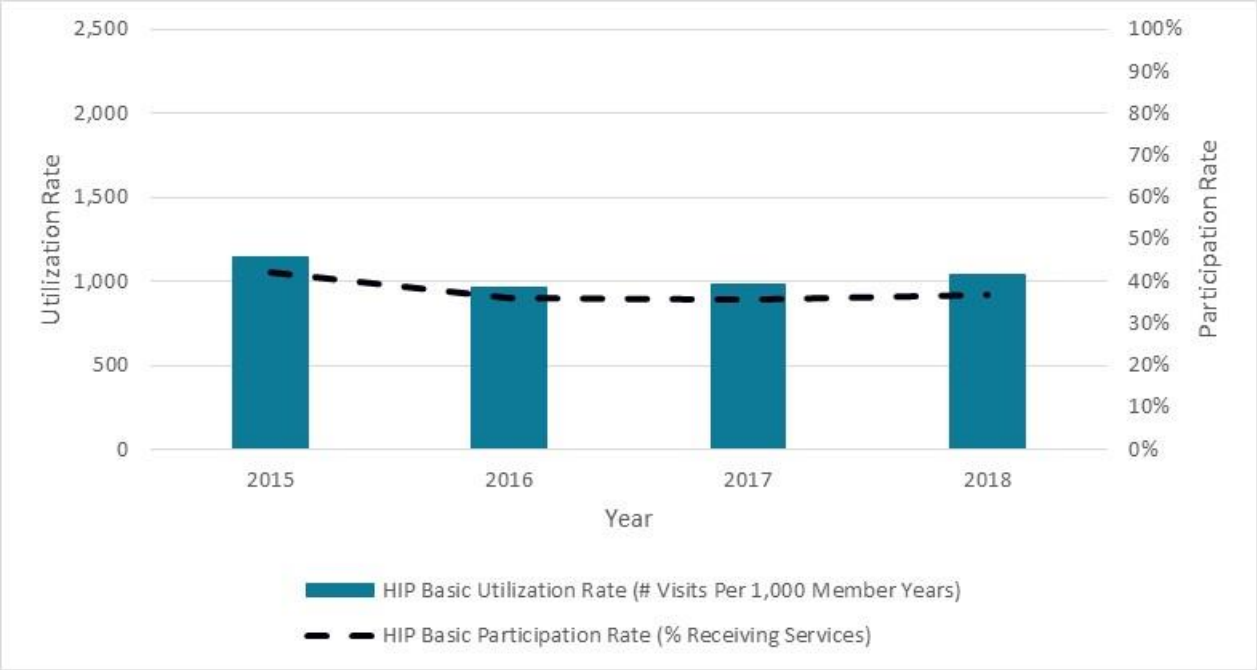
HIP Switchers: HIP Switchers' participation rate increased by 1.1 percentage points from 2015 (59.6%) to 2018 (60.7%) with a notable interim decrease to 54.3% in 2017. The utilization rate decreased by 4.0% overall (2,193 per 1,000 in 2015 as compared to 2,105 per 1,000 in 2018) with an interim decrease to 1,895 per 1,000 in 2017.

Exhibit F.1.18: Primary Care Visits, by Benefit Plan (February 2015 – December 2018)

Benefit Plan	Participation Rate				Utilization Rate			
	2015	2016	2017	2018	2015	2016	2017	2018
HIP Basic Only	42.1%	36.2%	35.8%	36.7%	1,141	966	982	1,040
HIP Plus Only	59.9%	59.0%	57.7%	60.7%	2,364	2,323	2,175	2,315
HIP Switchers	59.6%	57.8%	54.3%	60.7%	2,193	2,022	1,895	2,105
Total	**55.0%**	**53.7%**	**52.2%**	**56.9%**	**2,008**	**1,926**	**1,813**	**2,011**

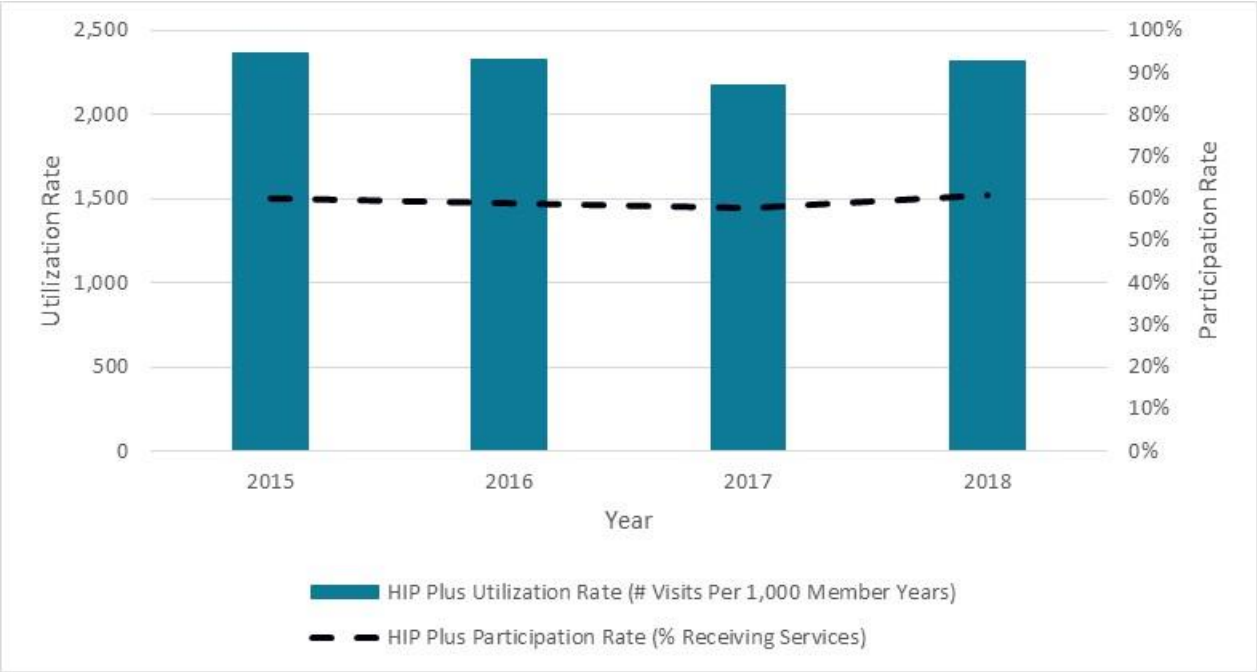
Source: HIP encounter data and monthly enrollment files, February 2015 – December 2018.

Exhibit F.1.19: HIP Basic Only Primary Care Visits Utilization and Participation Rates (February 2015 – December 2018)



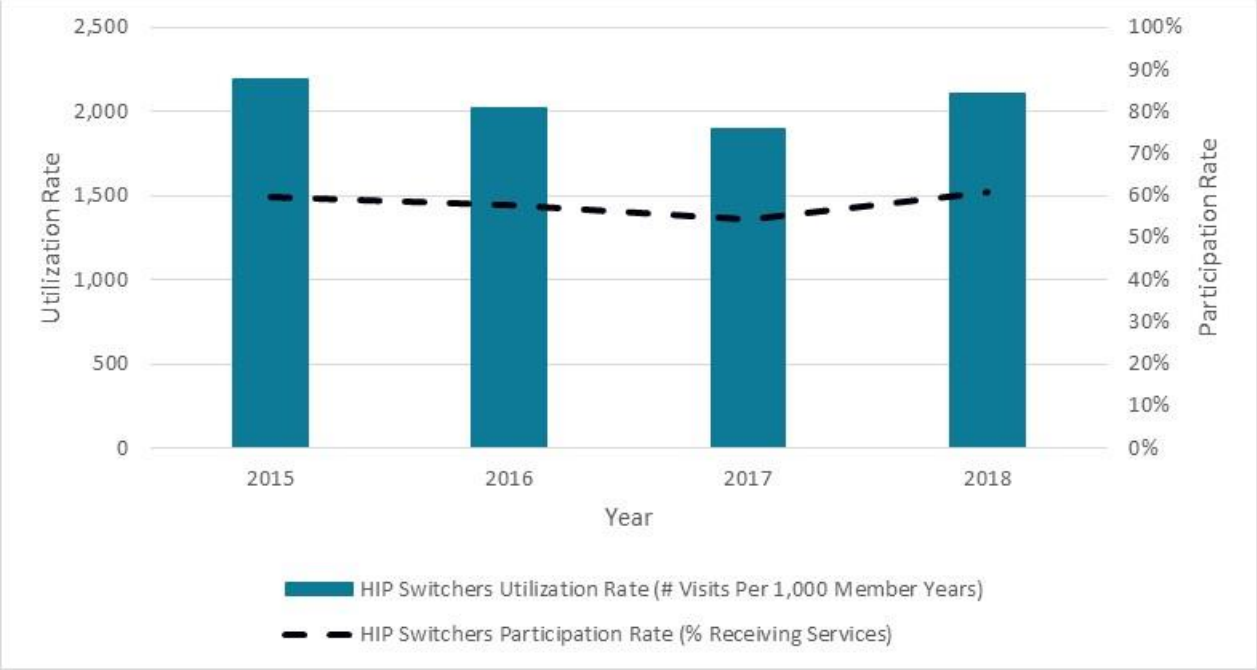
Source: HIP encounter data and monthly enrollment files, February 2015 – December 2018.

Exhibit F.1.20: HIP Plus Only Primary Care Visits Utilization and Participation Rates (February 2015 – December 2018)



Source: HIP encounter data and monthly enrollment files, February 2015 – December 2018.

Exhibit F.1.21: HIP Switchers Primary Care Visits Utilization and Participation Rates (February 2015 – December 2018)



Source: HIP encounter data and monthly enrollment files, February 2015 – December 2018.

Specialty Care Services

HIP members typically access specialty care through a referral from a PMP or health plan. The PMP generally serves as a "gatekeeper" to support appropriate access to the necessary specialist(s) a member may require.

Definition of Specialty Care Services

We used February 2015 to December 2018 encounter data to identify services provided by a range of physician specialists as identified on the medical claim. Examples of provider specialties include allergists, cardiologists, radiologists, and internal medicine providers with subspecialties indicating they are not primary care providers. These services may be provided as part of a hospital inpatient, hospital outpatient, other institutional provider stay, or as part of an ambulatory care visit.

Analysis Results for Specialty Care Services

The following narrative describes specialty care services participation and utilization rate trends by member benefit plan category. **Exhibits F.1.22** to **F.1.25** provide a summary of these rates by benefit plan; **Attachment IV: Service Utilization Reports (February 2015 – December 2018)** provides additional detail.

All HIP members: Both the participation and utilization rates decreased from 2015 to 2018. The participation rate decreased 4.5 percentage points (57.4% in 2015 and 52.9% in 2018) and the utilization rate decreased 12.2% from 2,584 visits per 1,000 in 2015 to 2,270 visits in 2018.

HIP Plus Only members: The utilization and participation rates for HIP Plus Only members both decreased from 2015 to 2018, with a larger dip in 2017. The participation rate decreased 4.9 percentage points from 2015 to 2018 (62.3% to 57.4%) with the utilization rate decreasing 11.3% during that same time period. HIP Plus Only members had higher participation and utilization rates than HIP Basic Only Members and HIP Switchers, but most notably for HIP Basic Only members. HIP Plus Only members utilized specialty care over 2.6 times as frequently as HIP Basic Only members in 2018 (2,750 per 1,000 as compared to 1,052 per 1,000). The HIP Plus Only member participation rate was 23 percentage points higher than HIP Basic Only member rate in 2018 (57.4% as compared to 34.1%). The gap in both the utilization and participation rates between these two groups of members grew from 2015 to 2018.

HIP Basic Only members: Similar to HIP Plus Only members, both the utilization and participation rates for HIP Basic Only members decreased from 2015 to 2018, with a larger dip in 2017. The participation rate decreased 10.5 percentage points from 2015 to 2018 (44.6% to 34.1%) with the utilization rate decreasing 27.6% during that same period. These members had lower participation and utilization rates compared to HIP Plus Only members, as described above.

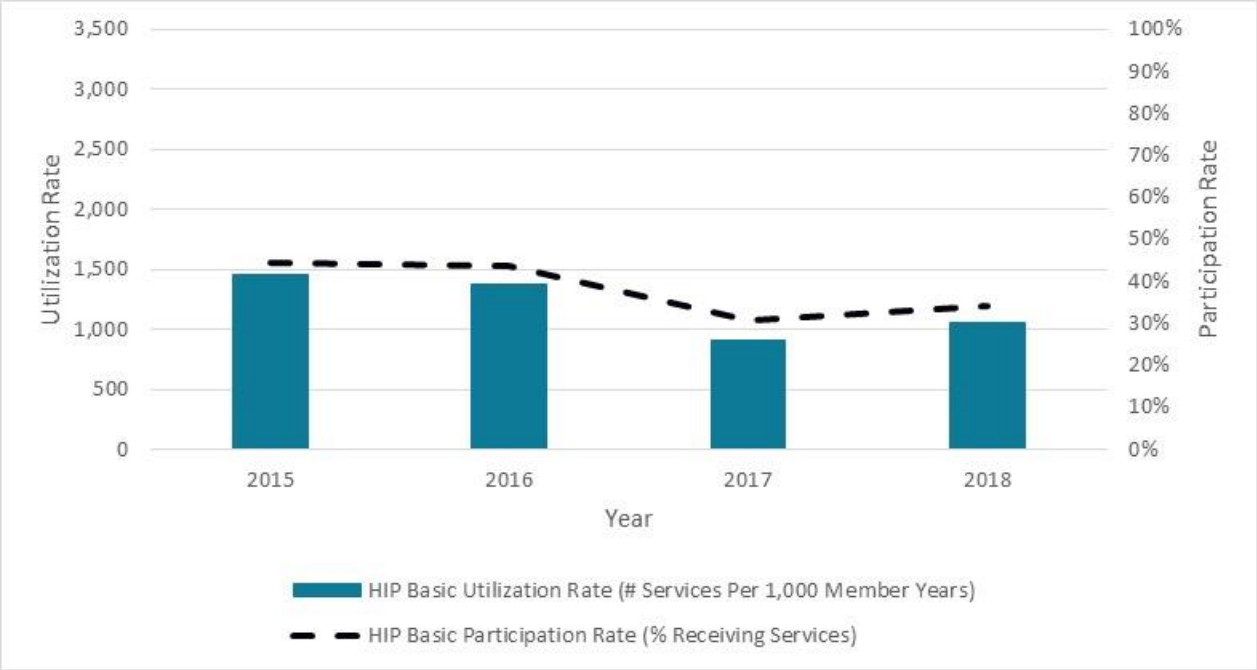
HIP Switchers: Similar to the other benefit plan categories, utilization and participation rates decreased from 2015 to 2018, with a larger dip in 2017. The HIP Switcher member results fell between the HIP Plus Only and HIP Basic Only member results for both the participation and the utilization rate.

Exhibit F.1.22: Specialty Care Services, by Benefit Plan (February 2015 – December 2018)

Benefit Plan	Participation Rate				Utilization Rate			
	2015	2016	2017	2018	2015	2016	2017	2018
HIP Basic Only	44.6%	43.6%	30.8%	34.1%	1,454	1,372	905	1,052
HIP Plus Only	62.3%	63.9%	54.4%	57.4%	3,100	3,292	2,543	2,750
HIP Switchers	61.5%	62.9%	47.8%	53.7%	2,679	2,614	1,850	2,135
Total	**57.4%**	**59.2%**	**47.9%**	**52.9%**	**2,584**	**2,690**	**1,989**	**2,270**

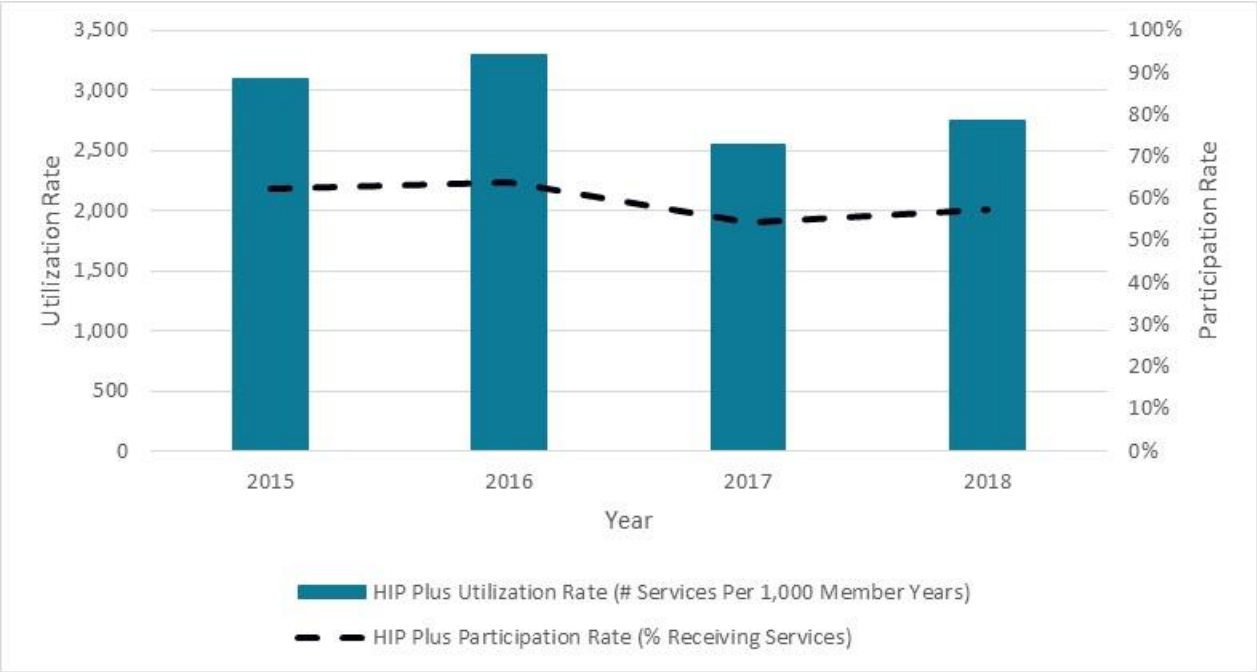
Source: HIP encounter data and monthly enrollment files, February 2015 – December 2018.

Exhibit F.1.23: HIP Basic Only Specialty Care Services Utilization and Participation Rates (February 2015 – December 2018)



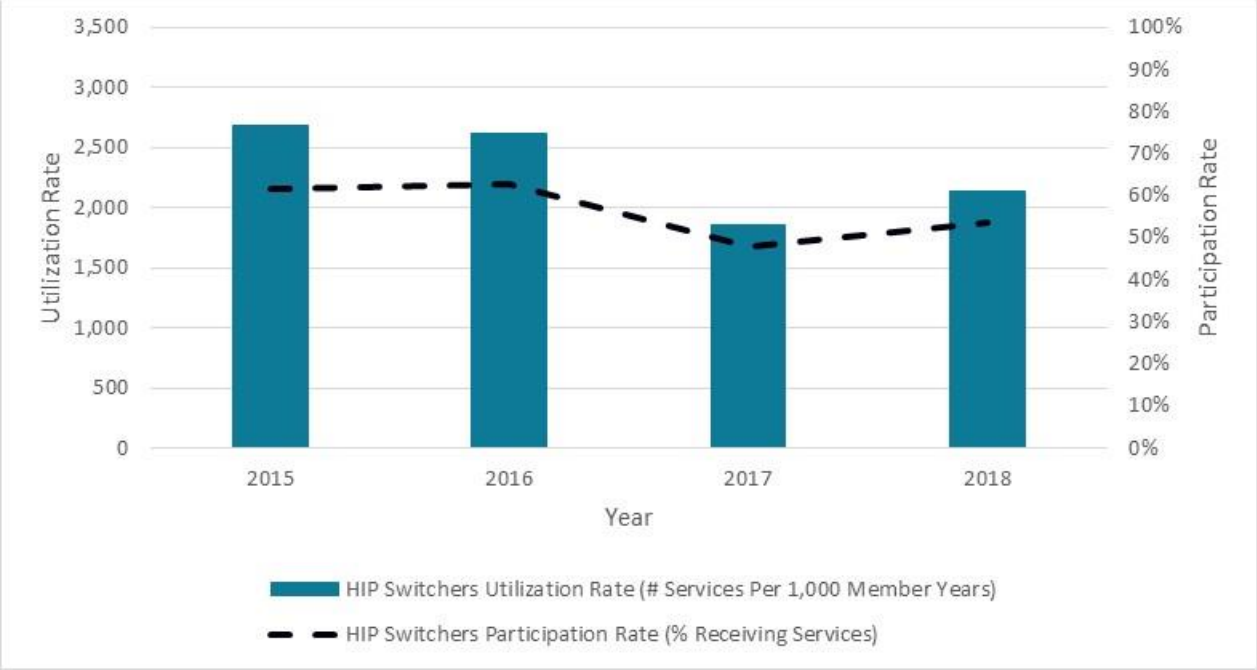
Source: MCE encounter data and monthly enrollment data from February 2015 – December 2018.

Exhibit F.1.24: HIP Plus Only Specialty Care Services Utilization and Participation Rates (February 2015 – December 2018)



Source: MCE encounter data and monthly enrollment data from February 2015 – December 2018.

Exhibit F.1.25: HIP Switchers Specialty Care Services Utilization and Participation Rates (February 2015 – December 2018)



Source: MCE encounter data and monthly enrollment data from February 2015 – December 2018.

Emergency Department Visits

The use of the ED for non-urgent services is commonly considered an inefficient use of resources that may reflect broader health system issues such as the lack of access to primary care or coordinated care.[40,41] Measuring and monitoring ED utilization trends can provide insight into the level of access to PMPs and preventive services within the HIP program.

An October 2017 study conducted by Lewin, assessed the copayment protocol developed by FSSA and approved by CMS in February 2016.[42,43] The assessment examined the impact of a graduated copayment policy on avoiding non-emergent ED visits. Specifically this analysis tested whether a $25 ED copayment after the first non-emergent ED visit (with an associated copayment of $8), affected ED utilization rates. The study also examined the utilization of a nurse hotline, primary care, and urgent care as a source of care to avoid ED visits. The study found few members that incurred the $25 copayment, as well as low utilization of the nurse hotline. Additionally, there was no consistent pattern in the differences in primary care and urgent care visits as the graduated ED copayment policy was not consistent. As of February 1, 2018, the State changed the graduated $25 copayment for non-emergent ED visits to $8 for all ED visits.

This research question analyzed overall ED utilization; see Research Question 2.1 for an analysis of potentially avoidable ED visits.

Definition of Emergency Department Visits

We used February 2015 to December 2018 MCE encounter data to identify ED visits using select CPT codes or revenue codes used to bill ED visits.

Analysis Results for Emergency Department Services

The following narrative describes ED services participation and utilization rate trends by member benefit plan category. **Exhibits F.1.26** to **F.1.29** provide a summary of these rates by benefit plan; **Attachment IV: Service Utilization Reports (February 2015 – December 2018)** provides additional detail.

All HIP members: Both the participation and utilization rates decreased from 2015 to 2018, with the utilization rate decreasing at a faster pace than the participation rate. Specifically, the participation rate increased from 42.3% in 2015 to 44.7% in 2016 before decreasing to a low of 41.1% in 2018. The utilization rate decreased 9.1% from 1,203 per 1,000 member years in 2015 to 1,093 per 1,000 member years in 2018.

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[40] Lin, MP., Baker, O., Richardson, LD., and Schuur, JD. (2018). Trends in Emergency Department Visits and Admission Rates among U.S. Acute Care Hospitals. JAMA Internal Medicine, 178(12),):1708–1710. Retrieved from https://.jamanetwork.com/journals/jamainternalmedicine/article-abstract/2706174

[41] Garthwaite, C. et al. (2019). All Medicaid Expansions Are Not Created Equal: The Geography and Targeting of the Affordable Care Act. Retrieved from https://www.brookings.edu/wp-content/uploads/2019/09/Garthwaite-et-al_conference-draft.pdf

[42] Healthy Indiana Plan 2.0: 2016 Emergency Room Co-Payment Assessment, The Lewin Group, Inc. October 4, 2017, Retrieved from https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/in/Healthy-Indiana-Plan-2/in-healthy-indiana-plan-support-20-2016-emrgncy-room-copymt-assessment-rpt-10042017.pdf

[43] CMS Letter from Andrea Casart to Joseph Moser, Emergency Department Copayment Protocol. (2016). Retrieved from https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/in/Healthy-Indiana-Plan-2/in-healthy-indiana-plan-support-20-appr-emerg-copay-protocol.pdf#page=10&zoom=100,0,306

HIP Plus Only members: The participation rate rose from 36.0% in 2015 to a high of 40.4% in 2016 then reverted back to a rate closer to the 2015 level by 2018 (36.5%). HIP Plus Only members' visits per 1,000, however, decreased almost 12% from 2015 to 2018, indicating that members who have used the ED are doing so at a lower frequency. Unlike the other service areas, the ED participation and utilization rates are lower for HIP Plus Only members as compared to HIP Basic Only members. Additionally, the difference between the rates for these two member groups has decreased over time.

HIP Basic Only members: The utilization rate for HIP Basic members fell 16.3% from 2015 to 2018 (1,345 per 1,000 in 2015 to 1,126 per 1,000 in 2018). The participation rate increased from 48.5% in 2015 to 49.6% in 2016 before decreasing to 47.9% in 2017 and then to a low of 42.8% in 2018.

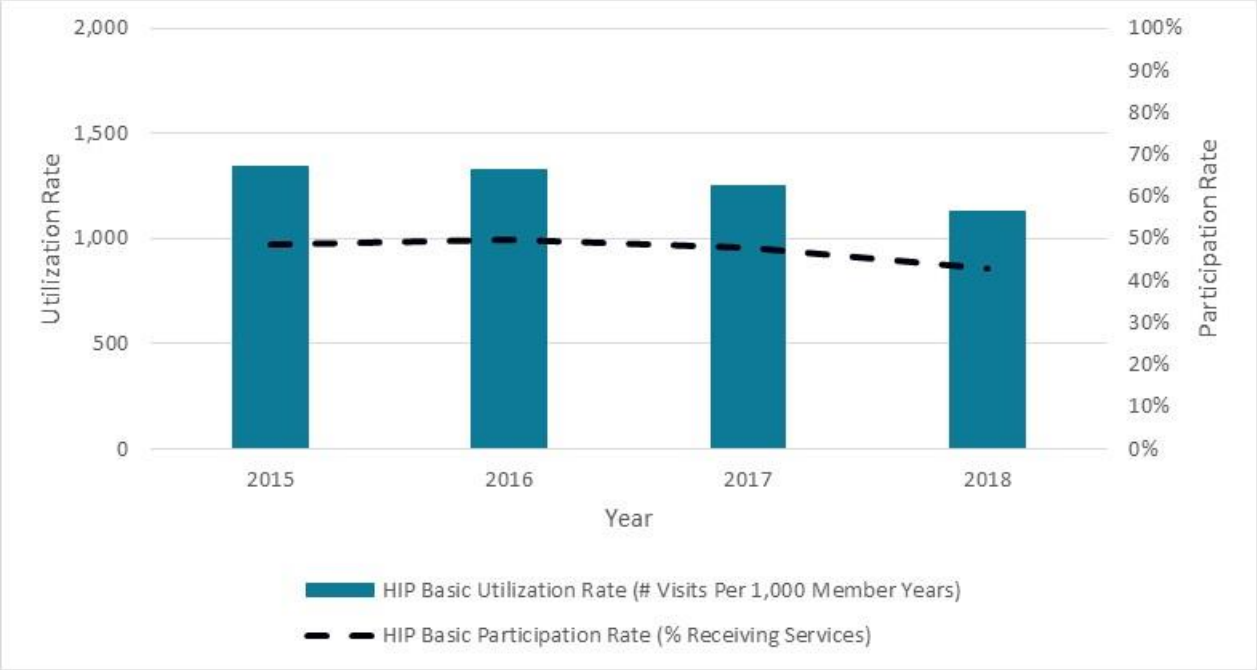
HIP Switchers: Unlike the HIP Plus Only and HIP Basic Only members, the HIP Switcher participation rate increased 4.6 percentage points from 48.3% in 2015 to 52.9% in 2018; the utilization rate increased 2.5% from 2015 to 2018 (1,460 per 1,000 as compared to 1,497 per 1,000).

Exhibit F.1.26: ED Participation and Utilization Rate by Benefit Plan (February 2015 – December 2018)

Benefit Plan	Participation Rate				Utilization Rate			
	2015	2016	2017	2018	2015	2016	2017	2018
HIP Basic Only	48.5%	49.6%	47.9%	42.8%	1,345	1,328	1,249	1,126
HIP Plus Only	36.0%	40.4%	38.4%	36.5%	1,046	1,064	1,003	924
HIP Switchers	48.3%	53.7%	52.6%	52.9%	1,460	1,592	1,550	1,497
Total	**42.3%**	**44.7%**	**43.3%**	**41.1%**	**1,203**	**1,216**	**1,169**	**1,093**

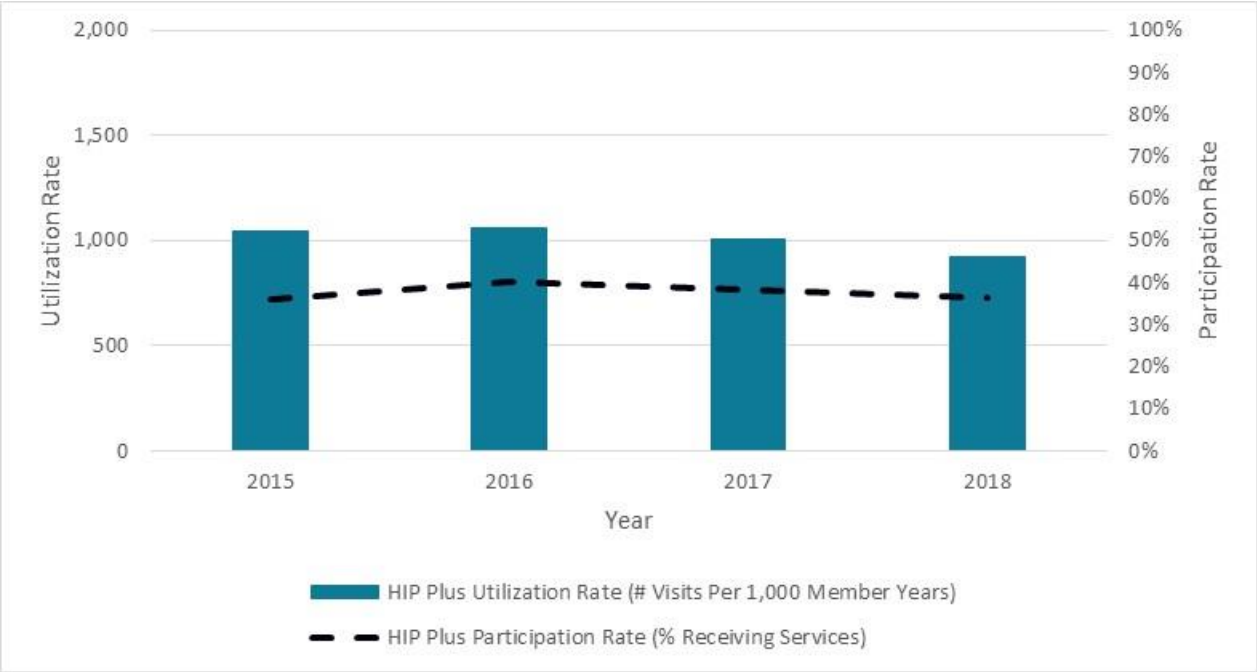
Source: HIP encounter data and monthly enrollment files, February 2015 – December 2018.

Exhibit F.1.27: HIP Basic Only ED Visit Utilization and Participation Rates (February 2015 – December 2018)



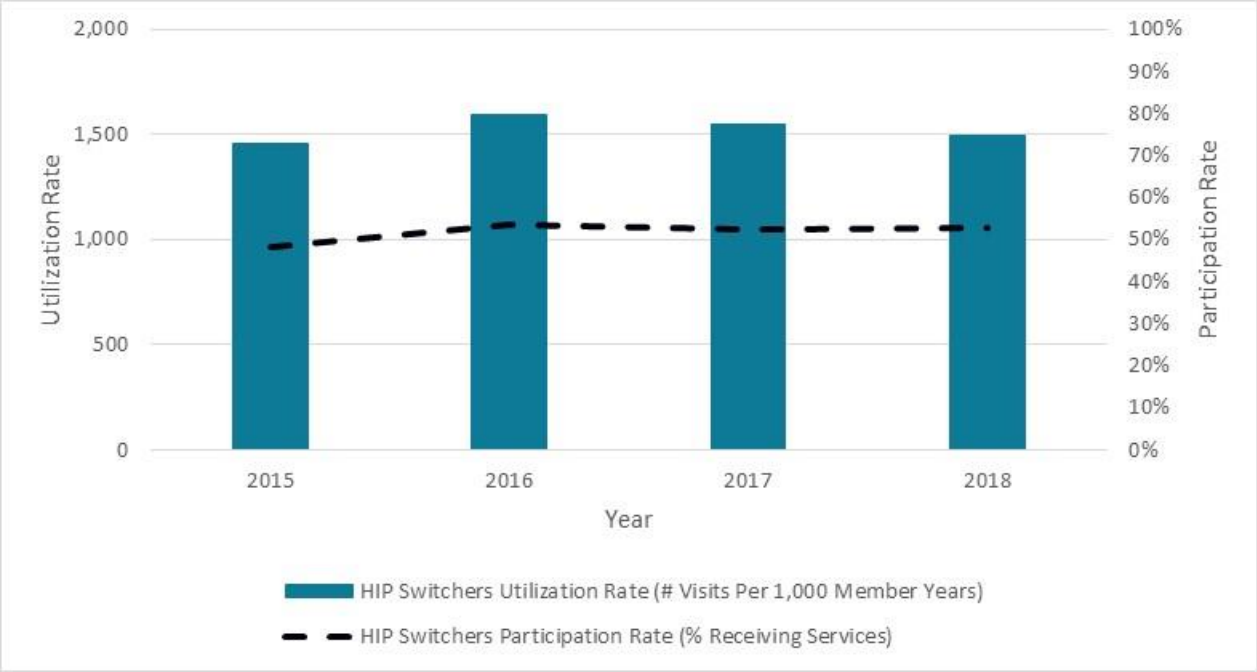
Source: HIP encounter data and monthly enrollment files, February 2015 – December 2018.

Exhibit F.1.28: HIP Plus Only ED Visit Utilization and Participation Rates (February 2015 – December 2018)



Source: HIP encounter data and monthly enrollment files, February 2015 – December 2018.

Exhibit F.1.29: HIP Switchers ED Visit Utilization and Participation Rates (February 2015 – December 2018)



Source: HIP encounter data and monthly enrollment files, February 2015 – December 2018.

Urgent Care Center Visits

The urgent care center represents a relatively new and expanding entity in state health care systems, and may provide a more efficient alternative to EDs for non-emergency care.[44] Urgent care centers treat primary conditions of a severity that do not warrant an ED visit, therefore avoiding the long waits and less efficient delivery provided for non-emergent, yet urgent care needs. The number of urgent care centers, including retail clinics, has grown over the past decade, and these centers are typically located in easily accessible places within a community.[45]

Identification of Urgent Care Center Visits

We used February 2015 to December 2018 claims data to identify urgent care center visits using the urgent care "Place of Service" code on the professional medical claim in addition to an accompanying ambulatory or outpatient procedure code, diagnosis code or revenue code from the HEDIS® value set directory for "Ambulatory Visits Value Set."

Analysis Results for Urgent Care Center Visits

The following narrative describes urgent care center participation and utilization rate trends by member benefit plan category. **Exhibits F.1.30** to **F.1.33** provide a summary of urgent care center participation and utilization rates by benefit plan. **Attachment IV: Service Utilization Reports (February 2015 – December 2018)** provides additional detail.

All HIP members: Both the participation and utilization rates increased overall for HIP members from 2015 to 2018. The participation rate increased from 6.9% for all HIP members in 2015 to 10.4% in 2018, while the utilization rate increased 38.2% from 123 visits per 1,000 in 2015 to 170 visits per 1,000 in 2018. Although the number of urgent care center visits represented only a small portion of ED visits in 2018 (for every visit to an urgent care center, there are over six visits to the ED), urgent care center use is increasing relative to ED utilization. The total number of urgent care center visits in 2015 were 10% of ED visits in 2015 as compared to 16% in 2018.

HIP Plus Only members: HIP Plus Only members were the highest utilizers of urgent care centers with increases over time in the utilization and participation rates. The participation rate increased from 7.9% in 2015 to 11.1% in 2018 (3.2 percentage points) while the utilization rate increased over 29% during the same time period (147 visits per 1,000 in 2015 to 190 visits per 1,000 in 2018). HIP Plus Only members utilized urgent care centers over 1.7 times as frequently as HIP Basic Only members in 2018 (190 visits per 1,000 as compared to 111 visits per 1,000). The HIP Plus Only member participation rate was 3.9 percentage points higher than the HIP Basic Only member rate in 2018 (11.1% as compared to 7.2%).

HIP Basic Only members: HIP Basic Only members' participation rate increased only 2.4 percentage points (4.8% in 2015 as compared to 7.2% in 2018). Over the same time period, however, HIP Basic Only members' urgent care center utilization rate increased 56% from 2015 (71 visits per 1,000) to 2018 (111 visits per 1,000). This combination of slower growth in the participation rate with faster growth in the utilization rate suggests that although a smaller percentage of HIP Basic Only members used urgent care

[44] Weinick, RM., Burns, RM., and Mehrotra, A. (2010). Many Emergency Department Visits Could be Managed at Urgent Care Centers and Retail Clinics. Health Affairs: Medical Malpractice & Errors, 29(9). Retrieved from https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2009.0748

[45] Ibid.

centers, they did so more frequently. These members had notably lower participation and utilization rates compared to HIP Plus Only members, as described above.

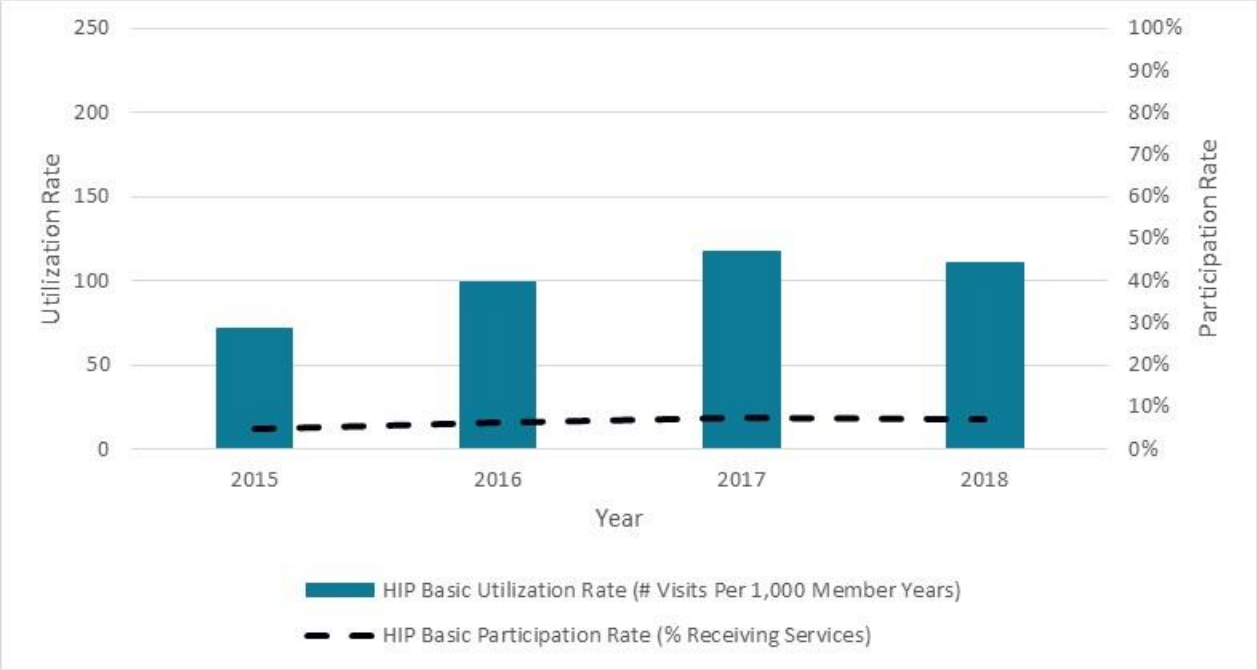
HIP Switchers: These members also experienced overall increases in urgent care center utilization, with a 3.5 percentage point increase in the participation rate from 2015 to 2018 (7.1% as compared to 10.6% in 2018) and a 38% increase in utilization rate (125 visits per 1,000 to 173 visits per 1,000 in 2018).

Exhibit F.1.30: Urgent Care Center Participation and Utilization Rate, by Benefit Plan (February 2015 – December 2018)

Benefit Plan	Participation Rate				Utilization Rate			
	2015	2016	2017	2018	2015	2016	2017	2018
HIP Basic Only	4.8%	6.2%	7.3%	7.2%	71	99	117	111
HIP Plus Only	7.9%	10.8%	11.6%	11.1%	147	192	202	190
HIP Switchers	7.1%	9.9%	10.7%	10.6%	125	172	188	173
Total	**6.9%**	**9.7%**	**10.5%**	**10.4%**	**123**	**165**	**177**	**170**

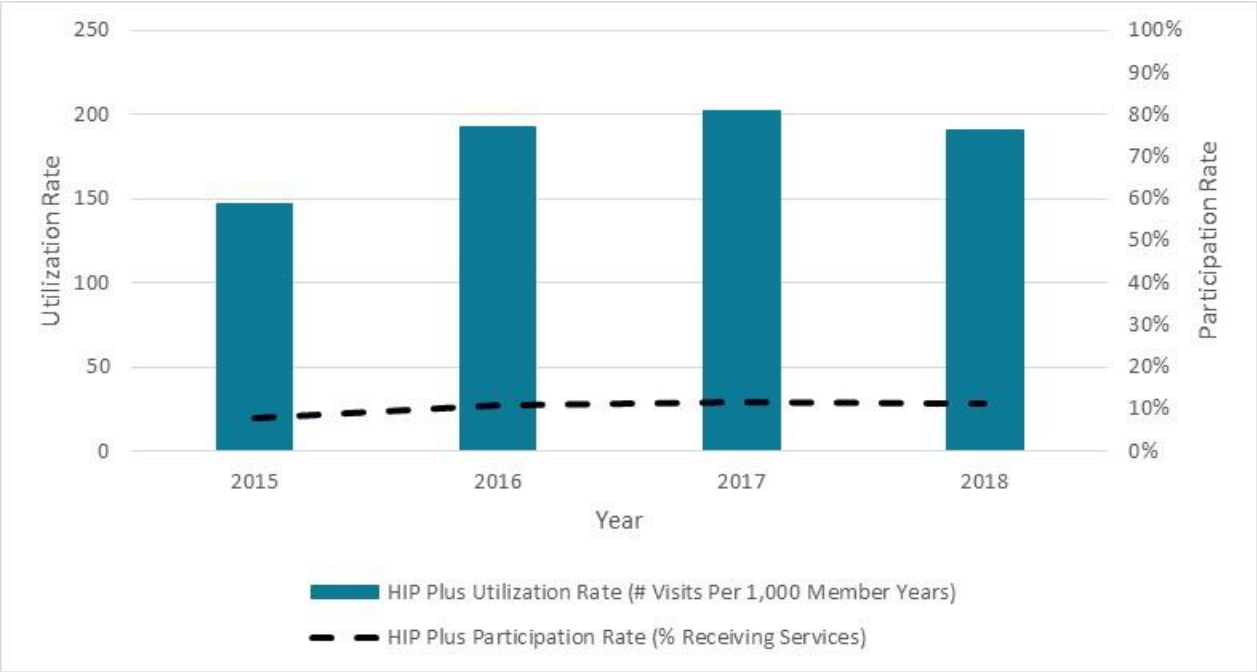
Source: HIP encounter data and monthly enrollment files, February 2015 – December 2018.

Exhibit F.1.31: HIP Basic Only Urgent Care Center Visit Utilization and Participation Rates (February 2015 – December 2018)



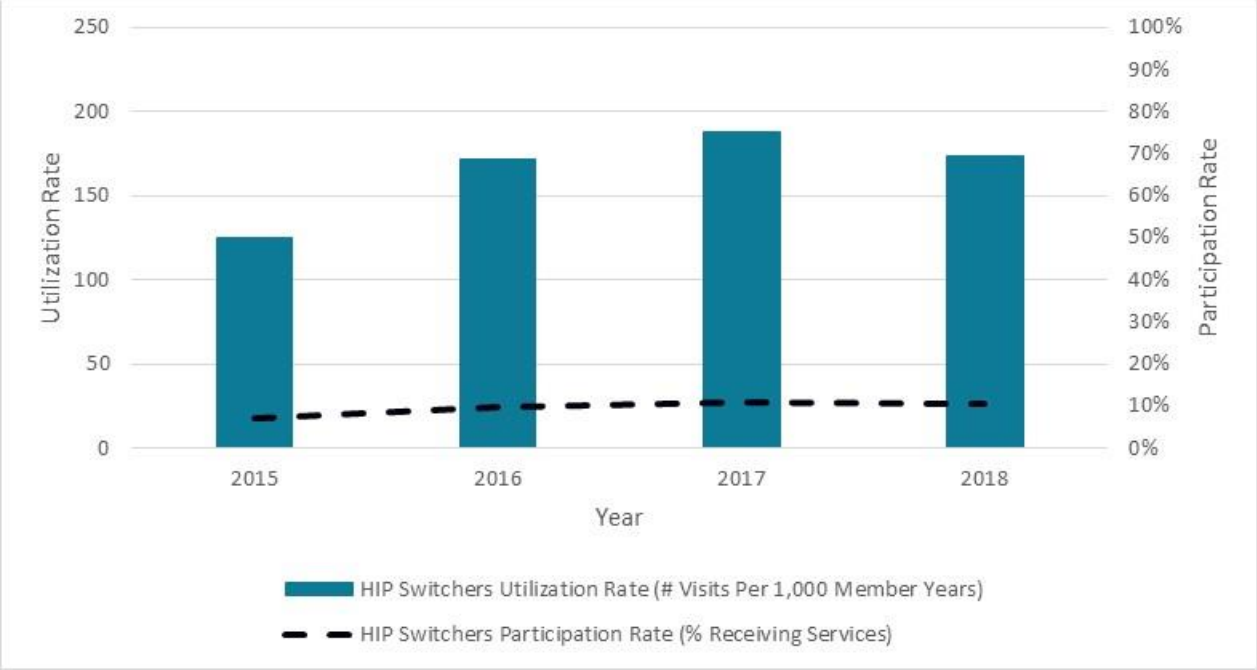
Source: HIP encounter data and monthly enrollment files, February 2015 – December 2018.

Exhibit F.1.32: HIP Plus Only Urgent Care Center Visit Utilization and Participation Rates (February 2015 – December 2018)



Source: HIP encounter data and monthly enrollment files, February 2015 – December 2018.

Exhibit F.1.33: HIP Switchers Urgent Care Center Visit Utilization and Participation Rates (February 2015 – December 2018)



Source: HIP encounter data and monthly enrollment files, February 2015 – December 2018.

Prescription Drug Adherence

The successful treatment of many physical and mental health conditions relies on adherence to a prescription drug regime. Multiple factors influence non-adherence including socio-economic variables, the cost of treatment, interactions between the patient and the health system, the patient's diagnosis, the patient's own cognitive capabilities and social supports, and factors related to the therapy itself. These therapeutic factors include the complexity of the therapy, adverse drug reactions, the duration of the therapy, and the impact of taking multiple medications.[46] Prescription drug adherence indicates people's ability to take responsibility for managing their condition and engaging with the health system to obtain assistance with this task.

Prescription Drug Adherence Analytic Methodology

We used pharmacy data from February 2015 to December 2018 to calculate a standard pharmaceutical measure called "percent days covered" by benefit plan category. This measure shows the percentage of days when the recipient had possession of the medication divided by the days in the period. For example, a member who has a 90-day supply in a 180-day period is 50% adherent. For this calculation, we define long-term adherence as rates of 75% days covered or greater, consistent with HEDIS® standards.

We limited this analysis to members with at least six months of enrollment following the first date in the period when a member filled a prescription for a drug, with no more than one gap (of up to 45 days) in enrollment, consistent with HEDIS® continuous enrollment criteria. We measured adherence for selected drug classes, so the analysis only includes members who filled a prescription in the relevant drug classes. We based the drug classes and the drugs, specifically the National Drug Codes (NDCs) included within each class, on HEDIS® specifications.[47] We included the following drug classes in the analysis: angiotensin converting enzyme (ACE) inhibitors and angiotensin-receptor blockers (ARBs), Attention-Deficit/Hyperactivity Disorder (ADHD) medications, anti-asthmatics, anti-depressants, anti-psychotics, Rheumatoid Arthritis medications, beta-blockers, bronchodilators, and statins.

Prescription Drug Adherence Results

The following narrative describes prescription drug adherence using the methodology described above. **Exhibits F.1.34** and **F.1.35** provide a summary of prescription drug adherence by benefit plan type.

All members: Overall prescription drug adherence in 2018 was the same as 2015; 78.1% of members prescribed drugs in the classes listed above adhered to their drug regimen at least 75% of the covered days. The rate decreased in 2016 to 76.7% but returned to 78.1% by 2018.

HIP Plus Only members: 79.6% of HIP Plus Only members met adherence requirements. Performance decreased from 2015 (80.1%).

[46] van Dulmen, S., Sluijs, E., van Dijk, L., de Ridder, D., Heerdink, R., and Bensing, J. (2007). Patient Adherence to Medical Treatment: A Review of Reviews. BMC Health Services Research, 7(55). Retrieved from https://bmchealthservres.biomedcentral.com/articles/10.1186/1472-6963-7-55

[47] National Committee for Quality Assurance. (2018). HEDIS® 2019 MLD of NDC Codes. Retrieved from https://www.ncqa.org/hedis/measures/hedis-2019-ndc-license/hedis-2019-final-ndc-lists/

HIP Basic Only members: Prescription adherence rates increased for HIP Basic Only members from 71.8% in 2015 to 75.9% in 2018. This rate is lower than HIP Plus Only members (by 3.7 percentage points in 2018), but the difference between the prescription adherence rate for HIP Plus Only members and HIP Basic members is decreasing over time.

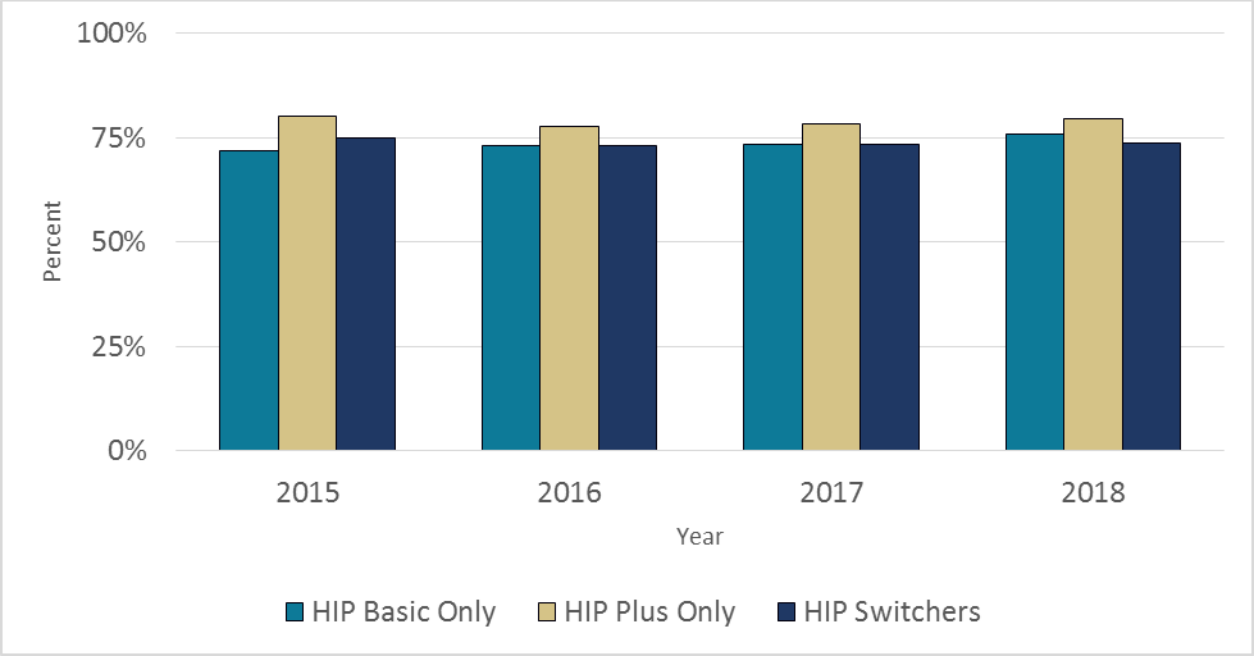
HIP Switchers: As of 2018, HIP Switchers had the lowest rate of prescription drug adherence at 73.7%. This rate decreased from 74.9% in 2015.

Exhibit F.1.34: Prescription Drug Adherence (75% Covered Days), by HIP Benefit Plan (February 2015 – December 2018)

Benefit Plan	2015	2016	2017	2018
HIP Basic Only	71.8%	73.1%	73.5%	75.9%
HIP Plus Only	80.1%	77.8%	78.3%	79.6%
HIP Switchers	74.9%	73.2%	73.3%	73.7%
Total	**78.1%**	**76.7%**	**77.0%**	**78.1%**

Source: HIP encounter data and monthly enrollment files, February 2015 – December 2018.

Exhibit F.1.35: Prescription Drug Adherence (75% Covered Days) for HIP Benefit Plans (February 2015 – December 2018)



Source: HIP encounter data and monthly enrollment files, February 2015 – December 2018.

Disease Management and Pregnancy Management Programs and Enrollment

Individuals with chronic conditions represent a large percentage of health care costs. The CMS estimates that people with chronic conditions, including mental health conditions, account for 90% of the nation's annual health care expenditures.[48] Approximately 60% of U.S. residents had at least one chronic condition in 2014 while 42% have multiple chronic conditions.[49] Individuals with chronic conditions consume significantly more services and have higher costs than individuals without chronic conditions. Health plans have addressed the issue of increasing prevalence of, and costs related to, chronic conditions by implementing disease management programs.

In Indiana, the State requires MCEs to provide disease management programs to their members. These programs must be multidisciplinary, continuum-based approaches to health care delivery that proactively identify members with, or who are at least at risk for, chronic medical conditions. The programs must emphasize the prevention of exacerbation and complications using cost-effective, evidence-based practice guidelines and patient empowerment strategies such as self-management. MCEs can provide incentives to members to participate in the disease management programs. MCEs encourage enrollment and participation in programs for several chronic disease conditions, including asthma, diabetes, chronic obstructive pulmonary disease (COPD), coronary artery disease (CAD), congestive heart failure (CHF) and chronic kidney disease (CKD). MCEs have also established disease management programs for depression, ADHD, and autism/pervasive developmental disorder. A program is available for pregnant mothers as well.

Disease management programs typically are not designed solely to decrease the cost and utilization of health care. Rather, disease management programs focus on improving a member's knowledge of his or her condition, enabling the member to better manage the disease, and guiding the member through the medical system to receive proper care. These steps help improve individuals' adherence to evidence-based treatment standards. Both the short-term and long-term effects of individuals' adherence with evidence-based medical standards are desirable. For example, providing incentives for diabetics to receive an annual HbA1c test does not have a direct and immediate consequence on costs. In fact, it adds a small amount to costs. However, over the long term, if members receive the test annually, and manage their diabetes better (using the HbA1c lab test results), the long-term effects can be significant on cost of care, productivity, and quality of life.

Health plans' design and administration of disease management programs will vary. Disease management programs usually exist alongside other medical management functions within a managed care organization, including population health programs, care management, medication management, and case management programs.

[48] Center for Medicare & Medicaid Services. (2017). National Health Expenditures 2017 Highlights. Retrieved from https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/highlights.pdf

[49] Buttorff, C., Ruder, T., and Bauman, M. (2017). Multiple Chronic Conditions in the United States. Retrieved from https://www.rand.org/content/dam/rand/pubs/tools/TL200/TL221/RAND_TL221.pdf

Approach to Quantitative Analysis

Each MCE provided data on disease management program participation from 2015 to 2018, which included pregnancy management programs. MCEs provide quarterly counts of members identified for enrollment for each of several condition-specific programs, the total number of members enrolled at any point during each quarter, the total number of members enrolled at the end of each quarter, and a count of the total contacts made to members enrolled at any point during the quarter. For this analysis, we focus on the number of members enrolled at any point during the final quarter of each measurement year.

Results of Quantitative Analysis

HIP member enrollment in disease management and pregnancy management programs has increased since 2015, with the highest increases occurring in the pregnancy program category (8,666 members in 2015 as compared to 29,933 in 2018) and the depression program category (13,899 members in 2015 as compared to 29,524 members in 2018).

As a percent of the MCE enrolled population, the pregnancy program category and the depression program category enrolled 5.3% and 5.2% of the MCE members in 2018, respectively, up from 2.2% and 3.6% in 2015. Diabetes, asthma, and COPD program categories each enrolled between 1.3% and 3.6% of the population between 2015 and 2018. **Exhibit F.1.36** shows the percent of the MCE enrolled population who were "ever enrolled" in the disease management each year. **Exhibit F.1.37** presents the annual growth rate for disease management programs.

The number and percent of the enrolled population in disease management programs reflects the prevalence of the disease condition itself and may vary based on the approaches the MCEs use to identify the disease condition. A 2017 study by the American Journal of Preventive Medicine reviewed five studies using a nationally representative survey instrument to measure the prevalence of chronic diseases in an adult Medicaid population.[50] The review showed variation in the prevalence of diseases due to the methodology used to identify patients with a chronic condition. One of the five studies used only self-reported survey responses, for example, while another used actual clinically measured observations such as blood pressure results. As such, a disease management program's performance cannot be fully evaluated based on enrollment numbers alone. Enrollment in disease management programs is also subject to the program design itself. An MCE's disease management program may focus on identifying fewer members, for example, but offer more intensive services or incentives.

[50] Chapel, J. M., et al. Prevalence and Medical Costs of Chronic Diseases Among Adult Medicaid Beneficiaries. *American Journal of Preventive Medicine, 53* (6), S143 - S154.

Exhibit F.1.36: Disease/Pregnancy Management Enrollment (% of MCE enrolled members) (2015 – 2018)

HIP 2.0 Disease / Pregnancy Management Program Category	2015 (N = 389,984)		2016 (N = 520,212)		2017 (N = 556,463)		2018 (N = 569,971)	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent
Asthma	11,299	2.9%	18,690	3.6%	19,799	3.6%	14,483	2.5%
Diabetes	11,214	2.9%	16,932	3.3%	17,251	3.1%	15,308	2.7%
Pregnancy	8,666	2.2%	7,604	1.5%	16,949	3.0%	29,933	5.3%
Chronic Obstructive Pulmonary Disease	5,084	1.3%	11,600	2.2%	12,514	2.2%	8,739	1.5%
Coronary Artery Disease	2,571	0.7%	4,196	0.8%	4,274	0.8%	3,702	0.6%
Congestive Heart Failure	1,259	0.3%	2,183	0.4%	2,308	0.4%	1,834	0.3%
Chronic Kidney Disease	959	0.2%	1,644	0.3%	1,839	0.3%	1,729	0.3%
Depression	13,899	3.6%	31,753	6.1%	33,642	6.0%	29,524	5.2%
ADHD	748	0.2%	1,144	0.2%	1,194	0.2%	1,002	0.2%
Autism/Pervasive Developmental Disorder	28	0.01%	75	0.01%	102	0.02%	127	0.02%

Source: Indiana HIP MCE Quarterly Reports, 2015 – 2018.

Exhibit F.1.37: Disease/Pregnancy Management Enrollment, Annual Growth Rate (2015 – 2018)

HIP 2.0 Disease/Pregnancy Management Program	HIP Disease Management Program Enrollment (% of MCE enrolled population)			
	2015-2016	2016-2017	2017-2018	Average Annual Growth Rate
Asthma	65.4%	5.9%	-26.8%	14.8%
Diabetes	51.0%	1.9%	-11.3%	13.9%
Pregnancy	-12.3%	122.9%	76.6%	62.4%
Chronic Obstructive Pulmonary Disease	128.2%	7.9%	-30.2%	35.3%
Coronary Artery Disease	63.2%	1.9%	-13.4%	17.2%
Congestive Heart Failure	73.4%	5.7%	-20.5%	19.5%
Chronic Kidney Disease	71.4%	11.9%	-6.0%	25.8%
Depression	128.5%	5.9%	-12.2%	40.7%
ADHD	52.9%	4.4%	-16.1%	13.7%
Autism/Pervasive Developmental Disorder	167.86%	36.00%	24.51%	76.12%

Source: Indiana HIP MCE Quarterly Reports.

It is difficult to show causation and even correlation between total enrollment in disease management programs and cost/quality measures for reasons discussed earlier (most notably the latency of the short- and long-term effects of disease management programs). HEDIS® measures, described in more detail below, are perhaps the one indicator of the effectiveness of disease management programs and their ability to sustain and improve quality levels related to evidence-based medical care (**Exhibits F.1.38** to **F.1.43**). For instance, **Exhibit F.1.42 Diabetes: Receiving HbA1c tests** shows rates in line with the national average and **Exhibit F.1.43 Medication Management for People with Asthma 75%,** shows relatively high rates compared to the national average and increasing at a pace faster than the national average. Disease management programs can directly impact member adherence to quality measures such as these.

HEDIS® Quality Process and Outcome Measures

The HEDIS® is a performance measurement tool for Medicaid, Medicare, and commercial health plans across the country. HEDIS® measures results are standard measurements by which consumers and health care payers can judge the quality of health plans. As such, a review of the 2015 to 2018 Indiana Medicaid MCE HEDIS® measures allows for identification of variation between Indiana HIP and national averages, and variation between health plans.

HEDIS® includes more than 90 measurements across six domains of care. These domains include effectiveness of care, access/availability of care, experience of care, utilization, and health plan descriptive information. HEDIS® measures provide a national standard benchmark from which to quantify the quality of care related to preventive services and chronic disease management. Each measure has very specific and standard technical specifications that Indiana HIP MCEs and health plans nationwide must follow. Certified HEDIS® auditors audit the data collection process, information systems, and results. The NCQA website provides additional information on the HEDIS® measures.

Indiana State Statute requires all MCEs to be (or become within one year of operation) NCQA accredited. The NCQA accreditation process requires the completion of specified HEDIS® measures, along with several other structural, process, and outcome-oriented requirements. As of 2019, all four Indiana HIP MCEs maintain NCQA accreditation. However, until 2018, one of the four MCEs had only partially completed HEDIS® and their NCQA accreditation has been granted on an interim basis. Therefore, we do not report this MCE's results in this evaluation. HEDIS® measures are not reported by the MCEs at the HIP Basic Only, HIP Plus Only, and HIP Switcher level.

Methodology for HEDIS® Analysis

Several primary care and preventive measures are included in the HEDIS® measure set. The selected set of measures included in this analysis represent a subset of key preventive care and chronic disease care measures, specifically:

- Breast Cancer Screening (BCS)
- Cervical Cancer Screening (CCS)
- Adult BMI Assessment (ABA)
- Controlling High Blood Pressure (CBP)
- Comprehensive Diabetes Care, receiving HbA1c testing
- Medication Management for People with Asthma 75% (MMA)

For the purposes of this evaluation, Lewin reviewed Indiana HIP MCE performance from 2015 to 2018 and compared results to the most recent and available national Medicaid averages from 2015 to 2017.[51] National Medicaid averages for 2018 were not publicly available when this Interim Evaluation Report was developed.

We display the HEDIS® measure results as percentages, typically the percent of a defined population that has received a specified service. For example, the "Cervical Cancer Screening" measure calculates the percent of women aged 21 to 64 who have received cervical cytology within the past three years or had cervical cytology/human papillomavirus co-testing in the past five years. This measure excludes women who were not continuously enrolled during the measurement year.

HEDIS® Results

The 2015 to 2018 HEDIS® measures analyzed for purposes of the Interim Evaluation Report demonstrate that Indiana HIP MCEs have mostly improved performance from 2015, generally in line with the national average. Three of the four MCEs reported data for 2015 to 2018, and are referred to as MCE 1, MCE 2, and MCE 3. Specifically:

- Five of the six measures showed slight, but steady, increases over the four-year period. The breast cancer screening measure was the exception, with an overall performance drop from 2015 to 2018. MCE 1's breast cancer screening rate decreased 16% from 2015 to 2018, MCE 2's dropped 13%, while MCE 3 showed an increase of 4% from 2015 to 2018. The national average breast cancer screening rate decreased less than 1% from 2015 to 2017.
- Breast cancer screening, cervical cancer screening, and diabetics receiving an HbA1c test measures had a small range of difference between the MCEs. All rates between MCEs for those measures were within a four-percentage-point range. Early detection of breast cancer and cervical cancer can reduce the risk of death from cancer, lead to a larger set of treatment options, and lower health care costs.[52] HbA1c testing in diabetics indicates that a diabetic is seeking treatment for and attempting to manage their condition. The test measures the average level of blood sugar over the last two to three months.[53]
- The Medication Management for People with Asthma Measure shows consistent performance above the national average with increases in measure scores for all three MCEs from 2015 to 2017. The MMA measure shows the percentage of people with asthma who remained on their controller medications at least 75% of the time. By maintaining adherence with asthma controller medications, people with asthma may lower their reliance on rescue medications and avoid emergency situations related to their asthma.[54] This, in turn, may lead to a decrease in ED visits. The 2017 Medicaid national average rate of 36.9% was surpassed by MCE 1's 51.0% rate, MCE 2's 48.4% rate, and MCE 3's 51.7% rate in 2017. Each MCE showed more improvement in 2018 as compared to 2017.

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[51] National Committee for Quality Assurance. (2018). The State of Health Care Quality. Retrieved from https://www.ncqa.org/report-cards/health-plans/state-of-health-care-quality-report/

[52] American Cancer Society. (2017). "American Cancer Society Recommendations for the Early Detection of Breast Cancer." Retrieved from https://www.cancer.org/cancer/breast-cancer/screening-tests-and-early-detection/american-cancer-society-recommendations-for-the-early-detection-of-breast-cancer.html

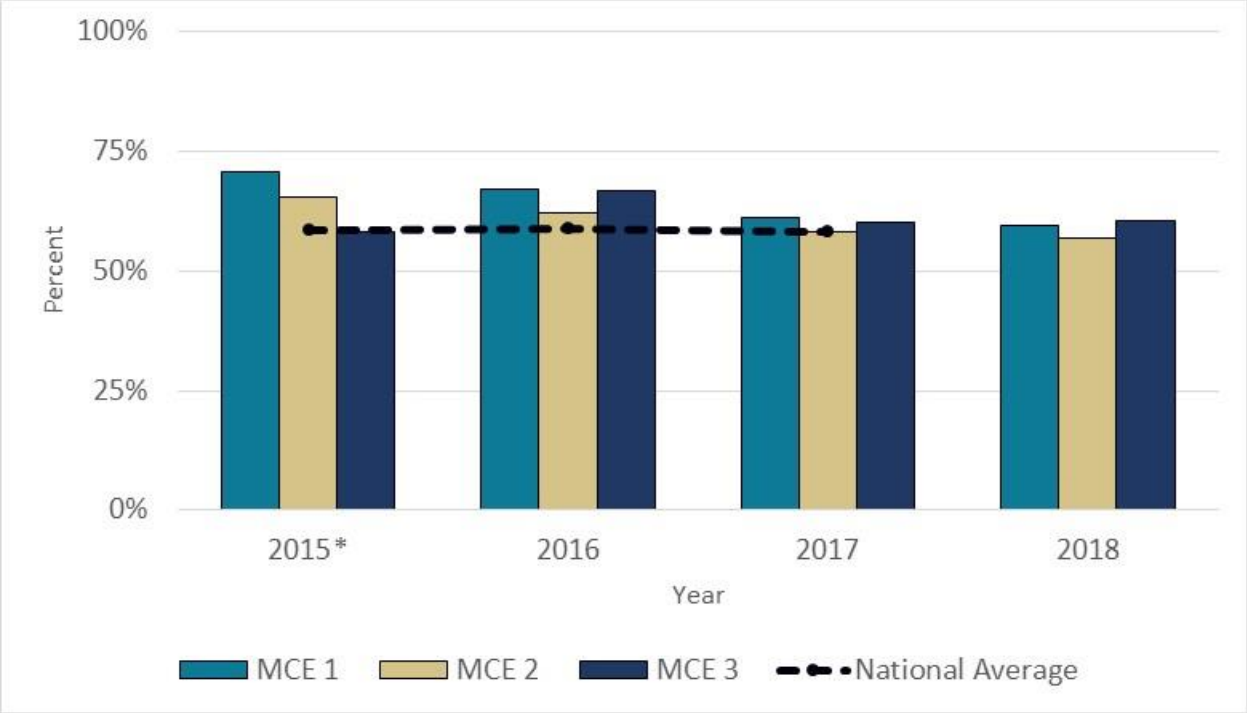
[53] WebMD, Hemoglobin A1c (HbA1c Test for Diabetes). Retrieved from https://www.webmd.com/diabetes/guide/glycated-hemoglobin-test-hba1c

[54] National Committee for Quality Assurance. (2018). The State of Health Care Quality. Retrieved from https://www.ncqa.org/report-cards/health-plans/state-of-health-care-quality-report/

- In 2017, the three MCEs performed better than the national Medicaid HMO average on at least four of the six selected measures, specifically:
    - Adult BMI Assessment (ABA)
    - Comprehensive Diabetes Care, receiving HbA1c testing
    - Breast Cancer Screening (BCS)
    - Medication management for People with Asthma 75% (MMA)
    - From 2015 to 2017, two of the three MCEs performed below the national Medicaid HMO average on two of the six selected measures, specifically
    - Controlling High Blood Pressure (CBP)
    - Cervical Cancer Screening (CCS)

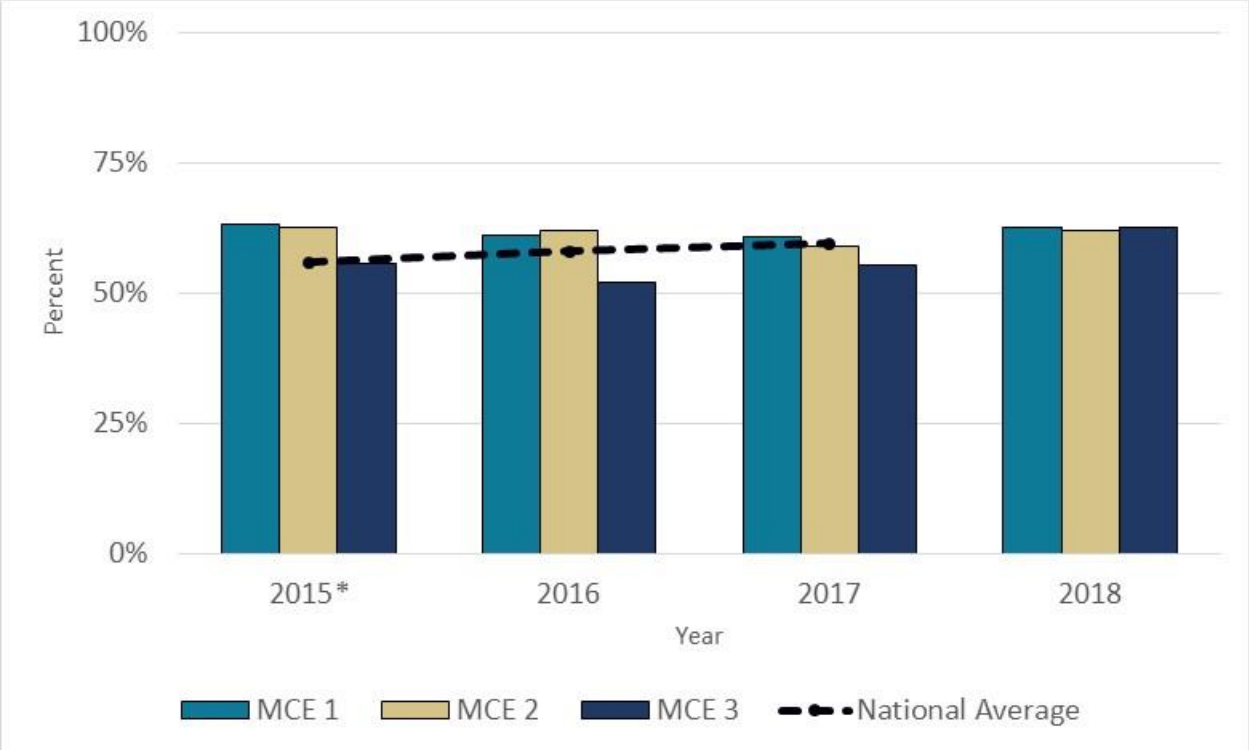
Exhibits F.1.38 to **F.1.43** provide a summary of each HEDIS® measure analyzed.

Exhibit F.1.38: Breast Cancer Screening HEDIS® Results, by MCE (2015 – 2018)



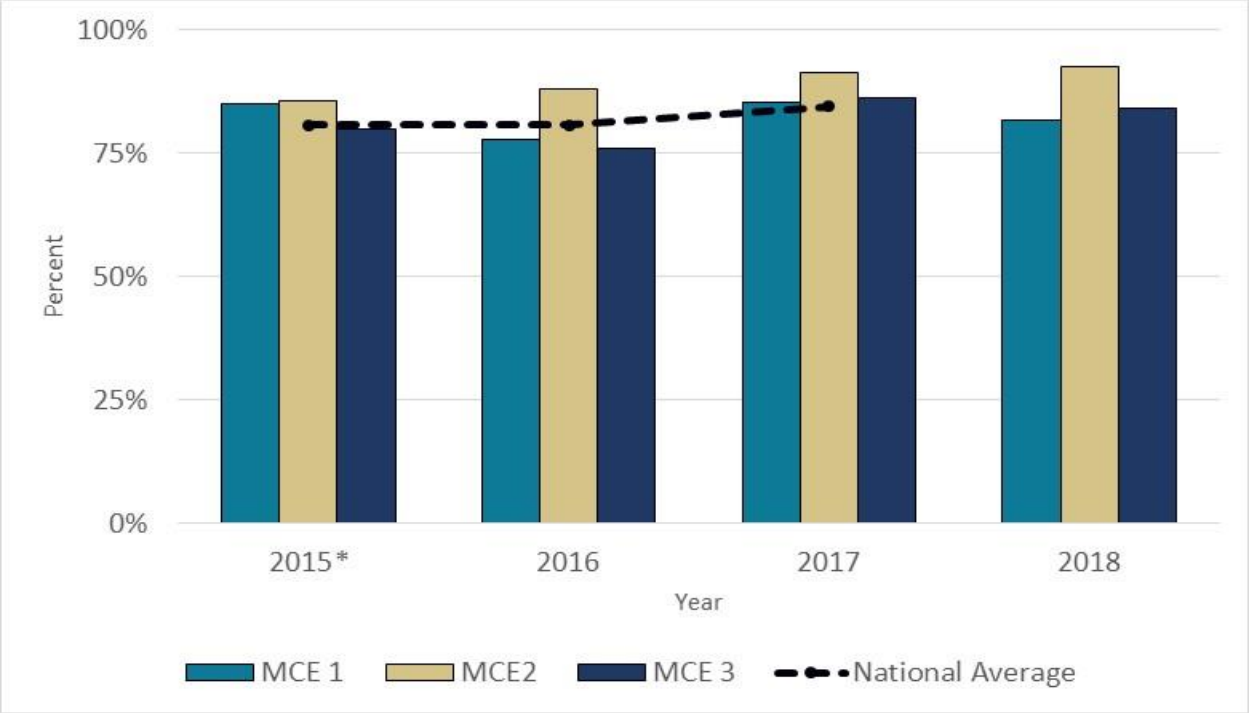
Source: Indiana HIP 2.0 MCE Annual HEDIS® Reports, 2015 – 2018.
Note: For 2015, the asterisk represents that HIP 2.0 was not yet in effect in January 2015.

Exhibit F.1.39: Cervical Cancer Screening HEDIS® Results, by MCE (2015 – 2018)



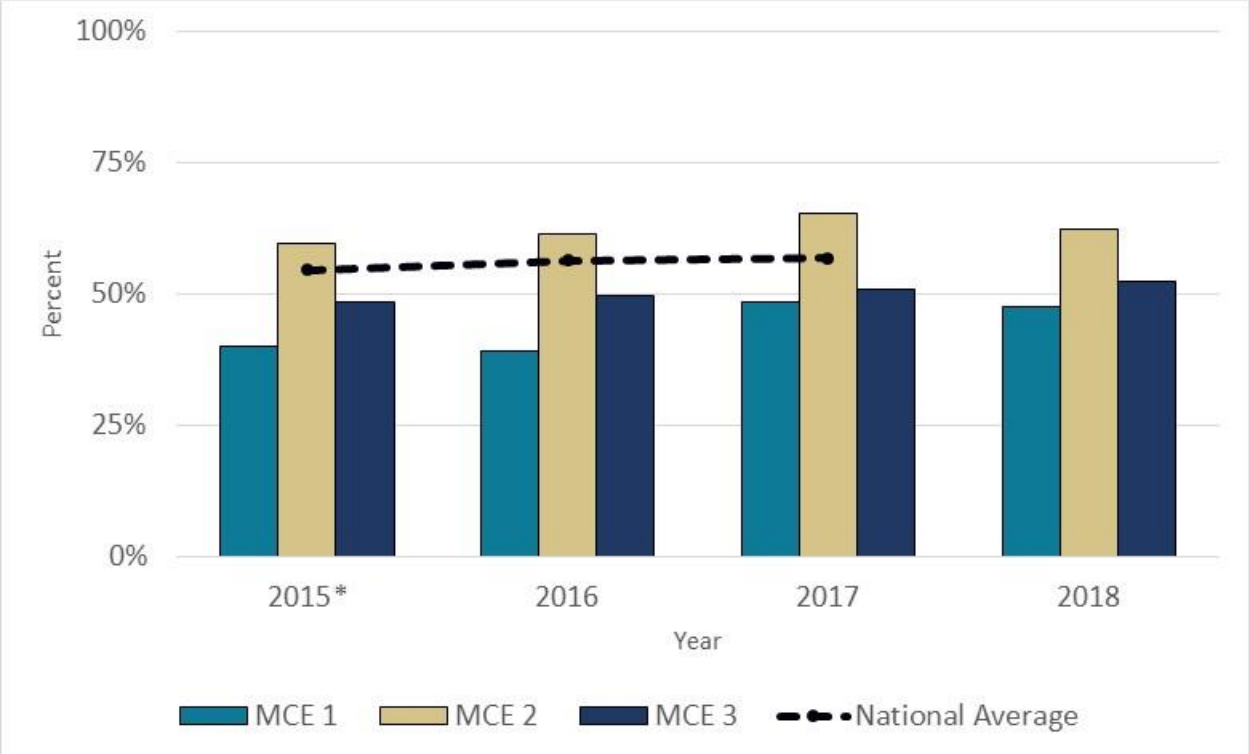
Source: Indiana HIP 2.0 MCE Annual HEDIS® Reports, 2015 – 2018.
Note: For 2015, the asterisk represents that HIP 2.0 was not yet in effect in January 2015.

Exhibit F.1.40: Adult BMI Assessment HEDIS® Results, by MCE (2015 – 2018)



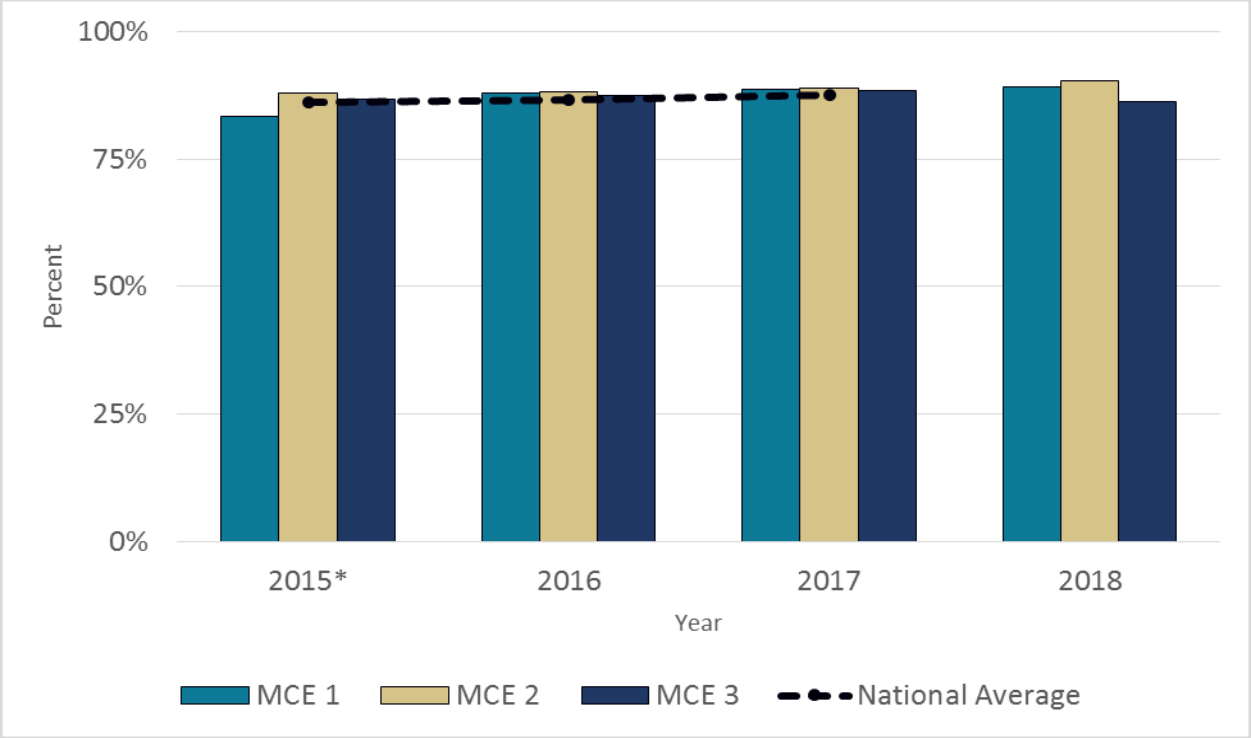
Source: Indiana HIP 2.0 MCE Annual HEDIS® Reports, 2015 – 2018.
Note: For 2015, the asterisk represents that HIP 2.0 was not yet in effect in January 2015.

Exhibit F.1.41: Controlling High Blood Pressure HEDIS® Results, by MCE (2015 – 2018)



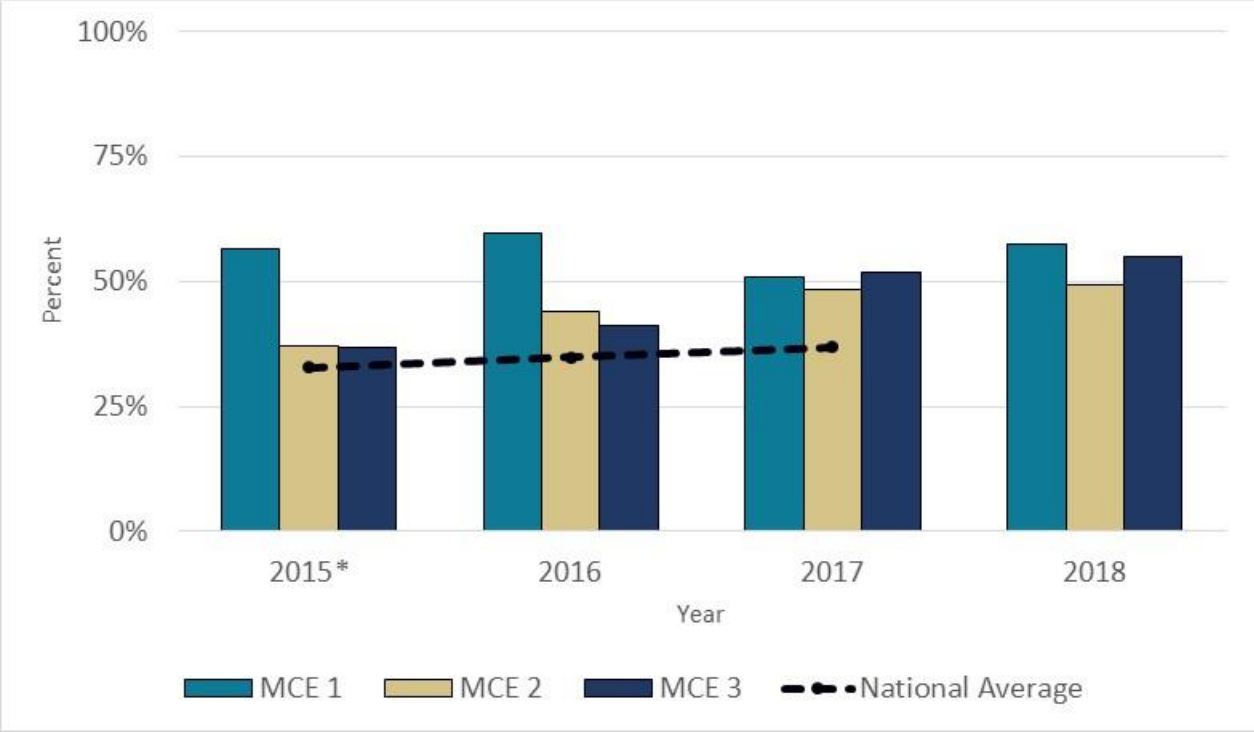
Source: Indiana HIP 2.0 MCE Annual HEDIS® Reports, 2015 – 2018.
Note: For 2015, the asterisk represents that HIP 2.0 was not yet in effect in January 2015.

Exhibit F.1.42: Diabetes: Receiving HbA1c test HEDIS® Results, by MCE (2015 – 2018)



Source: Indiana HIP 2.0 MCE Annual HEDIS® Reports, 2015 – 2018.
Note: For 2015, the asterisk represents that HIP 2.0 was not yet in effect in January 2015.

Exhibit F.1.43: Asthma Medication Management 75% HEDIS® Results, by MCE (2015 – 2018)



Source: Indiana HIP 2.0 MCE Annual HEDIS® Reports, 2015 – 2018.
Note: For 2015, the asterisk represents that HIP 2.0 was not yet in effect in January 2015.

Hypothesis 2 – Unnecessary emergency department service will not rise over time for HIP members.

This hypothesis focuses on examining whether HIP enrollment discourages unnecessary ED use. As described in Hypothesis 1, the ED is widely recognized as a misused and inefficient setting for delivering care to patients with non-emergent conditions.[55] The issue is of particular concern for state policymakers as nationally, Medicaid beneficiaries utilize the ED at nearly 4.5 times that of privately insured individuals and Medicaid policy is evolving in an attempt to reduce non-urgent use of EDs and improve the appropriateness of care in different settings.[56,57] New alternatives to ED care are becoming available; in addition to urgent care centers and retail clinics, internet-based telemedicine now offers a viable option for non-emergent and primary care treatable conditions.

Primary Research Question 2.1 – How have avoidable emergency department visits among HIP members changed over time?

To answer this research question, we calculated the percent of avoidable ED visits for HIP Basic Only, HIP Plus Only, and HIP Switchers by benefit plan category from February 2015 to December 2018.[58] This analysis does not take into consideration whether members were continuously enrolled during each annual period. This analysis further informs the analysis of the ED and urgent care center participation rates and utilization rates discussed in Hypothesis 1. It also informs discussions regarding access to primary care services.

Brief Summary: The New York University (NYU) Algorithm identified approximately 45% of ED visits in the HIP program in 2018 as "avoidable," that is, they are either "non-emergent" or "emergent—primary care treatable." The overall avoidable ED rate decreased from 2015 to 2018, from a high of 49.5% in 2015 to a low of 45.1% in 2018. When stratified by benefit plan type, HIP Basic Only members had the highest percentage of avoidable ED visits in 2018 at 46.3% compared to 45.2% for HIP Plus Only and 44.1% for HIP Switchers.

Approach to Analysis for Avoidable ED

Our analysis of avoidable ED visits used encounter data from February 2015 to December 2018 as submitted by the HIP MCEs. We used the NYU Avoidable ED algorithm, developed by John Billings.[59] The algorithm was developed to evaluate a set of ED cases and calculate an expected value and percentage of ED visits into the four main categories as described in **Exhibit F.1.44**.

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55 Kim, H., McConnell, KJ., and Sun, BC. (2017). Comparing Emergency Department Use Among Medicaid and Commercial Patients Using All-Payer All-Claims Data. Population Health Management, 20(4), 271-277. Retrieved from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5564052/#B1

56 National Center for Health Statistics. (2018). Health, United States, 2017: With Special Feature on Mortality. Retrieved from https://www.cdc.gov/nchs/data/hus/hus17.pdf

57 Mann, Cindy. (2014). Reducing Nonurgent Use of Emergency Departments and Improving Appropriate Care in Appropriate Settings. Retrieved from https://www.medicaid.gov/federal-policy-guidance/downloads/cib-01-16-14.pdf

58 We did not include months when an individual had conditional eligibility or presumptive eligibility status, or members that were eligible for Emergency Room services only (Emergency Room services flag of "Y").

59 NYU Wagner Graduate School of Public Service. (2016). NYU ED Algorithm Information Page. Retrieved from http://wagner.nyu.edu/faculty/billings/nyued-articles

Exhibit F.1.44: Avoidable ED Visit Algorithm, Classifications

ED Visit Classification	Description
Non-emergent	Immediate medical care was not required within 12 hours
Emergent/Primary Care Treatable	Treatment was required within 12 hours, but care could have been provided effectively and safely in a primary care setting
Emergent - ED Care Needed - Preventable/Avoidable	ED care was required based on the complaint or procedures performed/resources used, but the emergent nature of the condition was potentially preventable/avoidable if timely and effective ambulatory care had been received during the episode of illness
Emergent - ED Care Needed – Non-Preventable/Avoidable	ED care was required and ambulatory care treatment could not have prevented the condition

The algorithm also categorizes ED stays into additional categories to identify if they are:

- Mental-health related
- Alcohol related
- Substance-abuse related
- Injury related
- Unclassified

The model was "patched" in 2017 to provide capability for the algorithm to use ICD-10 codes, which became widely used in the U.S. in 2016. For this analysis, we use the "patched" version, which allows us to use both ICD-9 and ICD-10 diagnosis codes from HIP ED claims.

The NYU Avoidable ED Algorithm has gained wide acceptance since its introduction in 2000.[60] This analysis focuses on the "non-emergent" and "emergent-primary care treatable" classifications as *avoidable ED visits*. These two classifications and the conditions they include are considered avoidable and treatable in a primary care setting. In a 2008 study by The Lewin Group and General Dynamics Information Technology, it was found that just over one-third of the avoidable visits were for diagnoses related to acute bronchitis, inflammation of the middle ear, inflammation of the throat, voice disturbance and symptoms referable to the back.[61]

Analysis Results for Avoidable ED

The following narrative describes avoidable ED visits rate trends by member benefit plan category. **Exhibits F.1.45** to **F.1.50** provide a summary of these rates by benefit plan; **Attachment IV.6a: Service Utilization Reports (February 2015 – December 2018)** provides additional detail including all eight ED classifications used by the NYU Algorithm.

[60] Johnston, Kenton J et al. (2017). A "Patch" to the NYU Emergency Department Visit Algorithm. Health Services Research, 52(4), 1264-1276. Retrieved from https://www.ncbi.nlm.nih.gov/pubmed/28726238

[61] The Lewin Group/General Dynamics Information Technology. (2012). Evaluating Emergency Department Utilization: For Researchers using the Centers for Medicare and Medicaid Services Chronic Condition Data Warehouse (CCW).

The NYU Algorithm identified approximately 45.1% of ED visits in the HIP program in 2018 as "avoidable," that is, either they are either "non-emergent" or "emergent—primary care treatable." The overall avoidable ED rate decreased from 2015 to 2018, from a high of 49.5% in 2015 to the low of 45.1% in 2018. When stratified by benefit plan type, HIP Basic Only members had the highest percentage of avoidable ED visits in 2018 at 46.3% compared to 45.2% for HIP Plus Only and 44.1% for HIP Switchers. The avoidable ED rate decreased across all three benefit plan types from 2015 to 2018.

The drop in the avoidable ED rate from February 2015 to December 2018 is mostly due to the drop in the non-emergent subset of ED Visits. The overall rate for non-emergent ED visits decreased 4.1 percentage points from 23.8% to 19.7%. Each benefit plan type shows decreases of non-emergent visits from 2015 to 2018. This suggests that HIP members are using the ED less frequently for conditions that the NYU Algorithm does not consider an emergency.

Exhibit F.1.45: Avoidable ED Visits as a Percent of Total ED Visits, by Benefit Plan (February 2015 – December 2018)

Benefit Plan	2015	2016	2017	2018
HIP Basic Only	50.5%	47.6%	47.4%	46.3%
HIP Plus Only	48.0%	45.1%	45.3%	45.2%
HIP Switchers	51.2%	47.1%	46.2%	44.1%
All Members	**49.5%**	**46.2%**	**46.1%**	**45.1%**

Source: HIP encounter data files, February 2015 – December 2018.
Note: Avoidable ED visits represent the sum of non-emergent ED visits and emergent/primary care treatable ED visits.

Exhibit F.1.46: Non-Emergent ED Visits as a Percent of Total ED Visits, by Benefit Plan (February 2015 – December 2018)

Benefit Plan	2015	2016	2017	2018
HIP Basic Only	24.3%	22.2%	21.5%	20.5%
HIP Plus Only	22.6%	20.5%	20.1%	19.6%
HIP Switchers	25.8%	21.7%	20.8%	19.4%
All Members	**23.8%**	**21.2%**	**20.7%**	**19.7%**

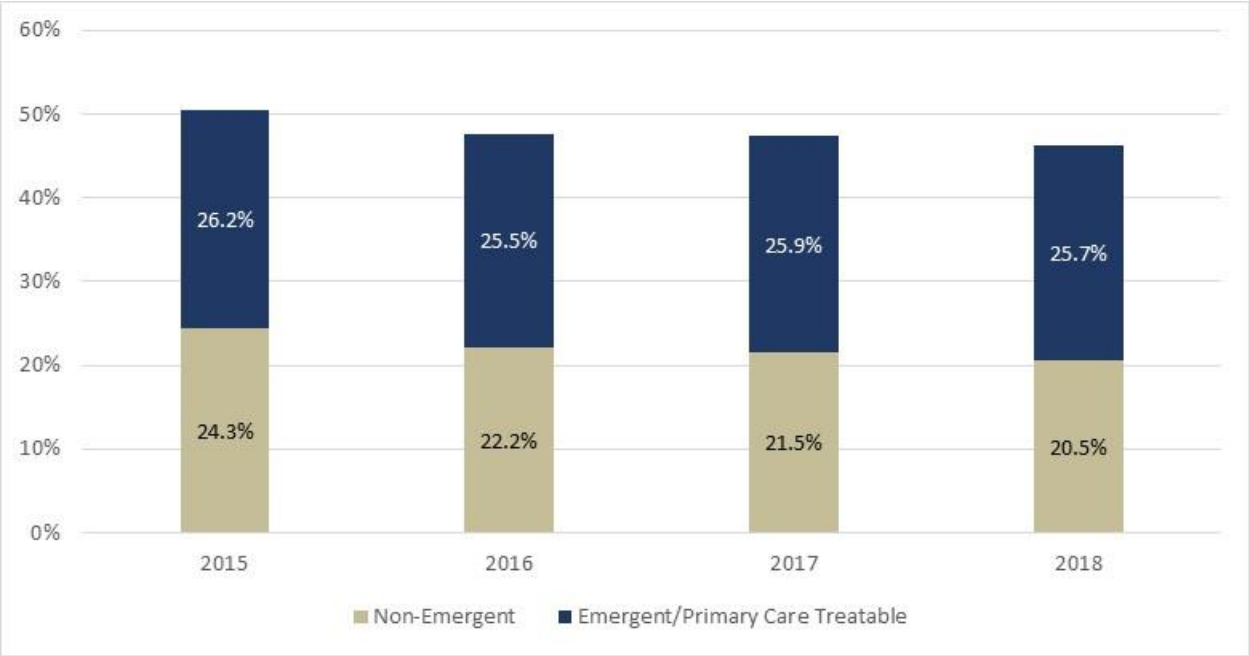
Source: HIP encounter data files, February 2015 – December 2018.

Exhibit F.1.47: Emergent/Primary Care Treatable ED Visits as a Percent of Total ED Visits, by Benefit Plan (February 2015 – December 2018)

Benefit Plan	2015	2016	2017	2018
HIP Basic Only	26.2%	25.5%	25.9%	25.7%
HIP Plus Only	25.4%	24.6%	25.2%	25.6%
HIP Switchers	25.4%	25.4%	25.4%	24.8%
All Members	**25.6%**	**25.0%**	**25.4%**	**25.4%**

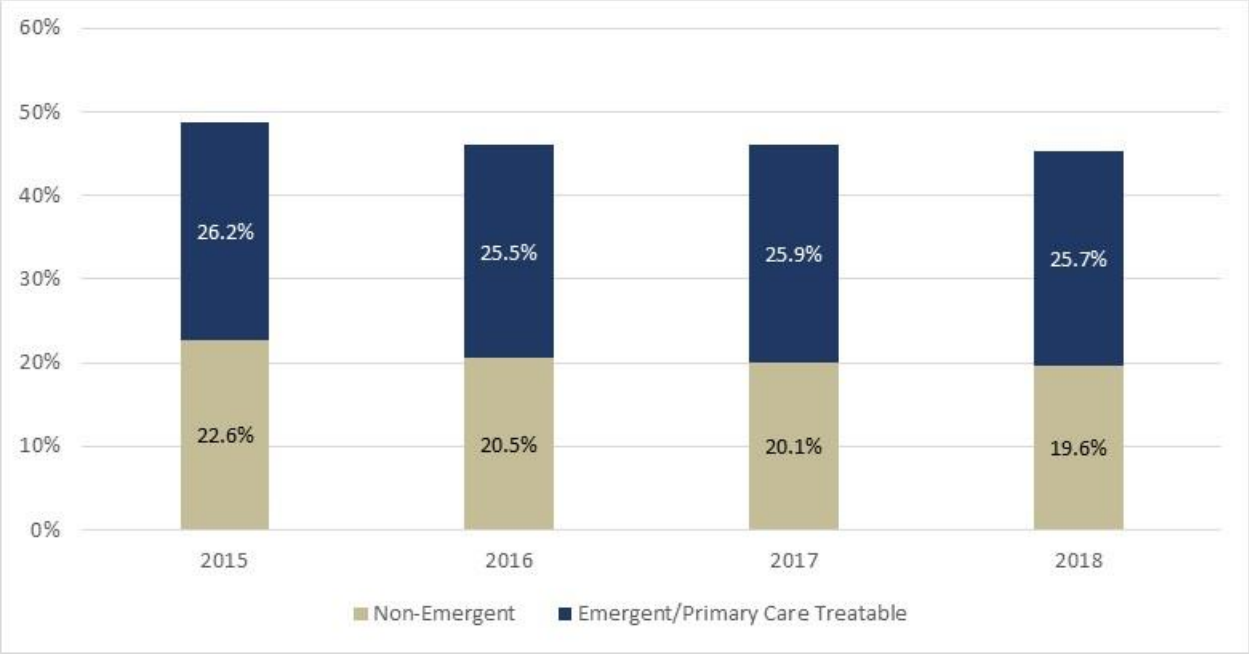
Source: HIP encounter data files, February 2015 – December 2018.

Exhibit F.1.48: HIP Basic Only Avoidable ED Visit Rate, by Visit Type (February 2015 – December 2018)



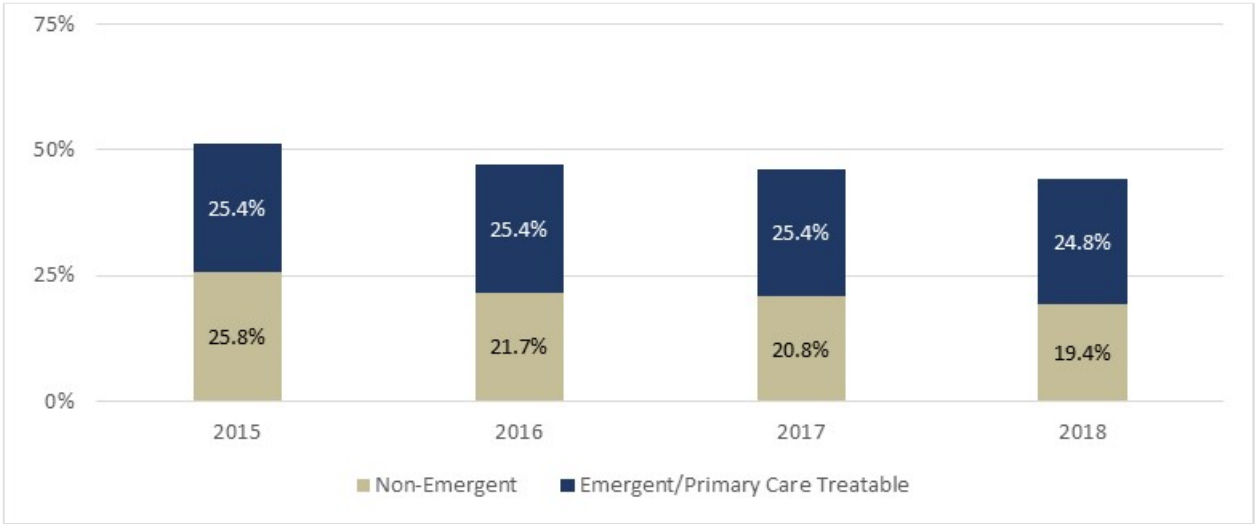
Source: HIP encounter data files, February 2015 – December 2018.
Note: Avoidable ED visits represent the sum of non-emergent ED visits and emergent/primary care treatable ED visits.

Exhibit F.1.49: HIP Plus Only Avoidable ED Visit Rate, by Visit Type (February 2015 – December 2018)



Source: HIP encounter data files, February 2015 – December 2018.
Note: Avoidable ED visits represent the sum of non-emergent ED visits and emergent/primary care treatable ED visits.

Exhibit F.1.50: HIP Switchers Avoidable ED Visit Rate, by Visit Type (February 2015 – December 2018)



Source: HIP encounter data files, February 2015 – December 2018.
Note: Avoidable ED visits represent the sum of non-emergent ED visits and emergent/primary care treatable ED visits.

Hypothesis 3 – HIP members will report positive health outcomes.

Primary Research Question 3.1 – How has reported health status for HIP members changed over time?

This hypothesis and research question focus on examining whether HIP member health status will reflect positive outcomes. The related analyses rely on Behavioral Risk Factor Surveillance System data from 2015 to 2018 and HIP member surveys that Lewin will conduct in 2020 and 2021. As such, we will address this hypothesis in the Summative Evaluation Report.

Hypothesis 4 – HIP members will report satisfaction with health care access.

This hypothesis examines whether enrollment in HIP will promote health care access through HIP member reporting of access to services and an analysis of Fast Track and presumptive eligibility policies to facilitate enrollment.

Primary Research Question 4.1 – What percentage of HIP members report getting health care as soon as needed?

This research question assesses the extent to which HIP members report getting health care as soon as needed. Related analyses rely on enrollment data from 2015 to 2020 and HIP member surveys that Lewin will conduct in 2020 and 2021. As such, we will address this hypothesis in the Summative Evaluation Report. We note, however, that the key informant interviews performed with four MCEs, nine State officials, and 27 members provided some insight into HIP member experience with accessing needed services. Specifically:

- State officials and MCE executives commonly discussed that members appreciate quick access to care, greater access to routine primary care, a robust provider network, and general satisfaction with plan coverage.
- Discussions from the member key informant interviews found that most of the members have been able to get the health care services they needed through HIP. These interviews are, by design, not a representative sample of all members.

The Summative Evaluation Report will reflect member surveys that Lewin will conduct in 2020 and 2021 and feedback from additional key informant interviews.

Primary Research Question 4.2 – To what extent do HIP members receive coverage through Fast Track and presumptive eligibility policies?

This research question assesses the proportion of HIP members that receive coverage through Fast Track and presumptive eligibility processes. As described in **Section B: Summary of HIP Demonstration**, the State expanded presumptive eligibility under HIP and also offered members the option of an initial $10 Fast Track POWER Account payment that allows a member to "lock in" a HIP Plus coverage start date (the first of the month that the member made the payment) while the application is processing and the member is completing the required verification. Without a Fast Track Payment, the member would have conditional enrollment following eligibility determination and would only have HIP coverage starting on the first of the month that the member paid after being found eligible.

The presumptive eligibility policy allows individuals with income meeting qualifications for HIP and not currently receiving Medicaid services to receive immediate access to health care. At point of care, health care providers may apply, on behalf of the individual, for short-term coverage under HIP through presumptive eligibility.

Both Fast Track and presumptive eligibility policies are important, as HIP does not include a retroactive coverage provision. Fast Track allows for an expedited enrollment process while presumptive eligibility allows members to receive HIP coverage while the eligibility process is being completed. New members enrolling in HIP Plus may use the Fast Track option. New members enrolling in HIP Basic or HIP Plus may use the presumptive eligibility option.

Brief Summary: Lewin's analyses found the following:

- The percentage of individuals using the presumptive eligibility process and Fast Track is declining. Specifically, the percentage of new HIP Plus members enrolling via Fast Track decreased from 9.9% of all new members in 2017 to 7.4% of all new members in 2018. The percentage of new HIP members enrolling using presumptive eligibility decreased from 17.3% to 14.4% from 2016 to 2018.
- Approximately 30.3% of Fast Track members were enrolled for six months or more in 2018 as compared to 33.7% of members using presumptive eligibility.
- Overall, HIP Basic members used the presumptive eligibility process more than HIP Plus members.

Approach to Quantitative Analysis

Lewin used monthly HIP enrollment data from February 2015 to December 2018 to identify members enrolled under Fast Track and presumptive eligibility. Although the Fast Track policy was in effect in 2015 and 2016, Fast Track data were only available for analysis from 2017 and 2018 due to a system conversion related to Indiana's new Medicaid Management Information System. **Exhibit F.1.51** summarizes how we identified the proportion of individuals enrolling using Fast Track or presumptive eligibility. Members who began the enrollment process under Fast Track but did not enroll are not included. These individuals either did not complete the eligibility process or they were found to not qualify for HIP.

Exhibit F.1.51: Summary of the Components of the Fast Track and Presumptive Eligibility Calculations

Calculation	Fast Track	Presumptive Eligibility
Numerator	Members with Fast Track status	Members with presumptive eligibility status
Denominator	New HIP Plus (RP, SP) members that do not have an "Emergency Room Services" flag. New members are defined as members that do not have the following in the 12 months prior to their HIP coverage: • Presumptive eligibility status • Any other monthly enrollment status besides conditional enrollment (RP, SP, RB, SB, MA, or PC) This denominator is likely overstated as data were not available from the State to identify which individuals were coming into HIP from a separate Medicaid program. Additional data indicating members transitioning into HIP from a separate Medicaid program are anticipated for the Summative Evaluation Report.	New members that do not have an "Emergency Room Services" flag and have one of the following enrollment statuses: HIP Plus (RP, SP), HIP Basic (RB, RP), and pregnant (MA). New members are defined as members that do not have any other monthly enrollment status besides conditional enrollment (RP, SP, RB, SB, MA, or PC) in the 12 months prior to their HIP coverage. This denominator is likely overstated as data were not available from the State to identify which individuals were coming into HIP from a separate Medicaid program for the Interim Evaluation Report. Additional data indicating members transitioning into HIP from a separate Medicaid program are anticipated for the Summative Evaluation Report.

We then used the following steps to compute the proportion of members enrolled under Fast Track by enrollment span:

- Identified members who began the enrollment process under Fast Track but did not complete full enrollment
- Counted the number of enrolled months for each member that completed enrollment and grouped them into enrollment spans (i.e., one to three months, four to six months)
- For each enrollment span, divided the number of unique members enrolling under Fast Track by the total number of new members enrolled

We used the same steps as above to identify the proportion of members enrolled under presumptive eligibility by enrollment span

Results of Quantitative Analysis – Fast Track

Just over one-third of individuals making Fast Track payments complete enrollment (**Exhibit F.1.52**).

Exhibit F.1.52: Final Enrollment Status of Members Making Fast Track Payments (2017 and 2018)

Enrollment Span	2017		2018	
	Members with Fast Track Status	Percent	Members with Fast Track Status	Percent
Individuals that did not complete enrollment	12,888	65.5%	9,819	65.8%
Individuals that completed enrollment	6,775	34.5%	5,094	34.2%
Total Individuals that Submitted Fast Track Payments	**19,663**	**100.0%**	**14,913**	**100.0%**

Source: Fast Track and monthly HIP enrollment files, 2017 – 2018.

The percent of HIP Plus members enrolling via Fast Track decreased from 9.9% of all new members in 2017 to 7.4 % of all new members in 2018. **Exhibit F.1.53** provides additional detail.

Exhibit F.1.53: Proportion of Members Using Fast Track by HIP Benefit Plan (2017 – 2018)

Benefit Plan	Jan 2017 – Dec 2017			Jan 2018 – Dec 2018		
	Total New Members	Total Fast Track	Percent Fast Track	Total New Members	Total Under Fast Track	Percent Fast Track
HIP Basic Only	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.
HIP Plus Only	66,425	6,564	9.9%	67,517	4,990	7.4%
HIP Switchers	4,047	211	5.2%	3,902	104	2.7%
Total	**70,472**	**6,775**	**9.6%**	**71,419**	**5,094**	**7.1%**

Source: Fast Track and monthly HIP enrollment files, 2017 – 2018.

In 2017, 54.2% of Fast Track recipients were enrolled for six or more months as compared to 30.3% in 2018. **Exhibit F.1.54** provides additional detail regarding the proportion of HIP members using Fast Track by months enrolled.

Exhibit F.1.54: Total Months of Coverage under Fast Track (2017 – 2018)

Enrollment Span	2017		2018	
	Members with Fast Track Status	Percent	Members with Fast Track Status	Percent
1 month	408	6.0%	733	14.4%
2 months	585	8.6%	637	12.5%
3 months	720	10.6%	759	14.9%
4 months	613	9.0%	705	13.8%
5 months	774	11.4%	717	14.1%
6 months	677	10.0%	540	10.6%
7 months	606	8.9%	411	8.1%
8 months	553	8.2%	363	7.1%
9 months	635	9.4%	139	2.7%
10 months	1,058	15.6%	45	0.9%
11 months	132	1.9%	29	0.6%
12 months	14	0.2%	16	0.3%
Total enrolled	**6,775**	**100.0%**	**5,094**	**100.0%**

Source: Fast Track and monthly HIP enrollment files, 2017 – 2018.

Results of Quantitative Analysis – Presumptive Eligibility

In the last four years, almost 30% of individuals beginning the presumptive eligibility process completed HIP enrollment, as illustrated in **Exhibit F.1.55.**

Exhibit F.1.55: Final Enrollment Status of Individuals Using Presumptive Eligibility (PE) Process (February 2015 – December 2018)

Enrollment Span	2015		2016		2017		2018	
	Members with PE Status	Percent	Members with PE Status	Percent	Members with PE Status	Percent	Members with PE Status	Percent
Individuals that did not complete enrollment	56,003	67.3%	56,831	64.9%	46,312	68.4%	51,653	70.6%
Individuals that completed enrollment in HIP	27,264	32.7%	30,767	35.1%	21,394	31.6%	21,529	29.4%
Total Individuals Using the Presumptive Eligibility process	**83,267**	**100%**	**87,598**	**100%**	**67,706**	**100.0%**	**73,182**	**100%**

Source: Presumptive eligibility and monthly HIP enrollment files, 2015 – 2018.

The percentage of new HIP members enrolling using presumptive eligibility decreased from 17.3% to 14.4% from 2016 to 2018.[62] Overall, HIP Basic members used the presumptive eligibility process more than HIP Plus members. The percentage of new HIP Basic members enrolled under presumptive eligibility decreased from 19.0% to 15.5% from 2016 to 2017 before rising to 21.9% in 2018. The percentage of new HIP Plus members enrolled under presumptive eligibility, on the other hand, steadily decreased from 16.5% in 2016 to 11.5% in 2018. **Exhibit F.1.56** provides additional detail.

Exhibit F.1.56: Proportion of Members Using Presumptive Eligibility (PE) by HIP Benefit Plan (January 2016 – December 2018)

Benefit Plan	Jan 2016 – Dec 2016			Jan 2017 – Dec 2017			Jan 2018 – Dec 2018		
	Total New Members	Total under PE	Percent PE	Total New Members	Total under PE	Percent PE	Total New Members	Total under PE	Percent PE
HIP Basic Only	59,643	11,359	19.0%	56,613	8,789	15.5%	44,195	9,677	21.9%
HIP Plus Only	107,003	17,645	16.5%	77,018	10,593	13.8%	76,285	8,768	11.5%
HIP Switchers	11,612	1,763	15.2%	15,852	2,012	12.7%	29,267	3,084	10.5%
Total	**178,258**	**30,767**	**17.3%**	**149,483**	**21,394**	**14.3%**	**149,747**	**21,529**	**14.4%**

Source: Presumptive eligibility and monthly HIP enrollment files, 2016 – 2018.

Note: We defined new members as members that do not have any other monthly enrollment status besides conditional enrollment in the month prior to their HIP coverage. The number of new members is likely overstated as data were not available from the State to identify which individuals were coming into HIP from a separate Medicaid program. We did not include 2015 in this analysis as 2014 data are not available to perform a "look back" to identify new members.

[62] We did not include 2015 in this analysis as 2014 data are not available to perform a "look back" to identify new members.

In 2017, 44.9% of presumptive eligibility recipients were enrolled for six or more months in total during the year as compared to 33.7% in 2018. **Exhibit F.1.57** provides additional detail regarding the proportion of HIP members using presumptive eligibility by months enrolled.

Exhibit F.1.57: Total Months of Coverage under Presumptive Eligibility (PE) (February 2015 – December 2018)

Enrollment Span	2015		2016		2017		2018	
	Members with PE Status	Percent	Members with PE Status	Percent	Members with PE Status	Percent	Members with PE Status	Percent
1 month	4,003	14.7%	2,954	9.6%	1,741	8.1%	2,186	10.2%
2 months	3,942	14.5%	3,853	12.5%	2,051	9.6%	3,215	14.9%
3 months	3,535	13.0%	4,124	13.4%	2,960	13.8%	3,581	16.6%
4 months	3,538	13.0%	3,826	12.4%	2,883	13.5%	2,995	13.9%
5 months	4,146	15.2%	2,848	9.3%	2,127	9.9%	2,287	10.6%
6 months	2,582	9.5%	2,526	8.2%	1,969	9.2%	1,848	8.6%
7 months	2,427	8.9%	2,225	7.2%	1,825	8.5%	1,556	7.2%
8 months	1,850	6.8%	2,591	8.4%	1,588	7.4%	1,555	7.2%
9 months	931	3.4%	2,327	7.6%	1,634	7.6%	1,042	4.8%
10 months	241	0.9%	1,618	5.3%	1,373	6.4%	679	3.2%
11 months	69	0.3%	1,750	5.7%	1,199	5.6%	515	2.4%
12 months	-	-	125	0.4%	44	0.2%	70	0.3%
Total enrolled	**27,264**	**100.0%**	**30,767**	**100.0%**	**21,394**	**100%**	**21,529**	**100%**

Source: Fast Track and monthly HIP enrollment files, February 2017 – December 2018.

Goal 2 – Increase community engagement leading to sustainable employment and improved health outcomes among HIP members

Indiana's community engagement requirement, known as Gateway to Work, is designed to provide an incentive for HIP members to attain employment or engage in other community activities correlated with improved health and wellness (e.g., employment, volunteer work, education, and training). All able-bodied HIP participants, not otherwise meeting an exemption or already working at least 20 hours per week, must engage in and report on qualifying activities for a minimum of eight months each calendar year starting in 2019.

Overview of Community Engagement Reporting Requirements

The State chose to gradually phase-in the reporting requirements, with voluntary reporting from January 2019 to June 2019 and then required reporting of five hours of qualifying activities per week starting July 1, 2019, increasing to 20 hours of qualifying activities per week by July 2020. **Exhibit B.10** in **Section B: Summary of HIP Demonstration** provides a summary of the phase-in requirements and **Exhibit B.9** provides a summary of qualifying activities and exempt populations.

As data were only available from January 2019 to June 2019 for this evaluation, the results for "members with a reporting requirement" described in this section reflect voluntary reporting only. As such, we describe these members as "members with a reporting requirement (voluntary basis only)."

FSSA notifies members of their Gateway to Work reporting status via U.S. mail. Members can also check their status online via the FSSA Benefits Portal, by calling their MCE, or by checking their MCE monthly POWER Account statement. Members report qualifying activities online using the FSSA Benefits Portal or via phone or in-person with their MCE. Beginning in March 2019, MCEs included the Gateway to Work reporting status on each monthly POWER Account statement.

All HIP members receive communications from the State and their MCE about the Gateway to Work program and related community engagement opportunities. Two categories of HIP members do not have to report qualifying activities, but may choose to do so:

- **Pre-qualified:** HIP members employed over 20 hours per week who have verified their employment for the purposes of income verification during the eligibility process do not need to report activities to their MCEs or the State.
- **Exempt from reporting:** Members may obtain various exemptions (e.g., caregiver of a dependent child under seven years old, medically frail, pregnant, student, homeless, institutionalized, TANF or SNAP recipient, age 60 years or older) from either eligibility data verified by the State or via their MCE. **Exhibit B.9** includes a list of exemptions and Research Question 10 provides an analysis of exempt members.

At the end of each calendar year, the State will determine whether members have met their reporting requirements. Under this approach, the State determines compliance in December and applies suspensions of enrollment for noncompliance in January of the following year. Effective October 31, 2019, the State temporarily removed the enrollment suspension for members who do not meet their reporting requirements pending the results of the federal lawsuit regarding CMS approval of HIP. For additional information on Indiana's community engagement policy, refer to **Section B: Summary of HIP Demonstration**.

Goal 2 Hypotheses and Implementation Questions

Four hypotheses and a series of implementation questions inform our analyses associated with *Goal 2 – Increase community engagement leading to sustainable employment and improved health outcomes among HIP members*. The four hypotheses focus on evaluating changes in income, employment, and health outcomes for individuals subject to community engagement requirements, in addition to the likelihood of transitioning to commercial health insurance after separating from HIP.

- **Hypothesis 1** – Medicaid beneficiaries subject to community engagement requirements will have higher employment levels than Medicaid beneficiaries not subject to the requirements.
- **Hypothesis 2** – Community engagement requirements will increase the average income of Medicaid beneficiaries subject to the requirements compared to Medicaid beneficiaries not subject to the requirements.
- **Hypothesis 3** – Community engagement requirements will improve the health outcomes of current and former Medicaid beneficiaries subject to the requirements, compared to Medicaid beneficiaries not subject to the requirements.
- **Hypothesis 4** – HIP policies including community engagement and required payment policies increase the likelihood that Medicaid beneficiaries transition to commercial health insurance after separating from Medicaid, compared to Medicaid beneficiaries not subject to the requirements.

The research questions associated with these hypotheses will rely on data from 2015 to 2020, including ACS data, HIP enrollment and other administrative data, and data from member surveys to be performed in 2020 and 2021. As such, the Summative Evaluation Report will address these hypotheses and the related research questions. We describe below the analyses related to the 10 implementation questions (research questions 5 to 12)

HIP Population Included in Goal 2 Analyses

The HIP population under analysis are those members in the January to June 2019 Gateway to Work referral status data, which includes members with enrollment statuses of HIP Plus (RP, SP), HIP Basic (SP, SB), HIP Plus Copay (PC), and Pregnant (MA). In June 2019, Indiana classified 18% of HIP members as required to report (voluntary basis only), 74.6% exempt from reporting, and 7.4% pre-qualified. Less than 1% of members identified as non-exempt actually reported. **Exhibit F.2.1** provides additional detail.

Exhibit F.2.1: Summary of Members by Reporting Status (June 2019)

Reporting Status	Total Members	Percent of Members	Members Reporting Qualifying Activities	Percent of Total Members Reporting Qualifying Activities
Required to report (voluntary basis only)	68,951	18.0%	1,041	1.5%
Exempt	286,106	74.6%	82	< 0.03%
Pre-qualified	28,496	7.4%	20	< 0.1%
Total	**383,553**	**100.0%**	**1,143**	**0.3%**

Source: Gateway to Work referral status data, June 2019. This data reflects all HIP members with community engagement reporting statuses. These members have enrollment statuses of HIP Plus (RP, SP), HIP Basic (SP, SB), HIP Plus Copay (PC), and Pregnant (MA).

Implementation Questions

The implementation questions for **Goal 2** quantify the number of members identified as required to report community engagement activities (versus exempt or "pre-qualified" through current work), the distribution of qualifying activities, member understanding of community engagement requirements, barriers to compliance (including reporting burden), availability of MCE supports, reasons for disenrollment, sources of health insurance coverage after disenrollment, and whether members who disenrolled for non-compliance with community engagement requirements are more or less likely to re-enroll. The remainder of this section provides the observations for each implementation question based on feedback from the key informant interviews and analysis of Gateway to Work administrative data. At the beginning of each research question, we provide a high-level summary of our observations.

Primary Research Question 5 – To what extent do individuals subject to community engagement requirements who become ineligible for Medicaid due to an increase in income obtain health insurance coverage?

This research question will assess the extent to which individuals obtain health insurance coverage after participating in HIP and disenrolling due to an increase in income. We will address this question in the Summative Evaluation Report as it relies on member surveys that Lewin will conduct in 2020 and 2021.

Primary Research Question 6 – What is the distribution of activities HIP members engage in to meet community engagement requirements?

Subsidiary Research Question 6a – How do activity patterns change over time?

Research Questions 6 and 6a assess the distribution of activities HIP members engage in to meet community engagement requirements and how that distribution changes over time. HIP members may fulfill community engagement requirements through a variety of qualifying activities, including:

Employment

- Employment (subsidized or unsubsidized)
- Health plan employment programs
- Job search activities
- Education related to employment (on-the-job training)
- Caregiving
- Homeschooling
- Members of the Pokagon Band of Potawatomi participating in the Pathways program

Education

- General Education:
  - High School Equivalency
  - Adult education
  - Post-secondary education
- Job skills training (e.g., Next Level Jobs)
- Vocation education or training
- English as a second language education

Community Service

- Community service/public service
- Volunteer work
- Gateway to Work community work experience

Other

- Qualifying activities based on State or MCE review
- MCE Qualifying Activities (MCE specific programs)
- Attending Alcoholic Anonymous or Narcotics Anonymous meetings
- Completing pre-suspension courses

The Gateway to Work administrative data available for analysis reflects reported activities from January 2019 to June 2019. As HIP did not require members to report community engagement activities prior to July 1, 2019, this data only includes members that voluntarily reported activities. Analyses for the Summative Evaluation Report will incorporate data reflecting 18 months of required reporting (July 2019 to December 2020) and include descriptive analyses of the distribution of activities reported, overall reporting rates by qualifying activity and HIP member reporting status, and changes in distribution of qualifying activities.

Brief Summary: Lewin found a relatively stable monthly distribution of the voluntarily reported qualifying activities from January to June 2019, with the exception of caregiving and education, with seasonality likely due to school schedules. The majority of members required to report qualifying activities (voluntary basis only) indicated employment as the qualifying activity (64.3%), with the next highest qualifying activity categories of volunteer work and caregiving (16.1% and 15.6%, respectively).

Approach to Quantitative Analysis

We used Gateway to Work administrative data from January 2019 to June 2019 to complete this analysis. This data included:

- Member referral status – required to report (voluntary basis only), pre-qualified, or exempt
- Total hours reported by member
- Qualifying activity type

While members also reported total hours, the timeframe for hours reported by each member varied. In some cases, it appeared that members reported actual hours worked on a daily basis while in other cases it appeared that members reported hours over a longer period. As a result, we did not sum hours by month and qualifying activity as part of this analysis.

We used the following steps to analyze the distribution of reported activities:

- Identified the HIP reporting status for each member by month.
- Identified the number of members reporting at least one hour of activity by qualifying activity type. As members may report more than one qualifying activity in a month, the same member may appear under more than one qualifying activity type.
- Calculated the percentage of members reporting by each qualifying activity type by: 1) month, and 2) for January to June 2019 (number of unique members reporting at least one hour of a qualifying activity in the time period divided by the number of unique members in that time period). We performed this calculation for all members, members required to report, members exempt from reporting, and pre-qualified members.

Results of Quantitative Analysis

Exhibit F.2.1 at the beginning of **Goal 2** provides a summary of member reporting status. Lewin found the distribution of reported qualifying activities relatively stable across months of data, with the exception of caregiving and education, with seasonality likely due to school schedules. Additional observations for members reporting qualifying activities include:

- The majority of members reported employment or work as the top category – 63.9% overall, 64.3% of members required to report (voluntary basis only), 61.1% of exempt members, and 83.7% of pre-qualified members.
- Among members required to report (voluntary basis only), volunteer work and caregiving represented the next highest categories at 16.1% and 15.6% of members, respectively, followed by education and job search at 8.0% and 7.2%, respectively.
- Members with exemptions reported volunteer work, caregiving, education, and job search in roughly uniform proportions (10.7%, 8.2%, 10.1%, and 11.8% of members, respectively).
- Among pre-qualified members reporting, 11.6% reported volunteer work, followed by job search, education, and caregiving (4.7%, 2.3%, and 1.2% of members, respectively).

We note that this distribution reflects the voluntary nature of the reporting and may change once the reporting requirements take effect. **Exhibit F.2.2** summarizes the cumulative reporting of community engagement activity by HIP members from January 2019 to June 2019. **Exhibits F.2.3 and Exhibit F.2.4** detail the monthly reporting of community engagement activity for members required to report (voluntary basis only) and members exempt from reporting, respectively (January to June 2019).

Exhibit F.2.2: Voluntary Reporting of Community Engagement Activities by Reporting Status and Activity Type (January 2019 – June 2019)

	Exempt from Reporting		Required to Report (voluntary basis only)		Pre-Qualified		Total Unique Members[a]	
Activity Type	Number	Percent	Number	Percent	Number	Percent	Number	Percent
Work	223	61.1%	1,542	64.3%	72	83.7%	1,781	64.7%
Looking for Work	43	11.8%	172	7.2%	4	4.7%	214	7.8%
Taking Classes	37	10.1%	192	8.0%	2	2.3%	224	8.1%
In Job Training/Apprentice	5	1.4%	26	1.1%	0	0.0%	31	1.1%
Homeschool Children	4	1.1%	69	2.9%	0	0.0%	70	2.5%
Caregiving	30	8.2%	375	15.6%	1	1.2%	401	14.6%
Volunteer Work/Public Service	39	10.7%	387	16.1%	10	11.6%	429	15.6%
Other	32	8.8%	108	4.5%	4	4.7%	137	5.0%
Total Unique Members[a]	**365**	-	**2,397**	-	**86**	-	**2,753**	-

[a] Percent reporting represents the number of members voluntarily reporting each activity type out of total unique members. Members may voluntarily report multiple qualifying activities and may change their reporting status from month to month. Therefore, the sum of members across all activity types or reporting status categories may exceed the total count of unique members.

Source: Gateway to Work activity file and Gateway to Work referral file, January 2019 – June 2019.

Exhibit F.2.3: Voluntary Reporting of Community Engagement Activities by Members Exempt from Reporting (January 2019 – June 2019)

	January 2019		February 2019		March 2019		April 2019		May 2019		June 2019	
Activity Type	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent
Employment	68	59.6%	60	56.6%	62	59.0%	72	63.7%	56	58.3%	48	58.5%
Searching for Work	13	11.4%	7	6.6%	9	8.6%	14	12.4%	7	7.3%	9	11.0%
Education	12	10.5%	14	13.2%	12	11.4%	5	4.4%	8	8.3%	4	4.9%
On-the-Job Training	1	0.9%	2	1.9%	1	1.0%	0	0.0%	0	0.0%	1	1.2%
Homeschooling	2	1.8%	1	0.9%	1	1.0%	1	0.9%	0	0.0%	0	0.0%
Caregiving	4	3.5%	8	7.5%	5	4.8%	3	2.7%	4	4.2%	18	22.0%
Volunteering	7	6.1%	6	5.7%	12	11.4%	13	11.5%	9	9.4%	10	12.2%
Other	13	11.4%	19	17.9%	15	14.3%	16	14.2%	16	16.7%	1	1.2%
Total Unique Members	**114**	-	**106**	-	**105**	-	**113**	-	**96**	-	**82**	-

Source: Gateway to Work activity file and Gateway to Work referral file, January 2019 – June 2019.

Note: Percent reporting represents the number of members voluntarily reporting each activity type out of total unique members. Members may voluntarily report multiple qualifying activities and may change their reporting status from month to month. Therefore, the sum of members across all activity types or reporting status categories may exceed the total count of unique members.

Exhibit F.2.4: Voluntary Reporting of Community Engagement Activities by Members Required to Report (January 2019 – June 2019)

	January 2019		February 2019		March 2019		April 2019		May 2019		June 2019	
Activity Type	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent
Employment	485	65.2%	520	65.9%	539	65.5%	540	63.0%	506	59.8%	640	61.5%
Searching for Work	43	5.8%	39	4.9%	33	4.0%	41	4.8%	47	5.6%	68	6.5%
Education	86	11.6%	83	10.5%	73	8.9%	61	7.1%	33	3.9%	34	3.3%
On-the-Job Training	8	1.1%	3	0.4%	8	1.0%	5	0.6%	4	0.5%	5	0.5%
Homeschooling	32	4.3%	27	3.4%	33	4.0%	26	3.0%	26	3.1%	11	1.1%
Caregiving	75	10.1%	89	11.3%	104	12.6%	126	14.7%	147	17.4%	194	18.6%
Volunteering	82	11.0%	89	11.3%	109	13.2%	127	14.8%	141	16.7%	169	16.2%
Other	26	3.5%	34	4.3%	34	4.1%	33	3.9%	47	5.6%	27	2.6%
Total Members (Unduplicated)	**744**	-	**789**	-	**823**	-	**857**	-	**846**	-	**1,041**	-

Source: Gateway to Work activity file and Gateway to Work referral file, January 2019 – June 2019.
Note: Percent reporting represents the number of members voluntarily reporting each activity type out of total unique members. Members may voluntarily report multiple qualifying activities and may change their reporting status from month to month. Therefore, the sum of members across all activity types or reporting status categories may exceed the total count of unique members.

Primary Research Question 7 – Do HIP members subject to community engagement requirements understand the requirements, including how to satisfy them and the consequences of non-compliance?

This research question assesses whether HIP members understand their community engagement reporting obligations and how to fulfill them. This understanding is critical: If a member is required to report and does not, then his or her HIP coverage is suspended. Effective October 31, 2019, the State temporarily removed the enrollment suspension for members who do not meet his or her reporting requirements pending the results of the federal lawsuit regarding CMS approval of HIP.

The information gathered to address this question is from key informant interviews in July and August 2019, reflecting experience during the voluntary period of the community engagement reporting requirements from January to June 2019.

Brief Summary: Feedback from members, providers, State officials, and MCE executives indicate that many HIP members have some level of understanding of the Gateway to Work program, their reporting status, and the consequences of not reporting. This understanding has been built through various layered communications methods and a variety of initiatives employed by the State, the MCEs, and providers. There is still a portion of members, however, who do not know their community engagement requirements, do not know how to report, or are unaware of the consequences of not reporting.

Results of Qualitative Analysis

Key Informant Interviews – Members

In general, members participating in the key informant interviews knew if they were exempt, already meeting the requirement, or required to report and the consequences if they did not meet the Gateway to Work reporting requirements. Findings from the key informant member interviews showed that, when asked about their knowledge of the requirements associated with reporting Gateway to Work hours, 19 of 27 knew their reporting status while eight did not. Overall, 16 of the 27 interviewees responded that they were exempt from reporting, three of the 27 interviewees responded that they were required to report hours (voluntary basis only), and eight of the 27 interviewees said they did not know if they were required to report Gateway to Work hours.

When asked about what would happen if they did not meet their Gateway to Work reporting requirements, 16 of 27 interviewees were aware of what would happen, with the remaining 11 of 27 respondents stating that they were unaware of what would happen if they fail to report. Based on the interviews, overall, more than half of the respondents understood that their coverage would be suspended if they failed to meet the requirements.

The observations from the member interviews were consistent with the State's March 2019 member email survey conducted to inform ongoing HIP member outreach and communications.[63] The State used

[63] This survey was distributed via email by FSSA from March 12-19, 2019, and yielded a 2.2% response rate (883 responses). The contractor conducting the survey indicated that this response was a statistically significant representation of the approximately 400,000 HIP members within ±3% and reflected a "good representation" across all 10 districts of the state. Lewin notes that the survey's function was limited to informing the State's communications strategy, and that its reliance on email to distribute the survey introduced notable selection bias inconsistent with surveys conducted for quantitative evaluation purposes.

the results of the survey to target communication with HIP members. For example, State officials indicated that if members reported that they knew their status but did not know how to report hours, the State would target communications towards how to report hours. Members responded to questions about Gateway to Work with approximately 94% stating they had heard something about Gateway to Work. Of those that were aware of the program, 83% of respondents stated that they knew their Gateway to Work reporting status and of that 83%, three of every four members, knew they were exempt (78%). Of those that responded that they were required to report hours (voluntary basis only), 47% responded that they knew how to report their hours, 28% did not know how to report hours, and 25% were not sure.

Key Informant Interviews – State Officials and MCE Executives

Per HIP requirements, the State and MCEs provide resources and information to members to learn about the Gateway to Work reporting requirements. The State has an overarching communications campaign to develop and disseminate messages to members using the Gateway to Work website, email, videos, and mail. FSSA also hosts the FSSA Benefits Portal for members to report Gateway to Work hours. The MCEs support members in reporting their hours over the phone and conduct plan-specific targeted outreach to their members. Although MCEs can develop plan-specific materials, FSSA pre-approves all communications. The State reviews all MCE information and State officials indicated that this approval process has supported consistency in messaging across the four MCEs and the State.

A few MCE executives indicated that the community engagement requirement is not a "typical" function of a health plan and the dedication of additional resources and staff has been necessary for effective implementation. MCE executives also discussed modifying their existing member outreach approach to connect members with community engagement opportunities and provide timely communication and support to members so they can understand and meet the reporting requirements.

State officials and MCE executives interviewed described a variety of strategies to support member understanding of the community engagement requirement. Strategies included additional training for staff members and changes to some administrative processes. **Exhibit F.2.5** outlines the communication strategies described in the key informant interviews.

Key Informant Interviews – Providers

Provider interviews intended to capture information based on their experience with HIP members' perspectives. Navigators, nurses, and administrators generally indicated familiarity with the community engagement requirements; physicians said they knew nothing about Gateway to Work. Navigators were the most familiar with Gateway to Work and its purpose. Of the providers who felt they understood the community engagement requirements, a few stated that the process was confusing to members. One provider stated that the multiple outreach letters mailed to members were more confusing than helpful. Another provider discussed the confusion members experienced at the rollout of the Gateway to Work program, but then described an example of a member calling them recently to share their success in reporting hours online. The same provider stated that once members were taught to report and do it successfully, the process became easy. Providers said they field many questions related to the requirements to support member understanding.

Exhibit F.2.5: Strategies Used to Communicate Community Engagement Requirements to Members Described in Key Informant Interviews

Interview Type	Strategies

State Officials	• Created call scripts specific to Gateway to Work designed to address member questions regarding reporting hours, how to check reporting status, where to find qualifying activities, and other ways to engage in the program
	• Provided Frequently Asked Questions (FAQs) documents and baseline training for HIP State officials and MCEs on supporting members' Gateway to Work compliance, how to record hours, and where to find various resources for members related to Gateway to Work
	• Developed proactive communication schedule to contact members at risk of non-compliance (e.g., at two months of not reporting, three months)
	• Used public relations firm to develop outreach and feedback strategies for members
	  ○ Performed geocaching to locate members where they are and conducted targeted outreach
	  ○ Integrated messages on various social media platforms with targeted advertisements, including Twitter, Facebook, and Instagram
	  ○ Developed and analyzed at least one member survey that solicited feedback on Gateway to Work for State officials to use for internal operations
	• Created instructional "how-to" videos for social media on how to record hours and where to find detailed information about Gateway to Work online
	• Distributed standardized informational resources such as pamphlets, reporting guides, FAQ documents, and videos to other stakeholders (e.g., community and/or health centers, MCEs, nonprofits) for distribution to members
	  ○ Included information on reporting hours and breakdown of Gateway to Work requirement
	  ○ Highlighted where to go for additional resources and/or support (including FSSA call center information)

MCE Executives	• Conducted member outreach about Gateway to Work requirements that included live and automated calls, emails, mail, and social media campaigns
	• Trained in-house special teams on Gateway to Work; these teams help members report and teach them how to report independently online (as applicable)
	  ○ Most MCEs conduct practice calls for these staff to develop skills, discuss challenges, and highlight areas for growth
	  ○ Some MCEs assign members to a specific team member to report hours, other MCEs route members to a group of dedicated staff
	• Provided basic training to all staff on the Gateway to Work requirement
	  ○ Most MCEs train all their staff to answer basic questions
	  ○ Staff are also trained to transfer members to their plan's specific Gateway to Work team if questions are more specific
	• Administered monthly, personalized outbound calls to remind members to report and notify them of their reporting status
	  ○ A few MCEs have monthly lists created that show what members qualify to report their hours and what members have or have not recorded their hours
	  ○ MCEs also list reporting status on the member's monthly POWER Account statement
	• Conducted in-person visits at community meeting places and workshops to connect with members and demonstrate how to record hours, provide information about opportunities, answer questions, and record hours on-site
	• Engaged and provided community partners with adequate informational materials and knowledge to support any member who may seek guidance

MCE executives and State officials reported working together in different capacities to engage members on an individual level. One MCE indicated that the monthly report MCEs provide to FSSA helps assess what members report or do not report. A State official highlighted that the standardized list of contacts that FSSA created supports individualized member engagement. State officials shared that the partnerships between the MCEs and community partners help accelerate the State communication efforts related to Gateway to Work.

The Summative Evaluation Report will include additional data and information on member understanding from State officials, MCEs, and members. We will collect these data through member focus groups, further key informant interviews with State officials and members, and member surveys.

Primary Research Question 8 – What are common barriers to compliance with community engagement requirements?

Barriers to compliance with the Gateway to Work reporting requirements relate to the ability of members to engage in and report qualifying activities and exemptions. These barriers may be administrative or operational in nature or may reflect broader issues, for example, related to member geographic location and access to transportation or community activities. An understanding of these barriers is important, because if a member is required to report but is unable to, Indiana may suspend his/her HIP coverage. The information gathered to address this question is from key informant interviews in July and August 2019, reflecting experience during the voluntary period of the community engagement reporting requirements from January to June 2019.

Brief Summary: Barriers to complying with reporting requirements noted in key informant interviews included time and paperwork, adequate and accurate member contact information, location of members in rural areas, access to the internet, and the scope of the "good cause" exemption.

Results of Qualitative Analysis

Key Informant Interviews – Members

While the key informant member interviews covered barriers to compliance with community engagement requirements, only three members indicated that they were required to report (voluntary basis). Two of these members reported that they had no issues meeting the hour requirements. Two of the three members that were required to report (voluntary basis) reported hours in-person at the MCE office instead of over the phone or online. Time and paperwork were the main barriers to compliance expressed by the two respondents reporting hours in-person; one of the respondents said that the process of reporting hours had been time-consuming due to the in-person office location and paperwork. The two reporting members rated their experience as good and very good. The member interview responses did not address whether members knew about their options to call or report hours online.

At the time of the interviews, the State had not fully implemented the reporting requirements so respondents' answers may change after implementation is complete. As part of the Summative Evaluation Report, Lewin will complete additional data collection and analysis to determine the impact of the Gateway to Work program.

Key Informant Interviews – State Officials and MCE Executives

Common themes regarding barriers to compliance emerged from the State official and MCE executive key informant interviews, specifically:

- **Obtaining current member contact information:** Some MCE executives and State officials described barriers to outreach to members, which include often not receiving updated physical and email addresses for members who have moved. Capturing and maintaining accurate contact information when a member moves has been difficult for MCEs and State officials and can result in information not reaching a member (i.e., lost communication about community engagement requirements). Some MCE executives and State officials also highlighted the barrier that arises when members do not check their mail or email.
- **Barriers specific to rural areas:** MCE executives and State officials described barriers to reaching members in rural areas, both in regard to general communications and communications specific to community engagement reporting requirements. Individuals from both groups reported targeting and establishing more community partnerships in rural areas to address these barriers. Both groups reported that rural members are more difficult to reach, especially if a member does not have Internet access.
- **Scope of "good cause" exemption:** MCE executives and State officials agreed that the "good cause" exemption has been beneficial and that an increased ability for certain member groups to access this exemption would support their compliance with community engagement requirements. This exemption enables members in select groups to become exempt from the engagement requirement. **Section B: Summary of HIP Demonstration** provides more detailed information about this exemption. State officials also provided additional information about use of the "good cause" exemption, specifically:
    - The State is monitoring for access issues that can affect rural communities and can extend a good cause exemption to counties with extremely limited broadband coverage and without an onsite Work One Center, a resource center designed to help individuals find a new or better job, choose a career, and access training.
    - The State is able to issue a good cause exemption of a member who is isolated due to conditions of parole.
    - The State is in the process of expanding the exemption to better account for unique circumstances such as restrictions due to religious affiliations.
    - The State has received member-submitted exemption requests related to being a caretaker of a dependent child. Effective October 1, 2019, the exemption for caretakers of a dependent child changed from caregivers with a child under age seven to under age 13.

MCE executives also indicated difficulties accessing the online Gateway to Work reporting database and that members have called to report issues with reporting their hours online via the FSSA Benefits Portal. MCE executives said that, according to their own staff and member reports, the system could sometimes be faulty with various glitches, making it harder to report hours. State executives have indicated that allowing time to resolve operational issues was part of the State's phase-in strategy, and that these system issues have been reported and resolved. Lewin will use the key informant interviews to be conducted for the Summative Evaluation Report to further explore if these operational issues are continuing.

Some MCE executives provided feedback that community engagement is a completely new area for most of them and that they have worked to alleviate this gap in experience by using the following strategies:

- Creating various internal trainings and routine check-ins (especially with Gateway to Work staff)
- Establishing and maintaining connections with a variety of community organizations
- Integrating Gateway to Work with their own existing partnerships to offer more opportunities for members to complete their requirement

Key Informant Interviews – Providers

In the key informant interviews, providers discussed their interpretations of member barriers to compliance with the community engagement requirements. A few providers expressed concern that as the number of required hours per month increases, more HIP members will become ineligible and have a more difficult time maintaining compliance. One provider stated that it is frustrating that authorized representatives are unable to see a member's status online. Another provider discussed the challenges some members face in accessing and navigating the reporting website, especially for members who may only have a cell phone. The provider said that reporting hours is difficult for members to do on a cell phone.

A provider also described the issue with redundancy of letters, stating that members are more likely to ignore the same information distributed in the mail, which puts them at risk for non-compliance. The provider suggested use of other forms of information distribution, such as through text messaging or other digital mediums, for improved member understanding and compliance.

We will present additional data and information on member understanding from State officials, MCEs, providers, and members in the Summative Evaluation Report. These data will include member focus groups and key informant interviews with State officials, providers, and members.

Primary Research Question 9 – Do HIP members subject to community engagement requirements report that they received supports needed to participate, such as links to volunteer opportunities or job and education resources?

This research question will provide context around the supports HIP members can use to meet the community engagement requirements. As this report only covers the first six months of the program when voluntary reporting was in effect, we will address this question in the Summative Evaluation Report based on the member surveys we will conduct in 2020 and 2021.

Primary Research Question 10 – What is the distribution of HIP members who are exempt, meeting the requirement through current work at 20 hours a week or more, or required to report qualified activities to maintain status? What is the distribution of exemption types and sources?

As detailed under Research Question 6, HIP members may be required to report community engagement activities to maintain enrollment in HIP, exempt from reporting requirements, or pre-qualified by prior employment at or above 20 hours per week. Reasons for exemptions include:

- Age 60 years or older
- Temporary Assistance for Needy Families (TANF)/ Supplemental Nutrition Assistance Program (SNAP) recipients
- Medically frail
- Pregnant women
- Homeless individuals
- Recently Incarcerated (up to 6 months from release)
- Certified illness or incapacity (temporary)
- SUD treatment
- Student (full or half time)
- Primary caregiver:
    - Dependent child below the compulsory age (seven and under prior to October 1, 2019; changed to under 13 years of age effective October 1, 2019)
    - Disabled dependent
    - Kinship caregiver of abused or neglected children
- Good cause exemption (e.g., hospitalization, domestic violence, or the death of a family member)

This research question provides descriptive quantitative analyses regarding the distribution of member reporting status and the types of exemptions.

Brief Summary: Approximately 75% of all HIP members were exempt from community engagement reporting requirements, as compared to 18% that were required to report and approximately 8% that were pre-qualified by prior employment. Lewin found the distribution of the reporting status of HIP members for each month remained constant from January to June 2019. Medical frailty, caretaking of children under seven years, and "other" emerged as the most common exemption reasons during the first six months of 2019. The "other" category includes SNAP and TANF recipients and other reasons, such as domestic violence and institutionalization.

Approach to Quantitative Analysis

We used Gateway to Work administrative data from January 2019 to June 2019 to identify those members determined exempt from reporting requirements and their related exemption reasons. The identification of exemption reasons can occur during the eligibility verification process, through information provided during enrollment, or as reported by the MCE based on information gathered during the coverage period (for example, after a request by a member). As members may receive more than one exemption, the same member may appear under several exemption reason categories. As a small percentage of members classified as exempt from reporting did not appear in the exemption reason files (<1%), the total number of members reported under the distribution of exemption reasons differs slightly from the number reported exempt in the distribution of referral status.

We then divided the total number of unique members associated with an exemption reason by the total number of exempt members to calculate the percentage of exempt members by exemption reason. Due to members being assigned more than one exemption reason category, these percentages will total above 100% if summed.

Results of Quantitative Analysis

Approximately 75% of all HIP members were exempt from community engagement requirements, as compared to 18% that were required to report and approximately 8% that were pre-qualified by prior employment. The most common exemption reasons were medical frailty, caretaking of children under seven years old, and "other." The State has indicated that exemption reporting increased after July 2019 when the six-month voluntary reporting period ended. **Exhibit F.2.6** provides the community engagement reporting status by month while **Exhibit F.2.7** provides additional detail by exemption reason.

Analyses for the Summative Evaluation Report will incorporate data reflecting 18 months of required reporting (through 2020) and include descriptive analyses of the distribution of members by reporting status, the distribution of exemption reasons, and the change in the distributions across time.

Exhibit F.2.6: Members by Community Engagement Reporting Status (January 2019 – June 2019)

Member Status	January 2019		February 2019		March 2019		April 2019		May 2019		June 2019	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent
Exempt	278,716	74.1%	281,357	74.0%	284,390	74.2%	287,964	74.5%	280,039	74.7%	286,106	74.6%
Pre-Qualified	29,153	7.8%	28,719	7.6%	28,557	7.4%	28,737	7.4%	27,552	7.3%	28,496	7.4%
Required to Report (voluntary basis only)	68,069	18.1%	70,021	18.4%	70,388	18.4%	69,770	18.1%	67,270	17.9%	68,951	18.0%
Total Members	**375,938**	-	**380,097**	-	**383,335**	-	**386,471**	-	**374,861**	-	**383,553**	-

Source: Gateway to Work referral status file, January 2019 – June 2019. Members are only included if they have a known referral status.
Note: Not all members found in the referral status file will also be found in the exemption reason file. Therefore, the monthly totals in this exhibit will not match to the monthly totals in **Exhibit F.2.7**.

Exhibit F.2.7: Members Exempt from Community Engagement Reporting by Exemption Reason (January 2019 and June 2019)

Exemption Reason	January 2019		June 2019	
	Number	Percent	Number	Percent
Medically Frail	97,713	34.7%	113,394	39.0%
Parent / Caretaker of child under 7 years	96,835	34.4%	99,392	34.2%
Student	32,272	11.5%	32,799	11.3%
60 Years Old	23,188	8.2%	23,125	8.0%
Pregnancy	21,410	7.6%	20,210	7.0%
Homeless	18,219	6.5%	18,716	6.4%
Disability	9,755	3.5%	9,481	3.3%
Recent Incarceration	5,072	1.8%	5,577	1.9%
Good Cause Exemption	2,711	1.0%	15	0.0%
Illness (Certified) or Incapacity (Temporary)	2,190	0.8%	250	0.1%
Caregiver of a Disabled Dependent	316	0.1%	460	0.2%
SUD Exemptions	42	0.0%	43	0.0%
Override by Gateway to Work Unit	15	0.0%	11	0.0%
Kinship Caregiver of an Abused or Neglected Child	13	0.0%	19	0.0%
Not Mapped in Referral File	283	0.1%	2	0.0%
Other (SNAP and TANF recipients and other miscellaneous indicators of barriers to community engagement, such as domestic violence and institutionalization)	131,401	46.7%	129,694	44.6%
Total Unique Members	**281,242**	-	**290,699**	-

Source: Gateway to Work exemption reason file, January 2019 – June 2019. The unique member monthly totals are higher than those in **Exhibit F.2.6** because the exemption reason file was developed approximately five months after the Gateway to Work referral file, allowing more time for data to be added.

Primary Research Question 10a – What strategies has the State pursued to reduce HIP member reporting burden, such as matching to State or MCE databases?

This research question identifies the strategies the State has pursued to date to reduce HIP member reporting burden, thus supporting compliance with community engagement reporting requirements. The State proactively uses data available to the eligibility system to determine if a member may already be exempt or prequalified. MCEs are also able to perform checks against claims data and other data sources to assign exemptions, and can retroactively assign members an exemption.

HIP members required to report qualifying activities can do so online using the FSSA Benefits Portal, over the phone by calling their MCE, or in-person by visiting their MCE office. Members must report the type of activity, date, location, and number of hours completed. While members have until the end of December to report hours for the year, the State and MCEs conduct targeted outreach to members throughout the year to increase reporting compliance. Members may retro-report at any point in time and may report at the frequency they choose throughout year (e.g., as frequently as every week or only once a year).

Brief Summary: Lewin found that the State and MCEs perform a range of data matching to proactively identify a member's reporting status, including potential exemptions from reporting. MCE executives and State officials have also worked closely on a variety of initiatives to reduce member reporting burden. Both entities reported collaborating on marketing and communication materials to ensure standardized language regarding how to report. The State also expanded the ways in which members can report their hours and made reporting timeframes more flexible.

Results of Qualitative Analysis

State officials and MCE executives used the following strategies to ease or reduce member reporting burden:

- Providing multiple avenues for reporting hours (i.e., online, phone, in-person)
- Allowing for variances in the timeframe reported (i.e., members can report hours at any time after completing the activity through the end of the year)

State officials reported implementing a variety of approaches to reduce member reporting burden, including:

- Using a communication campaign that includes print, digital, and other multimedia platforms to encourage and remind members about HIP benefits and reporting requirements. State officials indicated that this communication plan relies on simple and plain language and is aimed at teaching members how easy it is to report Gateway to Work hours. State officials also described working with the MCEs to remind members to report their hours via outbound calls, emails, text messages, mail, and social media.
- Facilitating reporting across many platforms to ensure the process is as easy as possible for members, specifically:
- Members can call their MCE to report their hours, log in to the FSSA Benefits Portal online on a desktop, smartphone, or tablet, or in-person at a MCE office.

- Members can also report their hours at any point all the way back to the start of the calendar year.
- Creating standardized language for its outreach materials and disseminating those materials to various partners, providers, MCEs, and other community resources to share with members. State officials indicated that these materials include information on how to find community engagement opportunities as well as specific details on how to report hours and where to look for support.

State officials reported using all data available via the eligibility system during the first six months of 2019—including SNAP and TANF status, employer verification, hours currently working, and student status—to proactively determine if a member is required to report. State officials also reported that MCEs can do similar scans of data to assign exemptions, for example:

- Identifying member participation in a MCE's educational program (e.g., General Educational Development [GED] exam)
- Using claims to identify a member's temporary illness or incapacity
- Matching to a city's database for individuals experiencing homelessness
- Verifying release dates from the Department of Corrections.

According to the State officials, there are plans to match to more data sources, including Next Level Jobs.

See Research Question 8 for reporting burden themes from the member key informant interviews. The Summative Evaluation Report will incorporate additional information from key informant interviews with State officials and MCE executives that will be held in 2020.

Primary Research Question 11 – What is the distribution of reasons for disenrollment among HIP members?

This research question assesses the distribution of reasons for disenrollment by HIP members overall and specific to members required to report community engagement qualifying activities in 2019 and 2020. Tracking the distribution of disenrollment reasons over time as the State phases in community engagement reporting requirements will allow the State to gauge any changes in the disenrollment reasons for members required to report community engagement activities. For purposes of this Interim Evaluation Report, data were available through March 2019. As community engagement reporting requirements were voluntary during this period of time, there are no disenrollments observed due to non-compliance with community engagement reporting requirements. As such, this data provides a limited baseline for reference purposes. Effective October 31, 2019, the State temporarily removed the enrollment suspension for members who do not meet their reporting requirements pending the results of the federal lawsuit regarding CMS approval of HIP. The Summative Evaluation will reflect data through 2020, which will capture the changes to the program based on the outcome of the court proceedings.

Brief Summary: Lewin found the distribution of reasons for disenrollment among HIP members overall and by community engagement reporting status category to be consistent during the period analyzed. The top three disenrollment reasons across all member groups were increased income, did not submit paperwork for redetermination, and failure to verify information. Members that were prequalified for reporting purposes were more likely to have disenrolled due to increased income.

Approach to Quantitative Analysis

Lewin used two sources of data for this analysis:

- Monthly enrollment and disenrollment data from December 2018 to April 2019 for HIP members with enrollment statuses of: HIP Plus (RP, SP), HIP Basic (RB, SB), HIP Plus Copay (PC), and Pregnant (MA)
- Gateway to Work administrative files from January 2019 to March 2019 containing the reporting status by member by month

We calculated monthly disenrollment rates for members by community engagement reporting status (January 2019 to March 2019). We used the disenrollment month corresponding to the last active month for a member in order to identify the corresponding member reporting status. We also calculated the disenrollment rate for all members, adding December 2018 for context. Finally, we developed a breakdown of disenrollment reasons across all members and by community engagement reporting status for January 2019 to March 2019 combined.

The State has a range of disenrollment reason codes available for use; typically, 100 codes are commonly used. Each member can have a maximum of five reason codes per month. Additionally, there is a consolidated set of nine disenrollment codes (developed for purposes of a separate federal evaluation).

1. Moved out-of-state
2. Increased income (e.g., employed with income over 138% FPL; child support income over 138% FPL)
3. Did not submit paperwork for redetermination (while there is an increase in redeterminations in the first quarter, other three quarters together could have more redeterminations than the first quarter)
4. Failure to verify information, for example, a member received a mid-year request to update information and did not complete it.
5. Non-payment of POWER Account Contribution (i.e., disenrolled from HIP Plus WITH six-month lockout)
6. Non-payment of initial POWER Account Contribution (i.e., never fully enrolled in HIP Plus)
7. Increased income and non-payment of POWER Account Contribution (i.e., disenrolled from HIP Basic WITHOUT six-month lockout)
8. Moved to another Medicaid category
9. Other (e.g., "deceased," "incarcerated")

Lewin used the above set of consolidated codes for analysis purposes. In some cases, members were assigned more than one disenrollment reason. We included all possible disenrollment reasons in the analyses.

Results of Quantitative Analysis

The overall disenrollment rate was 4.6% in December 2018; it decreased to 3.7% in January 2019, increased back 4.6% in February 2019, and then decreased to 4.5% in March 2019, as illustrated in **Exhibit F.2.8**. The disenrollment rates for members by community engagement reporting status during the February to March voluntary reporting time period were in a similar range (**Exhibit F.2.9**):

- Required to report (voluntary basis only) – 3.9% in January 2019 and 5.1% in March 2019
- Exempt from reporting – 3.8% in January 2019 and 4.4% in March 2019
- Pre-qualified – 4.1% in January 2019 and 5.3% in March 2019

Exhibit F.2.8: Overall HIP Monthly Disenrollment Rate (December 2018 – March 2019)

Month	Total Unique Members	Total Unique Members Disenrolled	% Disenrolled
December 2018	380,909	17,708	4.6%
January 2019	381,230	14,005	3.7%
February 2019	386,059	17,647	4.6%
March 2019	387,139	17,305	4.5%

Source: HIP monthly enrollment and disenrollment data, December 2018 to April 2019 for members with enrollment status of: Plus (RP, SP), Basic (SP, SB), HIP Plus Copay (PC), and Pregnant (MA). We did not include months when an individual had conditional eligibility or presumptive eligibility status, or members that were eligible for Emergency Room services only (Emergency Room services flag of "Y").

Exhibit F.2.9: Proportion of Members Disenrolled by Referral Status (January 2019 – March 2019)

Referral Status	January 2019			February 2019			March 2019		
	Total Members	Total Disenrolled	Percent Disenrolled	Total Members	Total Disenrolled	Percent Disenrolled	Total Members	Total Disenrolled	Percent Disenrolled
Exempt	268,392	10,248	3.8%	268,826	12,228	4.5%	271,567	11,852	4.4%
Pre-Qualified	28,042	1,162	4.1%	27,151	1,588	5.8%	27,088	1,423	5.3%
Required to Report (voluntary basis only)	65,544	2,545	3.9%	66,325	3,654	5.5%	66,811	3,430	5.1%
Total Members with Known Referral Status	**361,978**	**13,955**	**3.9%**	**362,302**	**17,470**	**4.8%**	**365,466**	**16,705**	**4.6%**

Source: February 2019 – April 2019 HIP disenrollment data and January 2019 – March 2019 Gateway to Work referral status data.

Note: Exhibit only includes members with a known community engagement status ("referral status") in the monthly Gateway to Work administrative files. The total number of January 2019 to March 2019 members are lower than those shown in **Exhibit F.2.8** because **Exhibit F.2.9** only includes members with a known referral status.

Exhibit F.2.10 presents the distribution of disenrollment reasons among all disenrolled individuals in the overall HIP population and by community engagement reporting status. The majority of disenrollments from January 2019 to March 2019—for all members and by community engagement reporting status (voluntary reporting period)—were associated with three disenrollment codes:

- Increase in income above the qualifying threshold for HIP Plus (138% FPL)
- Failure to verify information
- Failure to submit paperwork for redetermination

We also observed the following:

- Of the disenrolled members, Gateway to Work pre-qualified members were more likely to disenroll due to an increase in income; 49.3% of these members reported disenrollment for an increase in income during first quarter of 2019 as compared to 42.4% of members who were required to report and 38.4% of members who were exempt from reporting.
- Non-payment of POWER Account Contribution comprised a small percentage of disenrollment reasons, representing approximately 1.8% or less of disenrollment reasons (including non-payment with or without increase in income above the qualifying threshold for HIP Basic). The number of individuals in this category was low as the POWER Account Contribution "clock" resets in January and it takes 60 days, in addition to processing and notification time, before someone can be disenrolled for non-payment.
- There was a comparatively large percentage of individuals reporting disenrollment due to failure to verify information (21.8% of all disenrolled members) or submit paperwork for redetermination (22.9% of all disenrolled members).

The above disenrollment reasons should not be assumed to be consistent throughout the year without an analysis of additional data (to be performed for the Summative Evaluation Report). **Goal 4** provides additional detail on the State's disenrollment rate and related disenrollment reasons.

We note that some members will not verify new employment with the State when the State sends them a request to do so based on the results of data matching. As such, these members may have a closure reason that falls under another category (for example, failure to verify information). This may underestimate the number of members who close due to increased income, and may overestimate the number of members who close due to non-compliance or other reasons.

Exhibit F.2.10: Distribution of Disenrollment Reasons, by Member Community Engagement Reporting Status (January 2019 – March 2019)

Disenrollment Reason	All Members		Required To Report		Exempt from Reporting		Prequalified Reporting	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent
Increased Income (e.g., employed with income over 138% FPL; child support income over 138% FPL)	19,312	40.1%	4,085	42.4%	13,172	38.4%	2,055	49.3%
Did not submit paperwork for redetermination	11,023	22.9%	2,057	21.4%	7,953	23.2%	1,013	24.3%
Failure to Verify Information	10,474	21.8%	2,592	26.9%	7,175	20.9%	707	16.9%
Moved to Another Medicaid Category	3,350	7.0%	105	1.1%	3,182	9.3%	63	1.5%
Moved out-of-state	2,151	4.5%	510	5.3%	1,526	4.4%	115	2.8%
Increased Income + Nonpayment of POWER Account Contribution (i.e., disenrolled from HIP Basic WITHOUT 6 month lockout)	804	1.7%	50	0.5%	620	1.8%	134	3.2%
Non-payment of POWER Account Contribution (i.e., disenrolled from HIP Plus WITH 6 month lockout)[64]	25	0.1%	2	0.0%	20	0.1%	3	0.1%
Other (e.g., "deceased", "incarcerated")	1,136	2.4%	236	2.5%	807	2.4%	93	2.2%
Unknown	27	0.1%	1	0.0%	25	0.1%	1	0.0%
Total Unique Members	**48,121**	-	**9,626**	-	**34,323**	-	**4,172**	-

Source: February 2019 – April 2019 HIP disenrollment data and January 2019 – March 2019 Gateway to Work referral status data.
Note: Exhibit only includes members that are in the referral status file.

[64] The number of members in this category is low as the POWER Account Contribution "clock" resets in January and it takes 60 days in addition to processing and notification time before someone can be disenrolled for non-payment.

The Summative Evaluation Report will use disenrollment data through 2020 and survey data from members who have left HIP to further analyze and contextualize disenrollment trends by community engagement reporting status. This period will include the 18 months following the full implementation of community engagement requirements in July 2019. As part of this analysis, we will assess how disenrollment trends for HIP members that are required to report may be different from other members.

Primary Research Question 12 – Are HIP members who are disenrolled for non-compliance with community engagement requirements more or less likely to re-enroll than HIP members who disenroll for other reasons?

This research question will assess if HIP members who disenrolled for non-compliance with community engagement activities will be more or less likely to re-enroll than HIP members who disenroll for other reasons. We will address this question in the Summative Evaluation Report, which will include monthly administrative data through 2020. Effective October 31, 2019, the State temporarily removed the enrollment suspension for members who do not meet their reporting requirements pending the results of the federal lawsuit regarding CMS approval of HIP.

Goal 3 – Reduce tobacco use among HIP members, through a premium surcharge and the utilization of tobacco cessation benefits

The HIP tobacco surcharge policy charges members an increased monthly contribution for tobacco use to discourage tobacco use and increase the utilization of tobacco cessation benefits. Under this policy, the State assesses a surcharge on top of the POWER Account Contribution for members who continuously enroll for 12 months with the same MCE and self-identify as tobacco users during this period. If the member continues to self-identify as using tobacco, the State increases their monthly contributions by 50% beginning in the first month of their new benefit period. **Section B: Summary of HIP Demonstration** provides examples of the tobacco surcharge by income level. MCEs reported applying the tobacco surcharge to 2,662 members in 2019, representing <1% of the 569,971 HIP members in 2018.[65]

The State collects information on HIP member tobacco use during the HIP enrollment process (initial enrollment and during the plan selection period); members can also report changes in their tobacco use by calling their MCE or the State. While there are questions about tobacco use on the MCE health needs assessment, the MCEs do not use these responses to determine the tobacco surcharge due to concerns about members underreporting tobacco use during an assessment performed for clinical purposes.

MCE responsibilities include conducting active outreach and member education related to available tobacco cessation benefits, identifying tobacco users, and applying the surcharge. When deciding which members will be assessed the surcharge, the MCEs accept data on members using tobacco from the State and then identify members based on State criteria (members must be continuously enrolled for a year with a tobacco status with the same MCE). The following are the types of members that MCEs were able to evaluate for continued tobacco use for purposes of the tobacco surcharge:

- Members who voluntarily contacted their MCE to report their tobacco use status after one year
- Members who are continuously enrolled with the same MCE

The period for the tobacco surcharge resets when a member switches MCEs or disenrolls from HIP.

The hypotheses associated with this goal assess whether the tobacco contribution surcharge policy increases the use of tobacco cessation services and decreases tobacco use among the HIP population. While we will not perform the related analyses until the Summative Evaluation Report, per the HIP Evaluation Plan, we conducted some initial analyses on the prevalence of tobacco use and tobacco cessation services utilization. The population included in these analyses were members with monthly enrollment statuses of Regular Basic (RB), Regular Plus (RP), State Basic (SB), State Plus (SP), pregnant (MA), and HIP Plus Copay (PC). We did not include months when an individual had conditional eligibility or presumptive eligibility status, or members that were eligible for Emergency Room services only (Emergency Room services flag of "Y").

[65] Members with enrollment status values of Regular Basic (RB), Regular Plus (RP), State Basic (SB), State Plus (SP), pregnant (MA), and HIP Plus Copay (PC). We did not include months when an individual had conditional eligibility or presumptive eligibility status, or members that were eligible for Emergency Room services only (Emergency Room services flag of "Y").

Hypothesis 1 – The tobacco premium surcharge will increase use of tobacco cessation services among HIP members.

This hypothesis examines the effect of the tobacco surcharge policy on the use of tobacco cessation services. The research questions associated with this hypothesis explore tobacco cessation service use over time along with HIP member understanding of the policy and availability of/satisfaction with tobacco cessation benefits.

Primary Research Question 1.1 – What impact has the tobacco premium surcharge had on the use of tobacco cessation benefits for HIP members?

As the analyses related to this research question rely on encounter data through 2020, we will not fully address this research question until the Summative Evaluation Report. An analysis of 2015 to 2018 MCE encounter data for HIP members does provide, however, an initial view of tobacco cessation service use.

Brief Summary: An initial view of 2015 to 2018 tobacco cessation service utilization includes the following observations:

- From 2015 to 2018, 5.8% to 8.7% of HIP members utilized a tobacco cessation service annually.
- Among members using tobacco cessation in 2018, most (88.5%) chose medications; of those approximately 50% of members used bupropion and 31.6% used a nicotine replacement.
- Tobacco cessation services were most common among members 51 years of age or older, females, non-Hispanic Whites, and rural residents.

Approach to Quantitative Analysis

Lewin used encounter data from February 2015 to December 2018 to identify use of tobacco cessation services. The encounter data analyzed represents all paid services including inpatient, outpatient, ED, and medications. Fields used in the analysis include date of service, NDC, and procedure code. We categorized tobacco cessation services as physician counseling[66] or medication, and classified tobacco cessation medications into three therapeutic compounds:[67]

- Nicotine replacement
- Bupropion (e.g., Wellbutrin™)
- Varenicline (e.g., Chantix™)

[66] Derived from recommendations by the American Lung Association (https://www.lung.org/assets/documents/tobacco/billing-guide-for-tobacco-1.pdf) and based on the following CPT4 procedure codes: 99406, 99407, D1302, G0436, G0437, S9453

[67] Yue X., Guo, JJ., Wigle, PR. (2018). Trends in Utilization, Spending, and Prices of Smoking-Cessation Medications in Medicaid Programs: 25 Years Empirical Data Analysis, 1991-2015. American Health & Drug Benefits. Retrieved from https://www.ncbi.nlm.nih.gov/pubmed/?term=30464795

We downloaded NDCs from the Food and Drug Administration National Drug Code directory by searching the nonproprietary names,[68] and used encounter data to identify the following:

- Count of services (counseling and medication)
- Proportion of unique members utilizing each service
- Per member per year average utilization among those using cessation services
- Proportionate share of cessation services by type, including high-level combinations (e.g., counseling and medication)
- Cessation services by HIP demographic characteristics (shown as overall utilization as patterns of cessation utilization were similar for counseling and medication)

There are several limitations to this approach to identifying tobacco cessation services:

- **Reliance on tobacco-specific procedure codes:** While the analysis relies on codes specific to tobacco and/or smoking, providers can also bill for tobacco cessation counseling under general preventive counseling procedure codes (99381-99397). It is not possible to distinguish tobacco-specific counseling from other health behavior counseling billed using the general preventive counseling procedure codes, which may include diet, exercise, or substance use.
- **Use of Indiana Tobacco Quit Line:** Many providers may refer members to the Indiana Quit Line, which is a free resource for tobacco cessation that includes counseling and some nicotine replacement therapy (usually time-limited). The encounter data does not capture these referrals.
- **Use of over-the-counter medication:** Encounter data does not reflect members who received over-the-counter cessation medications such as nicotine replacement therapies.
- **Provider billing practices:** It is possible that providers are delivering tobacco cessation services but not billing for these services. Providers billed for the majority of cessation counseling services using procedure code 99406, representing 82% of all cessation counseling procedure codes, followed by procedure code 99407 at 13%. Procedure codes D1302 and S9453, which represent non-physician provider codes, were present on four occasions. Procedure codes G0436 and G0437 were discontinued in 2016, and were also infrequent.
- **Uses for bupropion:** Providers may prescribe bupropion for tobacco cessation, but also as an antidepressant. Although Ku et al.[69] propose using the 150 mg per 12-hour dosing formulations to produce conservative estimates, this analysis uses all NDCs for bupropion.

[68] U.S. Food & Drug Administration. (2019). National Drug Code Directory. Retrieved from https://www.accessdata.fda.gov/scripts/cder/ndc/index.cfm

[69] Ku, L., Bruen, B., Steinmetz, E., & Bysshe, T. (2016). Medicaid Tobacco Cessation: Big Gaps Remain In Efforts To Get Smokers To Quit. Health Affairs. Retrieved from https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2015.0756#EX4FN1

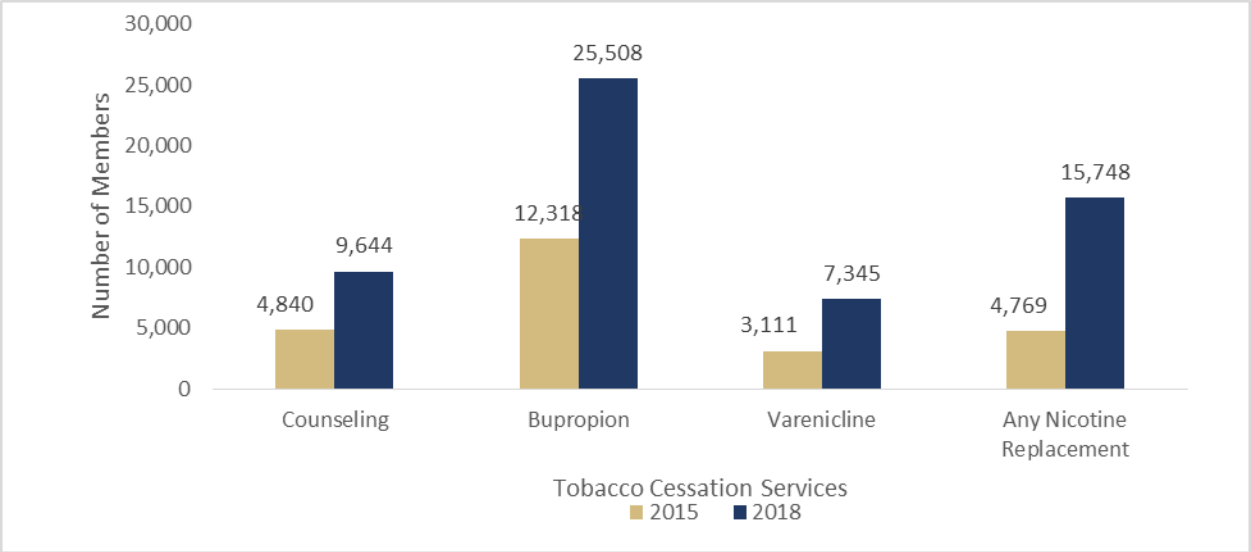
Results of Quantitative Analysis

The use of tobacco cessation services has remained relatively constant from February 2015 to December 2018. Among the total HIP population, approximately 5.8% to 8.7% of members utilized a tobacco cessation service annually. Utilization by service type varied:

- Counseling services – 1.2% of members in 2015, 1.5% in 2016, 1.6% in 2017 and 1.7% in 2018
- Medications
- Use of bupropion – 3.1% of members in 2015, 3.8% in 2016, 4.3% in 2017, and 4.5% in 2018
- Use of varenicline – 0.8% of members in 2015, 1.2% in 2016, and 1.3% in 2017 and 2018
- Nicotine replacement therapies – 1.2% of members in 2015, 2.4% in 2016, 2.6% in 2017, and 2.8% in 2018

Exhibit F.3.1 provides a summary of the number of members receiving tobacco cessation services.

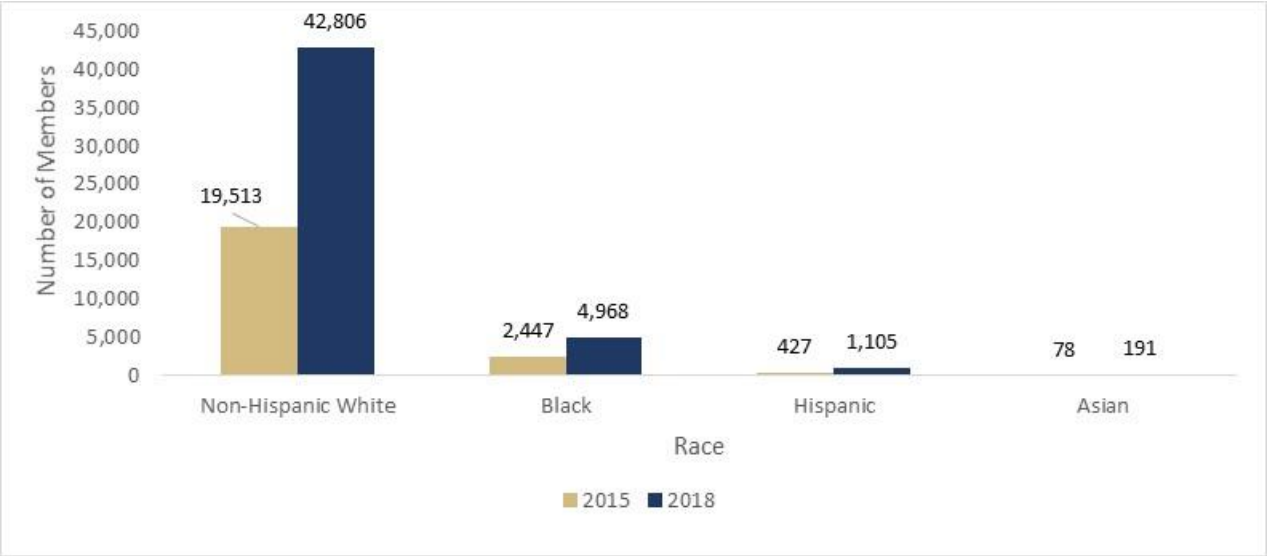
Exhibit F.3.1: Number of Members Receiving Tobacco Cessation Services, by Type of Service (February 2015 – December 2015 and January 2018 – December 2018)



Source: MCE encounter data, February 2015 – December 2015 and January 2018 – December 2018.

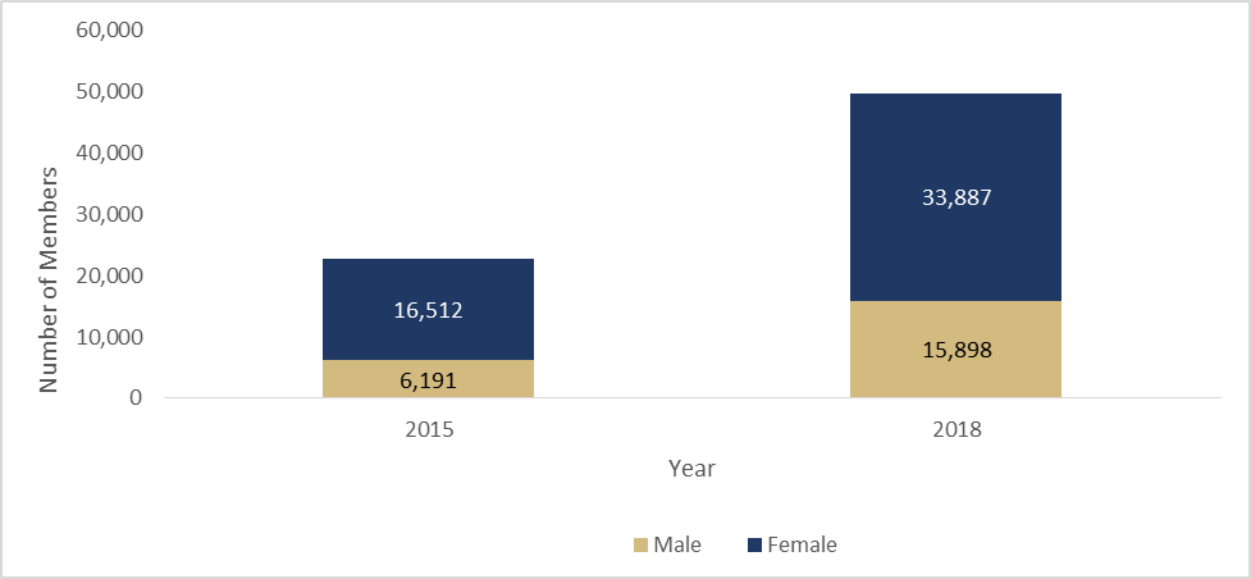
Cessation services were most common among older age categories, females, non-Hispanic Whites, and rural residents. These patterns were common across years in both the proportion of and average services utilized. These exhibits show increases in tobacco cessation services over time consistent with HIP enrollment trends; gains are greater among females, non-Hispanic Whites, and members in non-metro areas (based on the overall change in the percentage of members using services). **Exhibits F.3.2** to **F.3.5** provide specific visualizations of tobacco cessation service utilization by the various demographic characteristics using 2015 and 2018 as comparison years. **Exhibit F.3.6** provides a summary of tobacco cessation services used by HIP members. **Exhibit F.3.7** provides additional detail on tobacco cessation services used by demographic characteristics.

Exhibit F.3.2: Members Utilizing Tobacco Cessation Services by Race (February 2015 – December 2015 and January 2018 – December 2018)



Source: MCE encounter data, 2015 and 2018.

Exhibit F.3.3: Members Utilizing Tobacco Cessation Services by Gender (February 2015 – December 2015 and January 2018 – December 2018)

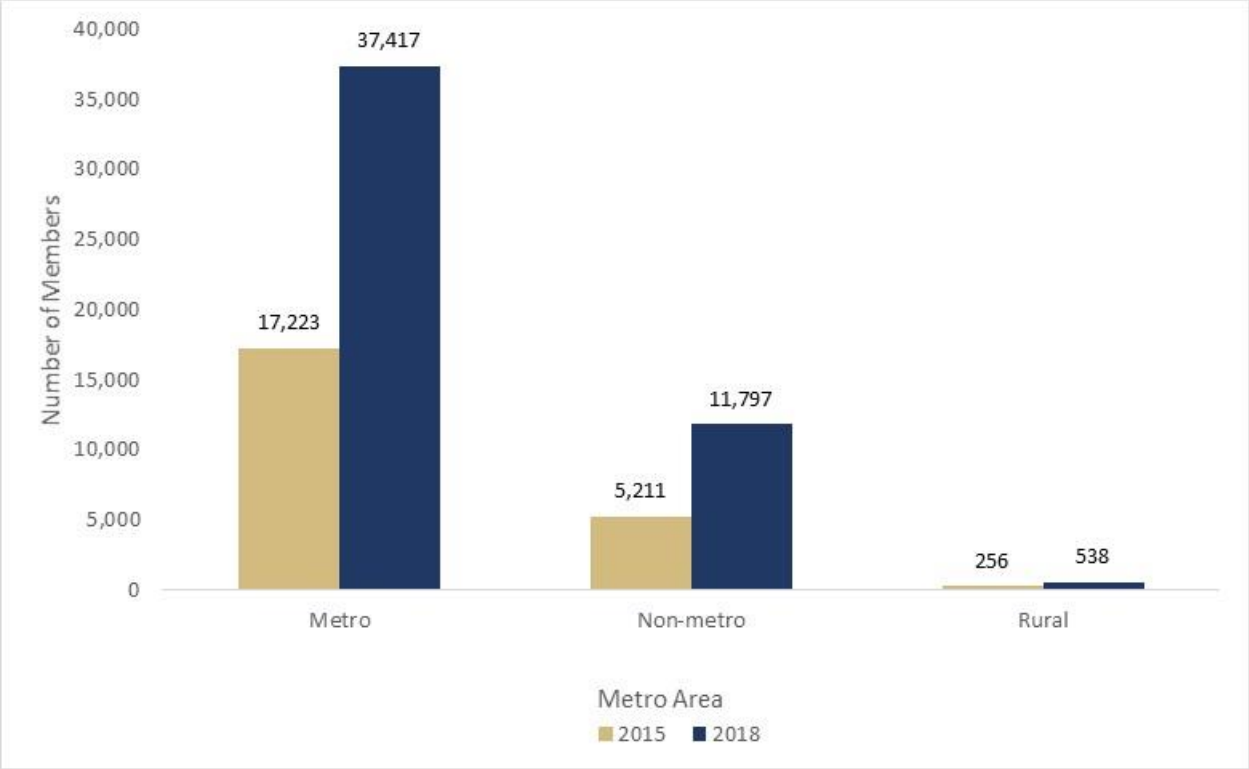


Source: MCE encounter data, 2015 and 2018.

Exhibit F.3.4: Members Utilizing Tobacco Cessation Services by Age (February 2015 – December 2015 and January 2018 – December 2018)

Source: MCE encounter data, 2015 and 2018.

Exhibit F.3.5: Members Utilizing Tobacco Cessation Services by Geographic Location (February 2015 – December 2015 and January 2018 – December 2018)



Source: MCE encounter data, 2015 and 2018.

Exhibit F.3.6: Tobacco Cessation Services Used by HIP Members (February 2015 – December 2018)

Type	February-December 2015 N= 389,984 members[a]			Calendar Year 2016 N=520,212 members			Calendar Year 2017 N=556,463 members			Calendar Year 2018 N=569,971 members		
	Count of services[b]	Members utilizing (%)[c]	Avg. services utilized per member per year[d]	Count of services	Members utilizing (%)	Avg. services utilized per member per year	Count of services	Members utilizing (%)	Avg. services utilized per member per year	Count of services	Members utilizing (%)	Avg. services utilized per member per year
Any Cessation Services	76,506	22,703 (5.82)	3.37	155,222	40,366 (7.76)	3.85	194,752	47,144 (8.47)	4.13	207,381	49,785 (8.73)	4.17
Counseling	6,771	4,840 (1.24)	1.40	13,237	7,834 (1.51)	1.69	17,979	8,996 (1.62)	2.00	16,994	9,644 (1.69)	1.76
Any Medication or Nicotine Replacement	69,735	19,080 (4.89)	3.65	141,985	35,230 (6.77)	4.03	176,773	41,515 (7.46)	4.26	190,387	44,078 (7.73)	4.32
Bupropion	52,817	12,318 (3.16)	4.29	94,320	19,772 (3.8)	4.77	119,762	23,941 (4.3)	5.00	128,603	25,508 (4.48)	5.04
Varenicline	6,318	3,111 (0.8)	2.03	15,608	6,255 (1.2)	2.50	18,333	7,223 (1.3)	2.54	19,489	7,345 (1.29)	2.65
Any Nicotine Replacement	10,600	4,769 (1.22)	2.22	32,057	12,497 (2.4)	2.57	38,678	14,707 (2.64)	2.63	42,295	15,748 (2.76)	2.69
Inhaler	346	168 (0.04)	2.06	552	191 (0.04)	2.89	398	166 (0.03)	2.40	455	174 (0.03)	2.61
Lozenge	136	59 (0.02)	2.31	430	177 (0.03)	2.43	640	287 (0.05)	2.23	801	380 (0.07)	2.11
Gum	980	409 (0.1)	2.40	2,326	979 (0.19)	2.38	3,338	1,492 (0.27)	2.24	3,806	1,627 (0.3)	2.3
Patch	9,138	4,293 (1.1)	2.13	28,749	11,746 (2.26)	2.45	34,302	13,616 (2.45)	2.52	37,303	14,678 (2.3)	2.5

[a] Total number of unique HIP members enrolled at any point in the calendar year, for any amount of time

[b] Count of services is equivalent to the appearance of a service in a claim, or a claim for a medication fill, and represents instances of counseling visits, initial medication fills, or medication refills. This is the total number of each service utilized during the calendar year, including multiple services utilized per member.

[c] The percentage of unique members utilizing each service at least once.

[d] Among members who utilized each service, this is the average number of times they used the service during the calendar year. This provides an indication of the frequency of use over time of each service.

Source: MCE encounter data, February 2015 – December 2018.

Exhibit F.3.7: Use of Tobacco Cessation Services Among HIP Members by Demographic Characteristics (February 2015 – December 2018)

Category		February-December 2015 N= 389,984 members[a]			Calendar Year 2016 N=520,212 members			Calendar Year 2017 N=556,463 members			Calendar Year 2018 N=569,971 members		
		Count of services[b]	Members utilizing (%)[c]	Avg. services utilized per member per year[d]	Count of services	Members utilizing (%)	Avg. services utilized per member per year	Count of services	Members utilizing (%)	Avg. services utilized per member per year	Count of services	Members utilizing (%)	Avg. services utilized per member per year
All	Overall	76,506	22,703 (5.82)	3.4	155,222	40,366 (7.76)	3.8	194,752	47,144 (8.47)	4.1	207,381	49,785 (8.73)	4.2
Age	Ages 19-30	14,350	5,018 (3.37)	2.9	27,836	8,600 (4.37)	3.2	35,349	9,987 (4.81)	3.5	36,518	10,394 (4.86)	3.5
	Ages 31-40	23,084	6,720 (6.53)	3.4	43,516	11,315 (8.33)	3.8	53,757	13,212 (9.07)	4.1	58,153	14,113 (9.48)	4.1
	Ages 41-50	21,446	5,863 (8.45)	3.7	42,702	10,368 (11.25)	4.1	52,893	11,878 (12.17)	4.5	55,221	12,120 (12.24)	4.6
	Ages 51+	17,560	5,070 (7.86)	3.5	41,122	10,050 (11.05)	4.1	52,660	12,030 (11.95)	4.4	57,418	13,117 (12.7)	4.4
	Missing	66	32 (0.73)	2.1	46	33 (0.74)	1.4	93	37 (0.77)	2.5	71	41 (0.8)	1.7
Gender	Male	18,925	6,191 (4.92)	3.1	43,839	12,520 (6.75)	3.5	56,927	15,107 (7.3)	3.8	59,091	15,898 (7.56)	3.7
	Female	57,581	16,512 (6.25)	3.5	111,383	27,846 (8.32)	4.0	137,825	32,037 (9.16)	4.3	148,290	33,887 (9.42)	4.4

Category		February-December 2015 N= 389,984 members[a]			Calendar Year 2016 N=520,212 members			Calendar Year 2017 N=556,463 members			Calendar Year 2018 N=569,971 members		
		Count of services[b]	Members utilizing (%)[c]	Avg. services utilized per member per year[d]	Count of services	Members utilizing (%)	Avg. services utilized per member per year	Count of services	Members utilizing (%)	Avg. services utilized per member per year	Count of services	Members utilizing (%)	Avg. services utilized per member per year
Race	Non-Hispanic White	68,095	19,513 (7)	3.5	137,593	34,791 (9.37)	4.0	171,862	40,578 (10.25)	4.2	182,458	42,806 (10.62)	4.3
	Black	6,085	2,447 (3.14)	2.5	12,427	4,177 (4.05)	3.0	15,925	4,822 (4.42)	3.3	17,005	4,968 (4.46)	3.4
	Hispanic	1,324	427 (2.22)	3.1	2,747	779 (2.97)	3.5	3,814	1,020 (3.54)	3.7	4,249	1,105 (3.55)	3.8
	Asian	248	78 (0.96)	3.2	539	148 (1.32)	3.6	554	134 (1.06)	4.1	707	191 (1.4)	3.7
	Other	88	29 (5.68)	3.0	225	49 (6.82)	4.6	211	50 (6.62)	4.2	200	72 (9.14)	2.8
	Unknown	666	209 (3.89)	3.2	1,691	422 (5.47)	4.0	2,386	540 (5.89)	4.4	2,762	643 (6.31)	4.3
Rural-Urban Status	Metro	57,697	17,223 (5.64)	3.3	116,752	30,300 (7.44)	3.9	147,296	35,678 (8.19)	4.1	155,354	37,417 (8.37)	4.2
	Non-metro	17,974	5,211 (6.45)	3.4	36,872	9,603 (8.91)	3.8	45,584	10,957 (9.51)	4.2	49,593	11,797 (10.05)	4.2
	Rural	783	256 (7.49)	3.1	1,542	440 (9.73)	3.5	1,791	479 (9.91)	3.7	2,177	538 (10.9)	4.0
	Unknown	52	13 (3.32)	4.0	56	23 (4.36)	2.4	81	30 (5.83)	2.7	257	33 (7.17)	7.8

[a] Total number of unique HIP members enrolled at any point in the calendar year, for any amount of time

[b] Count of services is equivalent to the appearance of a service in a claim, or a claim for a medication fill, and represents instances of counseling visits, initial medication fills, or medication refills. This is the total number of each service utilized during the calendar year, including multiple services utilized per member.

[c] The percentage of unique members utilizing each service at least once.

[d] Among members who utilized each service, this is the average number of times they used the service during the calendar year. This provides an indication of the frequency of use over time of each service.

Source: MCE encounter data and HIP monthly enrollment data, February 2015 – December 2018.

Among members using cessation services, members used 3.4 services per member per year in 2015, 3.8 in 2016, 4.1 in 2017, and 4.2 in 2018. That is, members were typically using some combination of approximately four services per year, including:

- **Counseling:** 1.4 counseling services per member per year in 2015, 1.7 in 2016, 2.0 in 2017 and 1.8 in 2018.
- **Medications:** 3.7 medications per member per year in 2015, 4.0 in 2016, 4.3 in 2017, and 4.3 in 2018.

Additional observations include:

- Medications were the most common cessation service; 84.0% of members using tobacco cessation services used medications in 2015, 87.3% in 2016, 88.1% in 2017, and 88.5% in 2018.
- Approximately half of members using tobacco cessation services used bupropion across all years analyzed.
- In 2015, 21% of members using tobacco cessation services used nicotine replacement, 31% in 2016, 31.2% in 2017, and 31.6% in 2018.
- Among nicotine replacement therapies, the patch was the most commonly observed type.
- Combinations of cessation services were observed among 8.3% of members using cessation services in 2015, 11.8% of members in 2016, 12.7% in 2017, and 13.4% in 2018. The most commonly observed combination was counseling with medication representing 6.7% of members with more than one service type observed in 2016, 7.1% in 2017, and 7.9% in 2018.

Exhibit F.3.8 provides additional information on the use of tobacco cessation services by HIP members.

Exhibit F.3.8: Relative Use of Tobacco Cessation Services Among HIP Members Who Used Any Cessation Services (February 2015 – December 2018)[a]

Category	February-December 2015 N=22,703 (%)	Calendar Year 2016 N=40,366 (%)	Calendar Year 2017 N=47,144 (%)	Calendar Year 2018 N=49,785 (%)
Counseling	4,840 (21.3)	7,834 (19.4)	8,996 (19.1)	9,644 (19.4)
Any Medication or Nicotine Replacement	19,080 (84)	35,230 (87.3)	41,515 (88.1)	44,078 (88.5)
Bupropion	12,318 (54.3)	19,772 (49)	23,941 (50.8)	25,508 (51.2)
Varenicline	3,111 (13.7)	6,255 (15.5)	7,223 (15.3)	7,345 (14.8)
Any Nicotine Replacement	4,769 (21)	12,497 (31.0)	14,707 (31.2)	15,748 (31.6)
Inhaler	168 (0.7)	191 (0.5)	166 (0.4)	174 (0.3)
Lozenge	59 (0.3)	177 (0.4)	287 (0.6)	380 (0.8)
Gum	409 (1.8)	979 (2.4)	1,492 (3.2)	1,627 (3.3)
Patch	4,293 (18.9)	11,746 (29.1)	13,616 (28.9)	14,635 (29.4)
Any Combination	1,890 (8.3)	4,771 (11.8)	5,996 (12.7)	6,663 (13.4)
Counseling + (Any Medication or Nicotine Replacement)	1,217 (5.4)	2,698 (6.7)	3,367 (7.1)	3,937 (7.9)
Counseling + Any Nicotine Replacement	542 (2.4)	1,573 (3.9)	1,913 (4.1)	2,296 (4.6)
Any Nicotine Replacement + Any Medication	767 (3.4)	2,436 (6.0)	3,190 (6.8)	3,330 (6.7)

[a] Unduplicated HIP members who utilized any tobacco cessation services during the calendar year.

Source: MCE encounter data, February 2015 – December 2018.

Subsidiary Research Question 1.1a – Do HIP members understand the premium surcharge policy?

This research question addresses whether HIP members understand the tobacco surcharge.

Brief Summary: Results from the member interviews suggest that HIP members generally know about HIP policies, including the tobacco surcharge and available cessation services. MCE executives indicated that they have provided members, in particular those identified as tobacco users and/or being assessed the surcharge, with multiple communications on the tobacco surcharge and the availability of tobacco cessation services.

Results of Qualitative Analysis

Results from the member interviews suggest that HIP members are generally aware of the tobacco surcharge. Based on the member interviews, 23 of 27 members responded that they were aware of the different aspects of HIP, including the tobacco cessation services and the surcharge. However, we asked members broadly about HIP at a specific point in time and so those members may not have been responding directly about the tobacco surcharge. The member interviews did include a question for members who have self-reported as using tobacco regarding their understanding of the surcharge. However, this question provided very limited context given how few individuals responded to this question.

MCE representatives indicated that they did not feel able to specifically speak to awareness of the surcharge among all members. However, they did provide the following feedback:

- MCEs have provided members, in particular those being assessed the surcharge, with multiple communications to inform them of the changes and information about available tobacco cessation services. The MCEs have distributed this information to all members through updates on websites, member handbooks, member newsletters, flyers at member events, social media accounts, and communications as part of case management services.
- MCEs provided additional, more directed outreach, specifically to those members identified as tobacco users and eligible for the surcharge. Each of the MCEs sent letters to members prior to surcharge going into effect to make them aware of changes and provide them with information about available cessation services and initiatives.
- All of the MCEs have been tracking and billing for the surcharge on monthly POWER Account statements for members assessed the surcharge. The MCEs separate the surcharge from the standard POWER Account Contribution on invoicing to highlight the additional cost to members using tobacco.

Lewin reviewed data collected from 36 provider interviews related to tobacco cessation services and the tobacco surcharge. Of the 15 respondents for the question on knowledge of the tobacco surcharge, only four providers knew about the tobacco surcharge that HIP members have to pay if they do not quit smoking; of those, two stated that they had conversations with HIP members about the surcharge. One provider speculated that the surcharge might "make patients mad" and not necessarily motivate them to change their behaviors. Another provider stated that they explain the surcharge to their tobacco-using HIP patients, many of whom express confusion and/or frustration at the surcharge, often citing their right to autonomy in their choice to smoke.

Subsidiary Research Question 1.1b – Do HIP members know about the cessation services offered through HIP?

This question assesses the extent to which HIP members know about the tobacco cessation services offered through HIP.

Brief Summary: Results from the member interviews suggest that individuals know about available cessation services (counseling and medication), although few reported actually using services. Results from member and provider interviews suggest that some members would like to access tobacco cessation services not currently covered, specifically group therapy services and a new type of nicotine patch.

Results of Qualitative Analysis

Results from member and provider interviews suggest that some members would like to access tobacco cessation services not currently covered, specifically group therapy services and a new type of nicotine patch. According to feedback received during the HIP member interviews, members were aware of available cessation services (counseling and medication), but few reported actually using services. One provider said that members do not know what services are available to them. Again, MCE executives indicated that they did not feel that they could fully speak to member knowledge of services, but that they thought they had communicated information well to members about tobacco cessation services

and specific MCE initiatives. MCE executives reported promoting the Indiana Tobacco Quitline, the Baby and Me Tobacco Free initiative for pregnant women, and assistance as part of case management services. Additionally, they reported that they have been working with FSSA and the Indiana State Department of Health to support these services for their members and to access relevant data to assist in tracking member engagement.

At least two of the MCEs reported that initial data from the Indiana Tobacco Quitline indicated that member engagement in tobacco cessation services had increased but some data issues still make engagement difficult to access. MCE executives conveyed that they were encouraged by the support they receive from the State to aid in their efforts and to improve the quality and availability of Indiana Tobacco Quitline data to better measure member participation.

Additionally, all of the MCEs interviewed reported having revised incentive schema to encourage participation in tobacco cessation services, and that FSSA has supported MCEs revised incentive structures. **Exhibit F.3.9** outlines various programs and/or incentives that the four MCEs are using to encourage participation in tobacco cessation services.

Exhibit F.3.9: MCE Incentives for HIP Member Utilization of Tobacco Cessation Services

MCE	Incentives and Programs
Anthem[70]	• Smokers may earn up to $40 for quitting smoking through the *Indiana Tobacco Quitline*; members receive $20 upon sign up and another $20 upon completion of the program. • Pregnant smokers may enroll in the *Baby and Me Tobacco Free* program, which allows pregnant, smoking members to become eligible for rewards such as $25 diaper vouchers upon completion of the following steps: ○ Enroll in the program ○ Take prenatal smoking-cessation classes ○ Agree to take a monthly breath test ○ Stay smoke free after their baby is born
MDWise[71,72]	• Smokers may participate in *SMOKE-free*, the plan's program to assist with tobacco cessation. • *SMOKE-free* covers the following treatments, with some limits: gum, patch, lozenge, nasal spray, inhaler, prescription medication, and individual and group counseling. • Smokers may earn points to get free gift cards by completing a cessation program; eligible programs include the *Indiana Tobacco Quitline, Baby and Me Tobacco Free*, and/or a program through the member's hospital or clinic. ○ Members may also choose the POWER Account Contribution option as their reward, so the funds from accrued points will go towards HIP Plus plan payments.

[70] Anthem, Inc. (2018). Healthy Indiana Plan: Member Handbook. Retrieved from https://mss.anthem.com/in/inin_caid_hip_memberhandbook_eng.pdf

[71] MDwise. (2018). SMOKE-free Tobacco Cessation Brochure. Retrieved from https://www.mdwise.org/MediaLibraries/MDwise/Files/Health%20and%20Wellness/tobacco_cessation_brochure_1-17-18-accessible.pdf

[72] MDwise. (2019). Healthy Indiana Plan: SMOKE-free. Retrieved from https://www.mdwise.org/smoke-free?referer=/for-members/healthy-indiana-plan/health-and-wellness/smoke-free/

MCE	Incentives and Programs
CareSource[73,74]	• CareSource covers quit services and benefits including medicine, web-based education and tools, calls with a personal coach, behavioral counseling, and rewards opportunities. • Smokers may earn various gift card incentives for being tobacco free through the *MyHealth* program.
MHS[75]	• Smokers may earn up to $145 per year in My Health Pays[76] rewards by participating in the *Indiana Tobacco Quitline:* ○ Enrollment = $40 ○ Completion of 1st coaching call = $25 ○ Completion of 3rd coaching call = $30 ○ Completion of program = $50 • MHS covers quit aids, including Nicotine gum, lozenges, and patches, as part of the members' plan coverage

Subsidiary Research Question 1.1c – Are HIP members satisfied with tobacco cessation services?

This question assesses member satisfaction with tobacco cessation services.

Brief Summary: MCE executives reported receiving few complaints or disputes related to the new tobacco surcharge. The number of members reporting use of tobacco cessation services in the member interviews did not allow us to report on overall satisfaction with these services.

Each of the MCEs interviewed reported having received few complaints or disputes related to the new tobacco surcharge. Feedback from the member interviews specific to satisfaction with tobacco cessation services was limited to two members and not consistent, and is not considered sufficient to provide additional context. As stated above, at least two of the MCEs reported that engagement in cessation services, specifically the Indiana Tobacco Quitline, had increased among members after the implementation of new services and incentive structures. The MCE executives interviewed noted that they think members did not engage in services due to the following reasons:

- Member may not be ready to quit using tobacco
- Stigma associated with admitting tobacco use
- Somewhat transient nature of the population, making it difficult to maintain consistent communication with members

[73] CareSource. (2019). Indiana Benefits and Services: Rewards. Retrieved from https://www.caresource.com/in/plans/medicaid/benefits-services/additional-services/rewards/

[74] CareSource. (2019). HIP Tobacco Use Surcharge. Retrieved from https://www.caresource.com/in/plans/medicaid/hip-tobacco-use-surcharge/

[75] Managed Health Services. (2019). Healthy Indiana Plan Benefits & Services: Tobacco Services. Retrieved from https://www.mhsindiana.com/members/hip/benefits-services/smoking-cessation.html

[76] My Health Pays is the MHS rewards program in the form of a payment card. Members may use their My Health Pays card to help pay for utilities, transportation, telecommunications, childcare services, education, rent, POWER Account Contributions, and/or everyday items at Walmart.

Key informant interviews with providers indicated that many members might be aware of tobacco cessation services offered to them, but face external barriers to utilization. Some providers stated that getting someone to start tobacco cessation services is difficult; the member's level of motivation is critical to initiation and adherence to programming. One provider used strategic framing to encourage members to participate in the services. For example, the provider listened to the member breathing with a stethoscope and explicitly told the member that they had to stop smoking or they would not get adequate airflow to their body. Additionally, providers discussed difficulties in maintaining participation in tobacco cessation programs, with reasons related to both motivation and cost. One provider said that HIP's tobacco cessation program coverage should expand beyond 12 weeks, and another discussed the lack of reimbursement for group work as a reason for member disengagement. A provider also stated that members sometimes have trouble paying out-of-pocket for cessation services not covered under HIP (such as over-the-counter nicotine patches).

Overall, providers felt that members were satisfied with tobacco cessation services, with three of 15 respondents for the question describing members as "very satisfied" and five of 15 who stated members were "somewhat satisfied."

Hypothesis 2 – The tobacco premium surcharge and availability of tobacco cessation benefits will decrease tobacco use.

This hypothesis focuses on examining the effect of the tobacco surcharge policy and availability of tobacco cessation benefits on tobacco use. The research questions associated with this hypothesis explore tobacco use over time along with HIP member understanding of the policy and availability of/satisfaction with tobacco cessation benefits.

Primary Research Question 2.1 – Has tobacco use decreased among the target population?

As the analyses related to this research question rely on State administrative data through 2020, we will not fully address this research question until the Summative Evaluation Report. An analysis of State tobacco use files (October 2017 through the first quarter of 2019) does, however, provide context for the prevalence of tobacco use.

Brief Summary: According to an analysis of data collected by the State from new HIP applications beginning in 2017 (new enrollees or enrollees switching MCEs) and self-reported member tobacco use during enrollment, approximately 29% to 31% of new HIP members or members reporting during the MCE selection period use tobacco, somewhat lower than low income/Medicaid estimates for Indiana from other sources which range from 35% to 37%.[77,78] These new applications represent approximately 10% to 15% of the overall HIP population and are not a random sample of HIP members. Use of tobacco is highest for non-Hispanic Whites and members living in rural and non-metro areas.

[77] Ku, L., Bruen, B., Steinmetz, E., & Bysshe, T. (2016). Medicaid Tobacco Cessation: Big Gaps Remain In Efforts To Get Smokers To Quit. Health Affairs. Retrieved from https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2015.0756#EX4FN1

[78] UnitedHealth Foundation. (2019). America's Health Rankings Annual Report. Retrieved from https://www.americashealthrankings.org/explore/annual/measure/Smoking/state/IN

Approach to Quantitative Analysis

We estimated the prevalence of tobacco use using self-reported information from the State administrative data tobacco use files from October 2017 through the first quarter of 2019. There are two significant limitations to this data:

- **Data reflects a subset of HIP members:** This data was collected by the State from new applications (new HIP members or members switching MCEs) beginning in 2017 and self-reported member tobacco use during enrollment. It represents approximately 10% to 15% of the overall HIP population and is not a random sample. Therefore, selection bias is possible if new applicants use tobacco at a higher or lower prevalence than existing HIP members. The prevalence estimated using this method—ranging from 29% to 31%—is somewhat lower than low income/Medicaid estimates for Indiana from other sources, which are in the 35% to 37% range.[79]
- **Self-reported use:** Self-reported use and social desirability bias may mean that members underreport tobacco use, particularly in light of the possible surcharge.

Results of Quantitative Analysis

Tobacco prevalence stayed constant from October 2017 through the first quarter of 2019, with a higher prevalence among older age categories, males, non-Hispanic Whites, and members living in non-metro or rural areas. Overall, 31.3% of the members represented reported tobacco use in the fourth quarter of 2017, 29.3% in the first quarter of 2018, 29.0% in the second of quarter 2018, 29.2% in the third quarter of 2018, 29.5% in the fourth quarter of 2018, and 30.2% in the first quarter of 2019. Additional observations include:

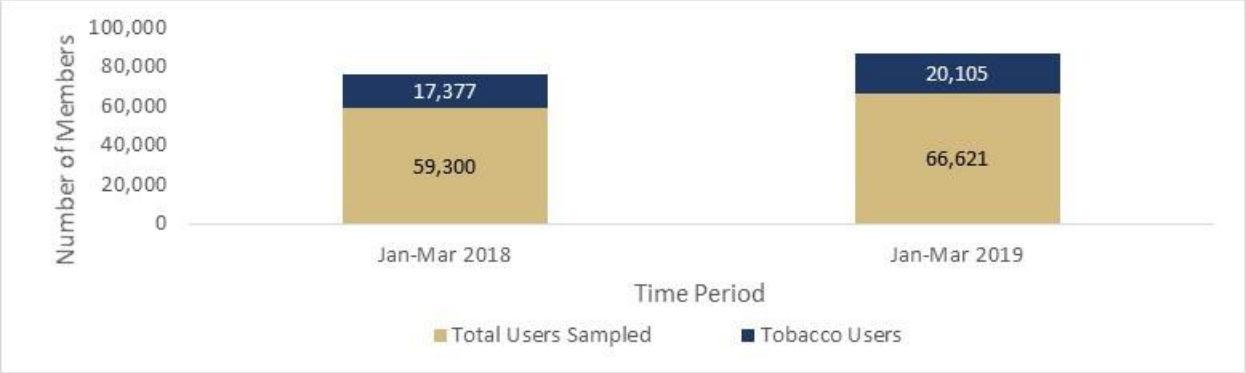
- Members in older age categories had a higher prevalence of tobacco use, with the youngest age category (19 to 30 years of age) having a prevalence ranging from 22.8% to 24.0% compared to the 41 to 50 years of age category which ranged from 33.6% to 37.8% and 51 years of age and older category which ranged from 32.2% to 37.4%.
- Males had a higher prevalence as compared to females, ranging from 35.5% to 37.4%.
- Non-Hispanic Whites had the highest prevalence as compared to members in other race categories, ranging from 34.7% to 36.7%.
- Members living in non-metro and rural areas had the highest prevalence as compared to members in metro areas, ranging from 36.3% to 46.1%.

Exhibits F.3.10 to **F.3.12** provide an overview of known member tobacco use by demographic characteristic, comparing January to March 2018 to January to March 2019.

Exhibits F.3.13 to **F.3.14** provide details on the prevalence of tobacco use. **Exhibit F.3.15** provides additional detail on tobacco use among HIP members. These exhibits show increases in tobacco cessation services consistent with HIP enrollment trends over time. Gains are greater for females, non-Hispanic Whites and non-rural residents.

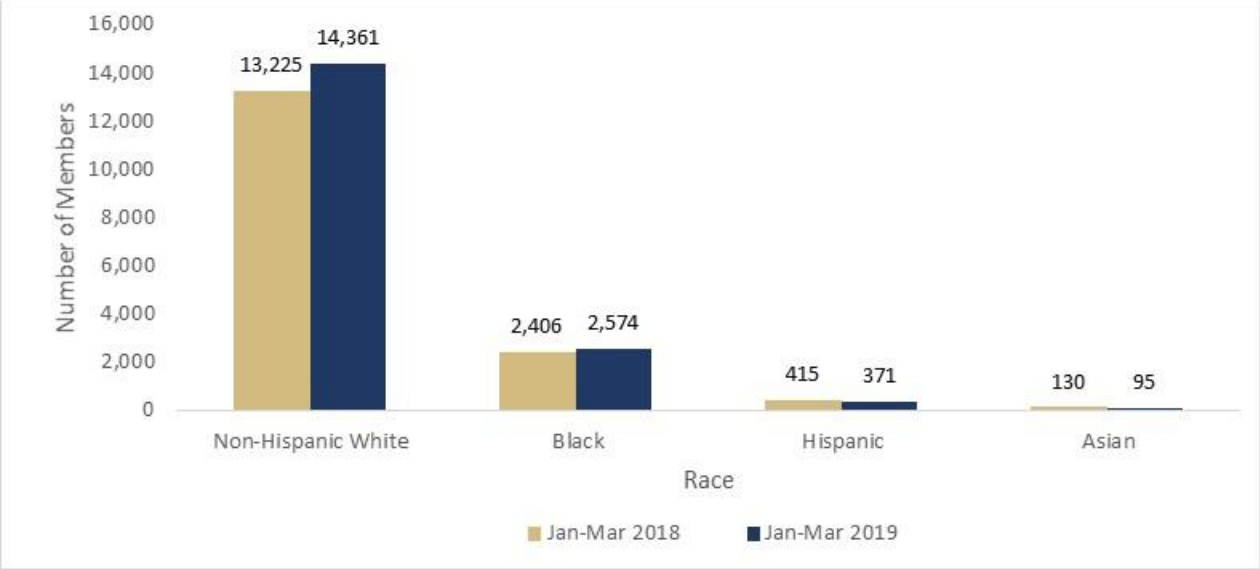
[79] Ibid

Exhibit F.3.10: Prevalence of Tobacco Use Among HIP Members (January 2018 – March 2018 and January 2019 – March 2019)



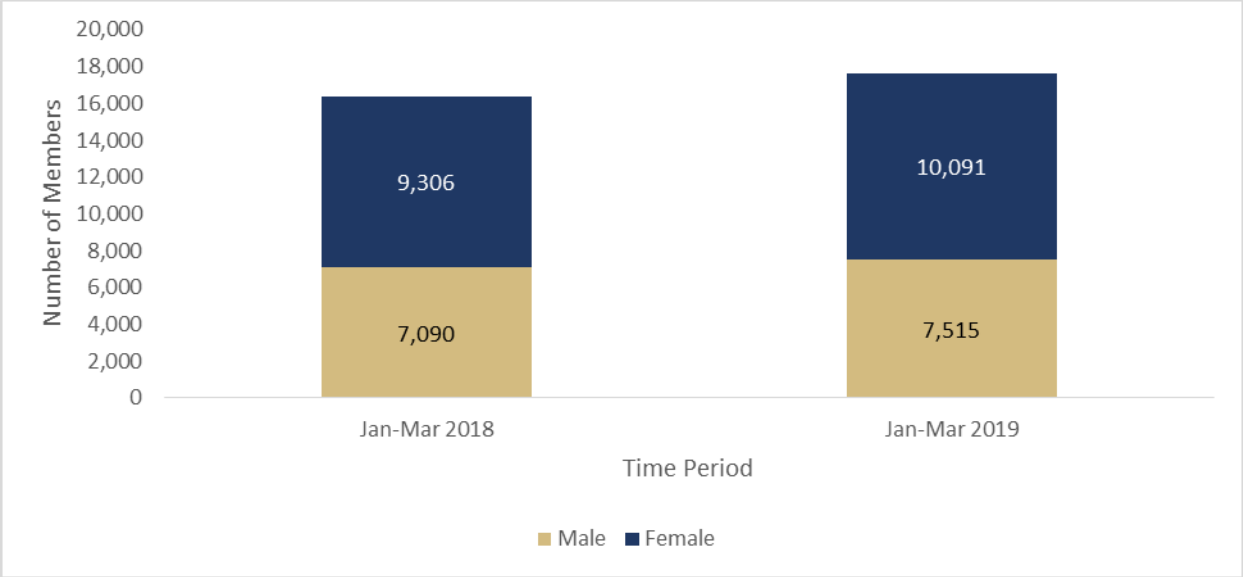
Source: Data was collected by the State from new applications (new HIP members or members switching MCEs) beginning in 2017 and self-reported member tobacco use during enrollment. Data represents approximately 10% to 15% of the overall HIP population, and is not a random sample.

Exhibit F.3.11: Prevalence of Tobacco Use Among HIP Members by Race (January 2018 – March 2018 and January 2019 – March 2019)



Source: Data was collected by the State from new applications (new HIP members or members switching MCEs) beginning in 2017 and self-reported member tobacco use during enrollment. Data represents approximately 10% to 15% of the overall HIP population, and is not a random sample.

Exhibit F.3.12: Prevalence of Tobacco Use for a Subset of HIP Members by Gender (January 2018 – March 2018 and January 2019 – March 2019)

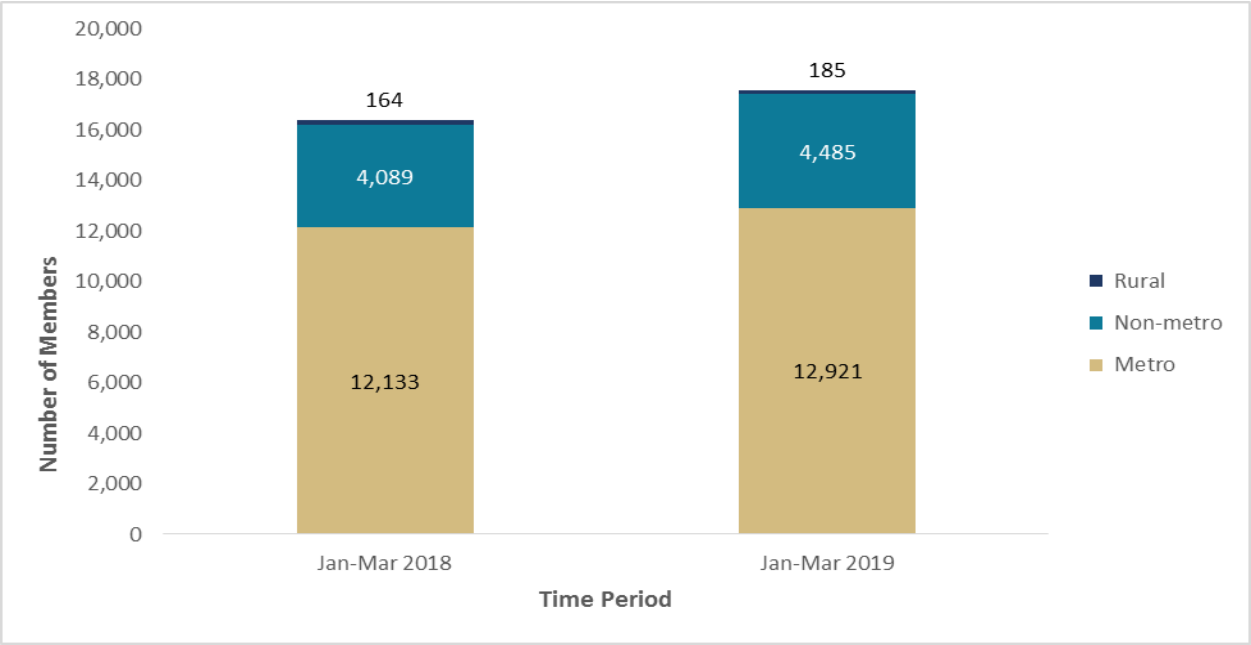


Source: Data was collected by the State from new applications (new HIP members or members switching MCEs) beginning in 2017 and self-reported member tobacco use during enrollment. Data represents approximately 10% to 15% of the overall HIP population, and is not a random sample.

Exhibit F.3.13: Prevalence of Tobacco Use for a Subset of HIP Members by Age (January 2018 – March 2018 and January 2019 – March 2019)

Source: Data was collected by the State from new applications (new HIP members or members switching MCEs) beginning in 2017 and self-reported member tobacco use during enrollment. Data represents approximately 10% to 15% of the overall HIP population, and is not a random sample.

Exhibit F.3.14: Prevalence of Tobacco Use for a Subset of HIP Members by Geographic Location (January 2018 – March 2018 and January 2019 – March 2019)



Source: Data was collected by the State from new applications (new HIP members or members switching MCEs) beginning in 2017 and self-reported member tobacco use during enrollment. Data represents approximately 10% to 15% of the overall HIP population, and is not a random sample.

Exhibit F.3.15: Known Tobacco Use Among HIP Members (October 2017 – March 2019)

Category		Oct-Dec 2017		Jan-Mar 2018		Apr-Jun 2018		Jul-Sep 2018		Oct-Dec 2018		Jan-Mar 2019	
		Members[a]	Tobacco Users[b] (%)[c]	Members	Tobacco Users (%)	Members	Tobacco Users (%)	Members	Tobacco Users (%)	Members	Tobacco Users (%)	Members	Tobacco Users (%)
All	Overall	44,264	13,840 (31.3)	59,300	17,377 (29.3)	59,658	17,295 (29.0)	61,204	17,884 (29.2)	60,254	17,768 (29.5)	66,621	20,105 (30.2)
Age	Ages 19-30	17,786	4,275 (24.0)	24,674	5,614 (22.8)	25,181	5,771 (22.9)	25,666	6,027 (23.5)	25,210	5,794 (23.0)	26,048	6,051 (23.2)
	Ages 31-40	11,195	3,861 (34.5)	15,470	5,039 (32.6)	15,421	4,985 (32.3)	16,273	5,395 (33.2)	15,491	5,144 (33.2)	16,615	5,732 (34.5)
	Ages 41-50	7,003	2,645 (37.8)	9,030	3,164 (35.0)	8,876	3,016 (34.0)	9,145	3,077 (33.6)	9,192	3,239 (35.2)	9,272	3,365 (36.3)
	Ages 51+	6,666	2,492 (37.4)	7,408	2,563 (34.6)	7,513	2,537 (33.8)	7,310	2,353 (32.2)	7,646	2,615 (34.2)	6,840	2,450 (35.8)
	Missing	1,614	567 (35.1)	2,718	997 (36.7)	2,667	986 (37.0)	2,810	1,032 (36.7)	2,715	976 (35.9)	7,846	2,507 (32.0)
Gender	Male	14,874	5,539 (37.2)	19,963	7,090 (35.5)	19,613	7,069 (36.0)	20,039	7,292 (36.4)	19,972	7,281 (36.5)	20,096	7,515 (37.4)
	Female	27,817	7,745 (27.8)	36,674	9,306 (25.4)	37,416	9,249 (24.7)	38,389	9,566 (24.9)	37,589	9,513 (25.3)	38,705	10,091 (26.1)
	Unknown	1,573	556 (35.3)	2,663	981 (36.8)	2,629	977 (37.2)	2,776	1,026 (37.0)	2,693	974 (36.2)	7,820	2,499 (32.0)
Race	Non-Hispanic White	28,681	10,522 (36.7)	37,485	13,225 (35.3)	38,307	13,282 (34.7)	39,042	13,665 (35.0)	38,339	13,517 (35.3)	39,412	14,361 (36.4)
	Black	9,111	2,133 (23.4)	12,104	2,406 (19.9)	12,207	2,327 (19.1)	12,628	2,430 (19.2)	12,573	2,544 (20.2)	13,218	2,574 (19.5)
	Hispanic	3,218	396 (12.3)	3,482	415 (8.9)	4,342	427 (9.8)	4,426	424 (9.6)	4,550	420 (9.2)	4,198	371 (8.8)
	Asian	1,005	78 (7.8)	1,456	130 (8.9)	1,283	116 (9.0)	1,386	124 (8.9)	1,124	112 (10.0)	1,151	95 (8.3)
	Other	57	22 (38.6)	88	20 (22.7)	91	23 (25.3)	73	21 (28.8)	66	23 (34.8)	75	17 (22.7)
	Unknown	2,192	689 (31.4)	3,482	1,181 (33.9)	3,428	1,120 (32.7)	3,649	1,220 (33.4)	3,602	1,152 (32.0)	8,567	2,687 (31.4)

Category		Oct-Dec 2017		Jan-Mar 2018		Apr-Jun 2018		Jul-Sep 2018		Oct-Dec 2018		Jan-Mar 2019	
		Members[a]	Tobacco Users[b] (%)[c]	Members	Tobacco Users (%)	Members	Tobacco Users (%)	Members	Tobacco Users (%)	Members	Tobacco Users (%)	Members	Tobacco Users (%)
Rural-Urban Status[d]	Metro	34,271	10,040 (29.3)	45,329	12,133 (26.8)	44,988	11,921 (26.5)	46,328	12,392 (26.5)	45,774	12,456 (27.2)	46,619	12,921 (27.7)
	Non-metro	8,041	3,077 (38.3)	10,850	4,089 (37.7)	11,492	4,175 (36.3)	11,568	4,252 (36.8)	11,336	4,165 (36.7)	11,692	4,485 (38.4)
	Rural	345	159 (46.1)	417	164 (39.3)	510	207 (40.6)	490	201 (41.0)	411	153 (37.2)	445	185 (41.6)
	Unknown	1,607	564 (35.1)	2,704	991 (36.6)	2,668	992 (37.2)	2,818	1,039 (36.9)	2,733	994 (36.4)	7,865	2,514 (32.0)

[a] Column displays the total number of unique HIP members who have their status as a tobacco user recorded during this quarter. See note regarding data source.

[b] Members with self-reported current tobacco use. See note regarding data source.

[c] Prevalence of tobacco use (row percentage) shown in parentheses. This calculation comes from the number of tobacco users during this quarter divided by HIP members with known tobacco use status, multiplied by 100. I.e., 31.3% of HIP members with a known tobacco status self-reported as tobacco users between October and December 2017.

[d] Rural-Urban status based on the U.S. Drug Administration Economic Research Service Rural-Urban Continuum Codes classification (https://www.ers.usda.gov/data-products/rural-urban-continuum-codes/documentation/)

Source: Data was collected by the State from new applications (new HIP members or members switching MCEs) beginning in 2017 and self-reported member tobacco use during enrollment. Data represents approximately 10% to 15% of the overall HIP population, and is not a random sample.

Goal 4 – Promote member understanding and increase compliance with payment requirements by changing the monthly POWER Account payment requirement to a tiered structure

HIP offers members a health savings-like account called a POWER Account with member contributions varying by benefit plan and income level. As of 2018, the State changed the determination of HIP Plus member contributions from a percent of income to a tiered structure in an effort to reduce administrative burden and support member understanding of payment requirements. This goal tests whether the tiered structure improves member understanding of and compliance with POWER Account payments

Summary of POWER Account and Enrollment in HIP Plus

As described in **Section B: Summary of HIP Demonstration**, the State funds POWER Accounts up to a ceiling of $2,500 per year. The State contributes an amount annually for each member that is equal to the difference between the required member contribution and the $2,500 ceiling. For HIP Plus members this monthly amount represents a combination of member, employer or not-for-profit, and/or State contributions. Members may also apply earned MCE incentives if those programs are offered as part of their plan. HIP Basic members pay copayments and the State fully funds the POWER Accounts and covers the member's $2,500 annual deductible.

HIP Basic members are able to move to the HIP Plus benefit plan at three different times provided they begin making POWER Account Contributions:[80]

- Benefit renewal period
- After receiving rollover
- After an increase in income

Individuals have 60 days to make a POWER Account Contribution after the State makes a determination of eligibility for HIP Plus. The State identifies individuals who are not transferring to HIP Plus from another non-HIP benefit category as conditionally eligible until the initial payment is made; the State does not provide benefits during this time.[81]

The State disenrolls HIP Plus members with incomes from 101% to 138% of the FPL who do not make monthly POWER Account Contribution payments (after a 60 day payment grace period). These members may not re-enroll for six months (also referred to as the "six-month lockout period"). Members determined medically frail or living in a domestic violence shelter or in a state-declared disaster area are

[80] The State immediately enrolls members transitioning to HIP from other Medicaid programs (including pregnant women in HIP exiting the postpartum period) in HIP Basic; these members have a 60-day opportunity to make an initial POWER Account Contribution payment.

[81] The State disenrolls eligible individuals with income more than 100% FPL for not making initial (first) POWER Account Contribution payment. These members are not locked out for six months. Eligible individuals with income at or less than 100% FPL can continue with HIP Basic coverage if they did not make the initial POWER Account Contribution payment within the 60-day grace period.

exempt from disenrollment due to non-payment regardless of income.[82] Members subject to a lockout period and identified by the State or MCE as medically frail can request a waiver to reenter the program.

All HIP members pay $8 for a non-emergency ED visit; HIP Basic members make additional copayments for doctor visits, hospital stays, non-emergency ED visits, and prescriptions.[83] HIP Plus members who are not HIP State Plan Plus receive an enhanced benefit plan that includes additional health care benefits such as coverage for dental, vision, and chiropractic services.[84] HIP State Plan provides certain members[85] with access to the Medicaid State Plan benefits in place of HIP Plus' approved Alternative Benefit Plan.

Change to a Tiered Structure for Member Contributions

Prior to 2018, HIP Plus members made POWER Account Contributions that varied by level of income. Specifically, HIP Plus members contributed no more than 2% of their household income and the State contributed the difference. As member incomes could vary by month, POWER Account Contribution levels would also vary. This monthly fluctuation posed difficulties for members in understanding their payment obligations (creating the potential for loss of coverage) and created additional administrative burden for the State and MCEs.

The State's transition to a tiered POWER Account Contribution structure in 2018 aimed to reduce administrative burden and support member understanding of payment requirements. Under this new structure, HIP Plus members make a fixed monthly payment based on income. Depending on income, member POWER Account Contributions range from $1 and $20. POWER Account Contributions for members who continue to use tobacco may increase by 50%. **Section B: Summary of HIP Demonstration** provides additional information about the POWER Account, POWER Account Contributions and the tobacco surcharge.

Goal 4 Hypotheses and Analysis

Goal 4 includes two hypotheses that assess the move to the POWER Account tiered payment structure. The qualitative and quantitative analyses related to these hypotheses and the five related research questions rely on the following data sources:

- Key informant interviews with members, providers, State officials, and MCE executives
- HIP enrollment and disenrollment data from February 2015 to December 2018

As the analyses performed for **Goal 4** reflect only 12 months of experience after implementation of the simplified payment tiers, the results presented here reflect Lewin's initial observations. We will include an additional two years of data in the analyses for the Summative Evaluation Report.

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[82] Members with income less than 100% FPL and not making POWER Account Contribution payments receive State Basic Plan benefits. Members with income more than 100% FPL receive HIP Plus Copay (PC) benefits. HIP Plus Copay members still have POWER Account Contribution obligations and also must pay copayments consistent with HIP Basic.

[83] Pregnant members have no cost sharing and there is a 5% of income quarterly cost sharing limit for all members.

[84] On June 10, 2015, the State submitted an approved copy of the Alternative Benefit Package (ABP) for HIP Plus as a State Plan Amendment to the Centers for Medicare and Medicaid Services. These benefits for the ABP were aligned using Essential Health Benefits. Indiana Family and Social Services Administration. (2014). Alternative Benefit Plan: Healthy Indiana Plan (HIP) 2.0 Plus. Retrieved from https://www.in.gov/fssa/hip/files/DraftPlusABP.pdf

[85] Medically frail, TMA participants, Section 1931 low-income (< 19% of the FPL) parents and caretakers, and low-income (< 19% of the FPL) 19 – 20 year olds.

Definition of HIP Member Population Used for Goal 4 Analyses

The analyses for this goal include fully enrolled HIP Plus and HIP Basic members. These members had coverage that was potentially affected by the change in the POWER Account payment tiers, specifically:

- HIP Basic members could move to HIP Plus if they made the required POWER Account Contribution payment amounts.
- Members with income at or below 100% of the FPL who did not make the required POWER Account Contribution payments could have moved from HIP Plus to HIP Basic.
- Members with income over 100% of the FPL could have been disenrolled for non-payment of the HIP Plus POWER Account Contribution (with exceptions as described above).

We identified members based on the following enrollment codes in the monthly enrollment data: HIP Basic (RB, SB) and HIP Plus (RP, SP). Members can have multiple enrollment codes in a month in the monthly enrollment data (at most three). In instances when member had both HIP Plus and HIP Basic (Regular or State) enrollment codes in one month, we classified the member as having HIP Plus Plan benefits.

In some cases, member enrollment status or member characteristics reflected situations where members would not have POWER Account Contribution payment obligations or be considered fully enrolled in HIP. As such, we excluded member months when members had the following enrollment statuses or member characteristics in the monthly enrollment data:

- Pregnant (MA)
- Pregnancy flag of "Y"
- HIP Plus Copay (PC)[86]
- Native American (NA)
- Conditionally enrolled (C)
- Transitional Medical Assistance (TMA) flag of "Y"[87]
- Emergency Room services flag of "Y"

Members can have multiple disenrollments in a year and multiple reasons associated with a disenrollment. We used the disenrollment data to identify the month when disenrollment occurred and the associated reason(s).[88]

[86] We excluded medically frail members having an enrollment status code of HIP Plus Copay (PC). The enrollment data also includes a flag for medically frail. The State and the MCEs can both designate members as medically frail based on eligibility determinations or claims. Additionally, providers or members can report medically frail status. Goal 4 analyses included members having "Y" (medically frail) for this flag as long as member met other Goal 4 population inclusion criteria.

[87] Low-income parents and caretaker whose income increases over 138% FPL can receive TMA for up to 12 months. HIP Plus members receiving TMA can continue receiving Plus benefits as long as the members make POWER Account Contribution payments.

[88] The disenrollment month in the disenrollment data indicates the month in which member disenrolled from a HIP plan and did not receive any HIP benefits for the month. A small number of members (less than 2% of the member population) had disenrollment and enrollment in same month. Most of these members had HIP Basic in the month(s) prior to disenrollment, then HIP Plus in the month with enrollment and disenrollment followed by HIP Plus or no HIP coverage.

Exhibit F.4.1 describes the HIP member categories used for **Goal 4** analyses. Total member counts for these categories will not match those used in **Goal 1**, **Goal 2,** and **Attachment II: HIP Sociodemographic Statistics** as analyses in those sections include pregnant members (having MA enrollment status or a pregnancy flag of "Y") and do not exclude members receiving TMA.

Exhibit F.4.1: Goal 4 Definition of HIP Member Categories

Category	Description
Goal 4 HIP Plus Members	Members meeting the **Goal 4** inclusion and exclusion criteria above who *have at least one month of the HIP Plus benefit plan* in the calendar year regardless of other enrollment status. This category is not the same as the "HIP Plus" category in **Goal 1**, **Goal 2,** and **Attachment II: HIP Sociodemographic Statistics** due to the differences in included and excluded members.
Goal 4 HIP Plus Only	Members meeting the **Goal 4** inclusion and exclusion criteria above who *have only the HIP Plus benefit plan* in the calendar year. This category is not the same as the "HIP Plus Only" category in **Goals 1 and 2** due to the differences in included and excluded members
Goal 4 HIP Basic Members	Members meeting the **Goal 4** inclusion and exclusion criteria above who *have at least one month of the HIP Basic benefit plan* in the calendar year regardless of other enrollment status. This category is not the same as the "HIP Basic" category in **Goal 1**, **Goal 2,** and **Attachment II: HIP Sociodemographic Statistics** due to the differences in included and excluded members.
Goal 4 HIP Basic Only	Members meeting the **Goal 4** inclusion and exclusion criteria above who *have only the HIP Basic benefit plan* in the calendar year. This category is not the same as the "HIP Basic Only" category in **Goal 1**, **Goal 2,** and **Attachment II: HIP Sociodemographic Statistics** due to the differences in included and excluded members.
Goal 4 HIP Switchers	Members meeting the **Goal 4** inclusion and exclusion criteria above who *have at least one movement between the HIP Plus and HIP Basic benefit plans* (between HIP Basic to HIP Plus or HIP Plus to HIP Basic) in the calendar year. For example, this category includes HIP Plus members receiving coverage under the HIP Basic benefit plan for at least one month or HIP Basic members having HIP Plus coverage for at least one month in the calendar year. This category is not the same as the "HIP Switcher" category in **Goal 1**, **Goal 2**, and **Attachment II: HIP Sociodemographic Statistics** due to the differences in included and excluded members.

Identification of FPL

For purposes of **Goal 4** analyses, we defined member FPL based on the first enrollment month in the calendar year under analysis. These assumptions for FPL was based on analyses of the income in enrollment data and feedback from the State. Member income level as defined by FPL can change across months of enrollment. Additionally, in some instances, the FPL in the enrollment data for certain member months was not consistent with HIP policy. For example, we observed the following:

- A small number of Goal 4 HIP Plus members with income at or less than 100% FPL had disenrollment with non-payment as a reason
- A small number of Goal 4 HIP Plus members having income over 100% FPL moved to HIP Basic within the calendar year

Based on discussions with the State, there are several possible reasons for these inconsistencies. For example:

- The member changed income in the calendar year under analysis
- Interplay between the required member notification for coverage changes (e.g., HIP Plus to HIP Basic) and when the State/MCE receives and updates data, in conjunction with member changes in FPL across months
- Inconsistencies in FPL data transfer between eligibility and the Medicaid Management Information System that resulted in null FPL values on disenrollment which appear as zero in the provided enrollment data and in some cases in the application of updated FPL numbers to prior months. The State has indicated that this data issue is resolved but in a minority of historical records included in this analyses these data artifacts remain.

Since the objective of **Goal 4** is to analyze member perception of POWER Account payment policy and continued coverage, Lewin included any HIP Plus members irrespective of the FPL in the monthly enrollment data in the related analyses.

Summary of Goal 4 HIP Member Enrollment, Disenrollment and Demographics

Exhibit F.4.2a provides a summary of the HIP member population identified for **Goal 4** analyses for 2016 and 2018; **Exhibit F.4.2b** shows a high-level summary of member disenrollment trends over time. The overall Goal 4 HIP member population increased by 8% between 2016 and 2018, with the Goal 4 HIP Plus Only population increasing by 7%, the Goal 4 HIP Basic population decreasing by 3% and Goal 4 HIP Switchers population increasing by 62%. Goal 4 member population distribution and trends are similar to overall HIP population for 2016 and 2018 (refer to **Attachment II: HIP Sociodemographic Statistics**), for example:

- The overall Goal 4 HIP member population has increased over time (8% increase from 506,597 in 2016 to 547,700 in 2018) in addition to the HIP Plus Only and HIP Switchers member populations. The number of HIP Basic Only members has decreased by about 3% between 2016 (159,873) and 2018 (154,641).
- The majority of HIP members were female and there was a slight decrease in the proportion of female members between 2016 and 2018 (approximately 64%[89] of the Goal 4 HIP population in 2016 was female and the proportion decreased in 2018 to 62%).
- The majority of the HIP members were between 19 and 39 years of age.
- The majority of the HIP members were non-Hispanic White (approximately 70% of Goal 4 HIP population). Approximately 20% of Goal 4 HIP members were Black. The proportion of non-Hispanic White members in Goal 4 HIP Plus Only population is higher (approximately 75%) as compared to Goal 4 HIP Basic Only population (approximately 64%).
- Approximately 80% of HIP members lived in a metro region.

[89] The overall Goal 4 member distribution by specific sociodemographic variable is calculated as the weighted total across the HIP member population for the calendar year. For example, the proportion of female members for HIP Goal 4 population in 2016 is summation of HIP member population multiplied by proportion of female members for the member population divided by total Goal 4 HIP population (64% = (159,873 X 0.640 + 305,975 X 0.629 + 40,749 X 0.687) / 506,597)

Member disenrollment (HIP Plus and HIP Basic members) appears to have increased across time. Approximately 2.7%[90] of June 2016 HIP recipients disenrolled in July 2016 (3.6% of HIP Basic and 2.5% of HIP Plus). In comparison, approximately 5.2% of June 2018 HIP recipients disenrolled in July 2018 (8.1% of HIP Basic and 4.1% of HIP Plus). Average monthly disenrollment in 2018 was approximately 40% higher compared to 2017. The majority of the increase in disenrollment was due to administrative reasons (see **Goal 4, Hypothesis 2 Research Question 2.2** for more details). State officials indicated that the increase in members disenrolling for other administrative reasons in 2018 was due to the alignment of the HIP verification policy with the Medicaid verification policy at the start of 2018. The number and proportion of disenrollment due to non-payment has decreased across time.

Exhibit F.4.2a: HIP Member Population by Selected Demographic Characteristics, 2016 and 2018
*Note: Analyses use the **Goal 4** definition of HIP member categories, as described in **Exhibit F.4.1***

Demographic Characteristics		Jan 2016 - Dec 2016			Jan 2018 - Dec 2018		
		Goal 4 HIP Basic Only	Goal 4 HIP Plus Only	Goal 4 HIP Switchers	Goal 4 HIP Basic Only	Goal 4 HIP Plus Only	Goal 4 HIP Switchers
All	**Total Population**	**159,873**	**305,975**	**40,749**	**154,641**	**327,225**	**65,834**
FPL	0%-22% FPL	72.2%	56.1%	50.4%	63.8%	48.5%	51.3%
	23%-50% FPL	6.2%	6.2%	10.7%	7.3%	7.3%	10.7%
	51%-75% FPL	8.3%	8.7%	15.9%	10.2%	10.2%	14.4%
	76%-100% FPL	8.8%	10.3%	17.4%	11.9%	12.4%	15.3%
	101%-138 FPL	3.9%	17.2%	5.1%	6.3%	21.1%	7.7%
	> 138% FPL	0.6%	1.4%	0.4%	0.4%	0.6%	0.5%
Gender	Female	64.0%	62.9%	68.7%	59.2%	61.9%	67.8%
	Male	36.0%	37.1%	31.3%	40.8%	38.1%	32.2%
Age Group	Age 19-29	43.2%	25.2%	30.0%	40.7%	24.7%	31.9%
	Age 30-39	30.5%	25.1%	33.5%	30.7%	25.2%	32.4%
	Age 40-49	14.1%	20.7%	21.2%	15.1%	20.5%	19.2%
	Age 50-59	7.1%	19.6%	12.3%	7.6%	19.5%	11.0%
	Age 60+	1.5%	7.6%	2.6%	1.9%	8.8%	2.6%
	Unknown	3.6%	1.7%	0.5%	4.0%	1.2%	2.9%
Race	Non-Hispanic White	63.6%	75.6%	68.6%	64.5%	74.1%	68.0%
	Black	28.0%	14.7%	23.4%	26.9%	15.0%	23.7%
	Hispanic	5.4%	4.8%	4.8%	5.6%	5.3%	5.3%
	Asian or Pacific Islander	1.2%	2.7%	1.5%	1.1%	3.2%	1.4%
	Other	1.7%	2.1%	1.7%	2.0%	2.5%	1.6%

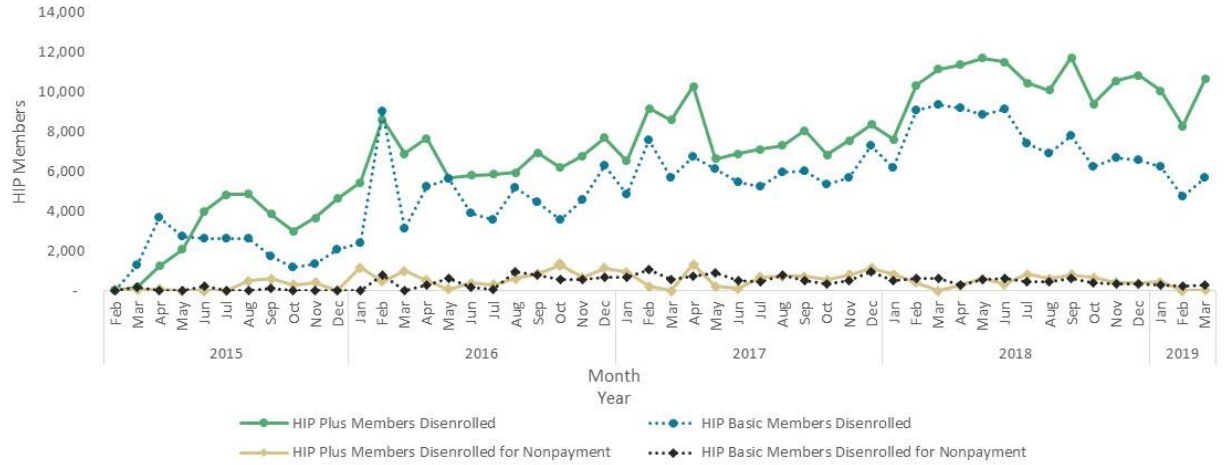
[90] The disenrollment rate is the proportion of enrolled members who disenrolled at the end of the month, calculated using the number of monthly disenrollments (Exhibit F.4.2b) and the number of monthly enrollments. For June 2016, for example, of the 343,982 members enrolled, 9,442 members disenrolled after June 2016 with July 2016 month of disenrollment in the disenrollment data (2.7% disenrollment rate).

Demographic Characteristics		Jan 2016 - Dec 2016			Jan 2018 - Dec 2018		
		Goal 4 HIP Basic Only	Goal 4 HIP Plus Only	Goal 4 HIP Switchers	Goal 4 HIP Basic Only	Goal 4 HIP Plus Only	Goal 4 HIP Switchers
Region	Metro	80.7%	77.0%	79.2%	80.4%	77.5%	78.8%
	Non-metro (20,000 or more)	6.9%	7.2%	6.6%	6.8%	7.1%	6.8%
	Non-metro (2,500 - 19,999)	11.7%	14.8%	13.3%	11.9%	14.4%	13.6%
	Non-metro (Rural, less than 2,500)	0.7%	1.0%	0.8%	0.8%	0.9%	0.8%
Medically Frail	Not Medically Frail	88.3%	80.2%	78.6%	83.4%	72.4%	67.5%
	Medically Frail	11.7%	19.8%	21.4%	16.6%	27.6%	32.5%

Source: HIP monthly enrollment files, Calendar Years 2016 and 2018.
Note: The top row provides the population count for each HIP member category as defined in **Exhibit F.4.1**. The percentages within each demographic characteristics denote the population distribution for the HIP member category by demographic characteristic. FPL is based on FPL observed in first month of enrollment in the calendar year.

Exhibit F.4.2b: Monthly Disenrollment Trend for Goal 4 HIP Basic and Plus Members, Overall and Disenrolled due to Non-Payment (February 2015 – March 2019)

Note**: Analyses use the **Goal 4** definition of HIP member categories, as described in **Exhibit F.4.1



Source: HIP monthly enrollment files, February 2015 – December 2018.
Note: Used reason codes "001" ("Non-payment of Initial POWER Account Contribution"),[91] "002" ("Non-payment of POWER Account Contribution with a six-month lockout) and "003" (increased income + non-payment of POWER Account Contribution, disenrolled without a six-month lockout) for non-payment. HIP Plus / HIP Basic in this chart represents the member benefit plan for the specific month (HIP Plus = RP, SP and HIP Basic = RB, SB).

[91] Reason code 001 typically applies for conditionally enrolled members (not in scope for Goal 4). However, analysis of the disenrollment data showed less than 10 instances in each year with HIP member having disenrollment with reason code 001. Most of these members never showed up as HIP Plus after the disenrollment.

Hypothesis 1 – HIP's new income tier structure for POWER Account Contributions will be clear to HIP members.

Lewin conducted analyses related to this hypothesis by analyzing feedback received during key informant interviews and reviewing enrollment and disenrollment trends during the first year of the HIP waiver renewal period (February 2018 to December 2018). We will continue these analyses for purposes of the Summative Evaluation Report using HIP enrollment and disenrollment data through 2020 along with 2020 and 2021 HIP member survey data.

Primary Research Question 1.1 – Do HIP members with POWER Account payment requirements understand their payment obligations?

The State and the MCEs both communicate with members about POWER Account Contribution policies. The State communicates general information about the POWER Account via online tools and maintains two call centers to answer member questions (enrollment broker and the Division of Family Resources). Some of these online tools include interactive tutorial videos, "how-to" guides, an eligibility and contribution calculator, and other documents that explain the POWER Account Contribution.[92] The MCEs inform their respective members about the policy and support compliance through online tools, outbound and inbound call centers, and other layered outreach including text message, email, mail, and social media. MCEs bill for and collect HIP Plus POWER Account Contributions and share monthly statements with all HIP members.

Brief Summary: MCEs and the State are responsible for communicating POWER Account Contribution requirements to HIP members. Lewin identified several themes related to member understanding through key informant interviews with MCE executives, State officials, providers, and HIP members.

MCE executives and State officials stated that member understanding has improved as a result of layered communications, ongoing education, and the transition to the tiered POWER Account structure. These interviewees also indicated that communications and education are invaluable given the complexity and confusion that sometimes arises related to the POWER Account policies, and that the tiered payments are easier for members to understand.

According to provider interviews, the majority of members have at least a baseline understanding of their POWER Account Contribution requirements and understand overall POWER Account policies. About half of the providers mentioned some sort of challenge with the POWER Accounts, including understanding of payment amount approvals, non-payments, renewal deadlines, and health literacy issues.

Most members interviewed had an understanding of the POWER Account as a whole, while fewer had an understanding of the consequences of non-payment. According to a survey administered to members by the State, the rate at which members with POWER Account Contribution requirements are making payments is increasing, and fewer members are confused about the POWER Account or have issues with making their POWER Account Contribution. All interviewees agreed that the various mechanisms for making POWER Account Contribution payments, such as online or in-person, are helpful for continued understanding of and compliance with POWER Account Contribution requirements.

[92] Indiana FSSA. POWER Accounts. Retrieved from https://www.in.gov/fssa/hip/2590.htm

Qualitative Results

A common theme from both the State official and MCE executive interviews was that the tiered POWER Account structure was an improvement over the pre-existing percent of income approach under HIP 2.0. Interviewees shared that the predictable monthly cost helps members to better understand their POWER Account Contribution amount. MCE executives commented that the tiered structure simplified the invoicing process and member-related communications, and that member understanding of the POWER Account Contributions had improved over time. While we did not ask members specifically about the switch to tiered payments, members varied in their level of understanding about the POWER Account Contributions. Findings from the member key informant interviews and a separate State 2019 email survey of HIP members[93] revealed that some members understand the POWER Account Contribution but that the POWER Account and rollover policies are still confusing to many members.

Both State officials and MCE executives shared that ongoing education and layered communications are critical as relaying information about POWER Account Contributions, POWER Accounts, and consequences of non-payment can be complex. State officials reported that HIP member understanding of POWER Account Contributions has been a focus area and they have seen improvements over time. Some MCE executives discussed issues with outreach to members via mail and email. For example, members with inaccurate address information or who do not frequently check their email or mail are less likely to understand the policy as most communications are shared through those channels.

The MCEs also specifically highlighted the variety of payment options members have to pay the POWER Account Contribution as beneficial to fulfilling payment obligations. Members can pay online, via U.S. mail, by phone, with cash or in-person payments with Moneygram, with an automatic bank deduction, or an employer or other non-member payer; some MCEs allow members to pay using their MCE-specific rewards program.

Member Key Informant Interviews

The key informant interviews with members included questions regarding POWER Account Contributions and member understanding of their obligations. Of the 27 member interviewees, 24 were aware of the POWER Account and the different aspects of HIP and 17 reported making payments towards their HIP coverage. When asked what would happen if they did not make payments, five of the 17 members who reported making payments stated that they knew failure to make a payment could affect their participation in the program, three responded that they did not know what would happen, and the remaining eight did not answer the question.

[93] This survey was distributed via email by FSSA and yielded a 2.2% response rate (883 responses). The contractor conducting the survey indicated that this response was a statistically significant representation of the approximately 400,000 HIP members within ±3% and reflected a "good representation" across all 10 districts of the state. Lewin notes that the survey's function was limited to informing the State's communications strategy, and that its reliance on email to distribute the survey introduced notable selection bias.

The State launched a separate communications campaign to explain various HIP-related definitions, which included materials and a video on POWER Accounts. According to a summary of a 2019 member email survey conducted by the State to improve ongoing communications and outreach, there have been improvements in member understanding of POWER Account Contributions.[94] The summary of the 2019 survey, which compared results to a similar survey in 2017, also included the following observations:

- Of the 883 respondents, 77% made their POWER Account Contributions as compared to 76% in 2017.
- Of the respondents who responded to a question about making a POWER Account Contribution, 13% said they do not make their POWER Account payments (statistically unchanged from 16% in 2017). Among those, the main reason for stopping a payment was that they could not afford a payment, which decreased from 45% in 2017 to 22% in 2019. Of the remaining responses, 8% of respondents said they did not know why or how they had to make a payment and 5% stated they did not know how to make a payment. The number of respondents reporting that they did not know why or how they had to make a payment decreased from 21% in 2017 to 8% in 2019.
- Once enrolled in HIP, 19% of respondents reported difficulties in making POWER Account payments, a decrease from 33% in 2017.
- Of respondents who had been confused about some part of HIP, 58% said they were confused by the POWER Account, a decrease of 11 percentage points from 69% in 2017.

While the feedback from State officials and MCE executives and the member key informant interviews indicate that the tiered POWER Account Contribution structure better supports member understanding of the related payment contributions, interviewees also acknowledged that achieving member understanding of POWER Accounts is challenging and an area of on-going focus. The State and MCEs recognized that the difference between POWER Accounts and POWER Account Contributions is difficult for members to understand and challenging to communicate.

State Key Informant Interviews

The State has been responsible for the POWER Account Contribution rollout and related policies. Per the interviews with State officials, some of these responsibilities and initiatives for improved member understanding of the POWER Account included:

- Hiring a marketing firm to conduct surveys to assess member understanding of various HIP policies and targeted member outreach (e.g., videos and social media).
- Tailoring the State communications across the HIP program, including multilingual brochures and strategic framing to encourage member buy-in related to the importance of health through investment in the POWER Account. State officials said this framing and the tiered system of the POWER Account have allowed members who may be uncomfortable with the idea of public assistance to buy-in to HIP more readily and feel a sense of value with their health coverage.

[94] This survey was distributed via email by FSSA and yielded a 2.2% response rate (883 responses). The contractor conducting the survey indicated that this response was a statistically significant representation of the approximately 400,000 HIP members within ±3% and reflected a "good representation" across all 10 districts of the state. Lewin notes that the survey's function was limited to informing the State's communications strategy, and that its reliance on email to distribute the survey introduced notable selection bias.

State officials discussed how the branding of the contribution as a cost-sharing feature and differing slightly from a premium can pose some confusion when members switch to commercial plans. While the State designed the POWER Account Contributions to be similar in nature to monthly premiums, the policy also explicitly avoids the word "premium" since the monthly POWER Account Contribution is deposited into an account and can be refunded or carried over between calendar years. Some interviewees hypothesized that this may cause some concerns about how to best support member transitions to commercial plans. On the other hand, some State officials appreciated the distinction between the contribution and a premium when explaining the policy to members. This issue is an example of HIP's complexities.

MCE Key Informant Interviews

In addition to informing members about the policy and supporting member compliance with the POWER Account Contributions, MCEs provided general communications to members about POWER Accounts and monthly statements with information about their individual payment amount. MCE executives described a variety of strategies used to communicate POWER Account policies to members, including:

- Layered communications via text message, phone, email, and mail to notify members of POWER Account payment responsibilities, including payment reminders and delinquency notices
- Strategic communications that encourage HIP Basic members to pay the monthly contribution and move to HIP Plus. For example, one MCE had a campaign encouraging members to "POWER Up to HIP Plus." Other MCEs highlighted the benefits of HIP Plus when communicating with members, emphasizing that HIP Plus provides the best value with low, predictable monthly payments, and additional benefits. MCEs also communicated the cost-benefit of HIP by telling members that they can save money by paying the monthly POWER Account Contributions instead of paying multiple copayments
- Designated POWER Account outbound call centers for member support
- Supplemental videos and other online instructional tools

One MCE executive reported that the MCE had created a separate invoice system[95] specifically for POWER Accounts to support member services and streamline internal administrative processes. Another MCE executive said that the MCE had combined the eligibility and invoicing system to maintain accurate and appropriate statements regardless of eligibility changes. One MCE executive shared that their organization has automated invoicing. Across MCEs, executives cited their respective customer service teams as a critical component to support member understanding of the POWER Account Contribution and rollover.

[95] The "invoice system" refers to the process of billing for and collecting HIP Plus POWER Account Contributions and sending monthly statements to members. HIP Basic members also receive monthly account statements to assist them in managing the POWER Account and copayments and to increase awareness of the cost of the health care services received.

Provider Key Informant Interviews

As part of the evaluation, Lewin reviewed interviews with 36 providers; the discussion around the POWER Account yielded mixed feedback. Some providers said that the POWER Accounts had been established for long enough that most members have a firm understanding of what they are and how to make payments smoothly. However, 17 of the 36 providers mentioned some challenges with the POWER Accounts.

Some providers discussed members' challenges with making payments, especially when a member is just starting out and determining the amount to pay. Other providers mentioned that members experience confusion regarding approval; some members assume the State has given final approval on their plan status and payment amount when the approval is actually provisional. One provider said there are some issues with non-payments and keeping track of renewal deadlines. Another provider described the deficiencies in member understanding as a result of random MCE placement. Specifically, the provider indicated that members who do not elect an MCE and are auto-assigned face more challenges with their POWER Account. The provider also said that auto-assigned members experience confusion with who to call, and once they are directed to their MCE, they must initiate more phone calls. The provider went on to describe issues with members' health literacy, for example, members' lack of skills to call the MCE and understand the information given on those calls. Overall, providers reported that the actual payment amount is less of a challenge than knowing what the payment amount is and when to make those payments. Three providers cited prepaid cards from Walmart as helpful in making payments; one said these are especially helpful to homeless members who cannot pay in cash.

Lewin will conduct additional key informant interviews and member surveys to fully address this research question for the purposes of the Summative Evaluation Report.

Primary Research Question 1.2 – Do HIP members with POWER Account payment requirements who initiate payments continue to make regular payments throughout their 12-month enrollment period?

Lewin used four years of State administrative data (February 2015 to December 2018) to analyze the extent to which HIP Plus members are able to continue making required POWER Account Contribution payments and how that ability may have changed upon implementation of the simplified payment tiers in 2018.

Brief Summary: Overall, Lewin found an increase in HIP Plus enrollment and a decrease in the rate of disenrollment with non-payment as a reason from 2016 to 2018. This might indicate potential member interest in HIP Plus coverage and improved member understanding of POWER Account Contribution payments. However, given that the new POWER Account policy was implemented in 2018 and disenrollment due to non-payment was declining prior to 2018, any impact of the change in payment tiers on disenrollment requires additional analysis over time. Lewin also found a decrease in the proportion of continued HIP Plus coverage from 2015 to 2017 that requires further study.

Quantitative Methodology

This research question assesses continuity of HIP Plus coverage using three outcome measures:

- **Measure 1:** Proportion of members in a calendar year with payment obligations who make a contribution before the end of the grace period – defined as continuously enrolled in HIP Plus until the end of the calendar year for this analysis.
- **Measure 2:** Proportion of members in a calendar year with payment obligations who are disenrolled due to non-payment.
- **Measure 3:** Proportion of members in a calendar year who moved from HIP Plus to HIP Basic due to non-payment by year.

Since only members with the HIP Plus benefit plan have a payment obligation, we focused our analyses on the HIP members enrolled in HIP Plus at *any time* during each calendar year (also see overall inclusion and exclusion criteria at the beginning of **Goal 4**). **Exhibit F.4.3** provides a description of the measure calculations. We used monthly HIP enrollment and disenrollment data from February 2015 to December 2018 for this analysis.

Exhibit F.4.3: Goal 4 Hypothesis 1 Research Question 1.2 Measure Calculation

Measure	Metric	Numerator	Denominator	Notes
Measure 1: Continuously enrolled in HIP Plus until the end of year	Proportion of HIP Plus members having continuous enrollment in a calendar year	Number of unique Goal 4 members enrolled in HIP Plus and having HIP Plus coverage with no break until the end of the calendar year	Number of unique Goal 4 members having HIP Plus coverage at any time during the calendar year	• Includes members having State or Regular Plus plans. • Excludes any members who disenrolled prior to the end of the calendar year (December) or moved to HIP Basic.
Measure 2: Disenrolled due to non-payment	Proportion of HIP Plus members disenrolled having non-payment as a reason	Number of unique Goal 4 HIP Plus members identified as having a disenrollment due to non-payment reason (disenrollment reason codes 001, 002 and 003[96]) in the calendar year following the first observation of enrollment in HIP Plus	Number of unique Goal 4 members having HIP Plus coverage at any time during the calendar year	• Members can have multiple disenrollments in a year; we counted the member only once if any of the disenrollments had non-payment as a reason.
	Members disenrolled for not making initial POWER Account Contribution payments	Number of unique individuals who did not have HIP Plus benefit plan coverage during the calendar year but had initiated (not paid) POWER Account Contribution payment (disenrollment reason codes 001 and 003)	n.a. (no proportion calculation)	• Raw counts of individuals (no proportion calculated)
Measure 3: Moved from HIP Plus to HIP Basic	Proportion of HIP Plus members who moved to HIP Basic	Number of unique Goal 4 members having HIP Plus for a particular month and moving to HIP Basic in the following months within the calendar year[a]	Number of unique Goal 4 members having HIP Plus coverage at any time during the year	• Members may switch plans multiple times during the year. This metric identifies unique members who moved from HIP Plus to HIP Basic at least once during the calendar year between two months. • We did not include the months of enrollment with TMA in the analyses for those members that had TMA at any time during the year. We considered the benefit plan prior to TMA and the benefit plan post-TMA in the calendar year to identify the potential move between benefit plans.

[a] Included all Goal 4 HIP Plus members irrespective of the FPL in the monthly enrollment data in the analyses (refer to discussion in *Identification of FPL* for details*)*.

[96] Disenrollment reason 001 is "Non-payment of Initial POWER Account Contribution (i.e., never fully enrolled in HIP Plus)". Disenrollment reason 002 is "Non-payment of POWER Account Contribution (i.e., disenrolled from HIP Plus WITH 6 month lockout)." Disenrollment reason 003 is "Increased Income + Non-payment of POWER Account Contribution (i.e., disenrolled from HIP Basic WITHOUT 6 month lockout).

Quantitative Results

Exhibit F.4.4a provides a summary of the outcome measures for this research question. The number of Goal 4 members enrolled in HIP Plus at any point in time during a year increased by almost 50% from 2015 to 2018 (265,400 and 393,059, respectively). Looking across time, almost 40% of Goal 4 HIP Plus members in 2018 (approximately 152,000) had HIP Plus coverage during some point in time (at least a month) every year from 2015 to 2018. These members may have also switched to HIP Basic, or disenrolled or reenrolled at some point during that same period (**Exhibit F.4.4b**).

For *Outcome Measure 1 (Continuously enrolled in HIP Plus until the end of year),* the number of continuously enrolled Goal 4 HIP Plus members increased from 202,119 in 2015 to 237,845 in 2018, although at a relatively lower rate of increase (18%) as compared to the rate of increase in the Goal 4 HIP Plus population (50%). The proportion of the Goal 4 HIP Plus population having continuous coverage has decreased over time. In 2015, 76% of the Goal 4 HIP Plus members had continuous coverage as compared to 65.8% in 2016, 63.4% in 2017 and 60.5% in 2018. A similar decrease in continuous coverage in 2018 was also observed in Goal 1 analyses for all HIP members (**Exhibit F.1.2**, with continuous coverage defined as 11 months or more of coverage in a calendar year).

The remaining two outcome measures (*Outcome Measure 2: Disenrolled due to Non-Payment and Outcome Measure 3: Moved from HIP Plus to HIP Basic*) explore possible causes of members not having continued coverage until the end of the year. As observed in **Exhibit F.4.2a** and **Exhibit F.4.2b**, the overall disenrollment rate has increased across time. However, the count and proportion of Goal 4 members who disenrolled from HIP Plus with non-payment as a reason (**Exhibit F.4.4**) is relatively low and seems to be decreasing over time (2.2% in 2016, 1.8% in 2017, 1.4% in 2018). The majority of the disenrollment with non-payment as reason were for members with income greater than 100% FPL[97] (3,812 in 2018, 4,458 in 2017).

Between 2016 and 2018, there were members who initiated HIP Plus enrollment but did not make the initial POWER Account Contribution payments and did not become HIP Plus members in that calendar year (approximately 6,000 members in 2016 and 8,000 in 2017). Most of these members received HIP Basic coverage. Additionally, there were approximately 1,000 members having disenrollment from HIP Plus due to non-payment of the POWER Account Contribution with a six-month lockout (disenrollment reason code 002) in each year (from 2016 to 2018). The majority of these disenrollment occurred in January for members enrolled in HIP Plus in the prior calendar year.

Between 6% and 9% of Goal 4 HIP Plus members moved to HIP Basic during a calendar year. Some of these members (almost 25% for 2018) had multiple transitions (in rare instances up to four) between HIP Plus and HIP Basic plans in a calendar year. **Attachment V: Exhibits V.1** and **V.2** provide detailed results by FPL.

The increase in Goal 4 HIP Plus enrollment and decrease in the rate of disenrollment with non-payment as a reason from 2017 to 2018 might indicate potential member interest in HIP Plus coverage and improved member understanding of POWER Account Contribution payments. However, given that the State implemented the new POWER Account policy in 2018 and disenrollment due to non-payment was declining prior to 2018, identifying the impact of the change in payment tiers on disenrollment will require additional analysis over time. The decrease in proportion of HIP Plus continued coverage requires additional study (see Research Question 2.2 which includes additional analyses related to continuous coverage). Lewin will use 2019 and 2020 data to update and expand on these analyses when developing the Summative Evaluation Report.

[97] Refers to the member population identified in the enrollment data with income between 100% – 138% FPL.

Exhibit F.4.4a: Outcome Measure Results for Research Question 1.2 (February 2015 – December 2018)

Note: *Analyses use the* ***Goal 4*** *definition of HIP member categories, as described in* ***Exhibit F.4.1****.* ***Exhibit F.4.3*** *provides a summary of the calculation of the different measures.*

Time Period	Goal 4 HIP Plus	Measure 1: Goal 4 HIP Plus Members Continuously Enrolled (Until End of Calendar Year)		Measure 2: Goal 4 HIP Plus Members Disenrolled from Plus due to Non-Payment		Measure 2: Members Disenrolled for Not Making Initial POWER Account Contribution Payment[b]	Measure 3: Goal 4 HIP Plus Members that Moved from HIP Plus to HIP Basic	
		Number	Percent	Number	Percent[a]		Number	Percent
2015	265,400	202,119	76.2%	2,133	0.8%	524	15,629	5.9%
2016	346,724	228,053	65.8%	7,662	2.2%	5,487	23,040	6.6%
2017	370,085	234,568	63.4%	6,781	1.8%	7,997	29,174	7.9%
2018	393,059	237,845	60.5%	5,500	1.4%	5,759	25,157	6.4%

[a] Percent calculated as proportion of all Goal 4 HIP Plus members having disenrollment with non-payment as a reason, regardless of FPL.

[b] Most of the members were enrolled in HIP Basic at some point during the calendar year. In 2018 for example, 4,668 of these members received HIP Basic coverage. Member counts include individuals disenrolled for non-payment of POWER Account Contribution who were not HIP Plus members during the calendar year.

Source: HIP monthly enrollment files, February 2015 – December 2018.

Exhibit F.4.4b: Number of 2018 Goal 4 HIP Plus Members by Number of Years of HIP Enrollment (January 2018 – December 2018)

Note*: Analyses use the* ***Goal 4*** *definition of HIP member categories, as described in* ***Exhibit F.4.1***

Number of Years With HIP Plus Coverage	Number of Years Having HIP Coverage (Basic or Plus - including 2018)				Total
	1 – 2018 Only	2 – 2018 + 1 year	3 – 2018 + 2 years	4 – All 4 years	
1 – HIP Plus in 2018 only	72,645	11,193	10,047	9,080	102,965
2 – HIP Plus in 2018 and 1 other year	-	68,668	11,516	12,097	92,281
3 – HIP Plus in 2018 and 2 other years	-	-	66,936	17,472	84,408
4 – HIP Plus in all 4 years	-	-	-	113,405	113,405
Total	**72,645**	**79,861**	**88,499**	**152,054**	**393,059**

Source: HIP monthly enrollment files, February 2015 – December 2018.

Note: We identified the number of years with HIP Plus coverage by looking across four years of member enrollment data to identify if a Goal 4 HIP Plus member in 2018 had enrollment during any of the four years. Members can have HIP coverage with a gap (e.g., we classify a member having coverage in 2015 and 2018 as having two years of HIP coverage). We identified the number of years with HIP Plus coverage by looking across four years of member enrollment data to identify if the HIP Plus member in 2018 had HIP Plus coverage during any other calendar year (using the Goal 4 definition). The State indicated at the end of the Interim Evaluation Report analysis period that there is the possibility that encounter data for some members in Quarter 4, 2018 may reflect more than one recipient identification number per member. As such, unique member counts for 2018 may be slightly overstated (refer to Section E: Methodological Limitation).

Hypothesis 2 – Enrollment and enrollment continuity will vary for the POWER Account payment tiers.

As discussed in **Section B: Description of the Demonstration and Implementation Plan** and at the beginning of **Goal 4**, the State implemented a simplified payment tier approach for member POWER Account Contributions in 2018. This hypothesis assesses the extent to which enrollment and enrollment continuity has changed since the implementation of this approach. As the related analyses reflect only 12 months of experience after implementation of the simplified payment tiers, the results presented

here reflect Lewin's initial observations. We will expand on the analyses presented here using two additional years of data for purposes of the Summative Evaluation Report.

Primary Research Question 2.1 – Is there a relationship between POWER Account payment tiers and total and new enrollment in Medicaid?

This research question assesses whether a relationship exists between the new POWER Account payment tiers and changes in HIP enrollment. We analyzed total and new enrollment counts for HIP Plus members (most likely to be impacted by POWER Account payment changes) for this research question.

Brief Summary: The total number of HIP Plus members increased between 2015 and 2018. However, the number and proportion of new HIP Plus members between 2017 and 2018 were lower compared to 2016. Additionally, although the proportion of members in higher FPLs increased across time, the number of new HIP Plus members having income greater than 100% FPL was lower in 2017 and 2018 compared to 2016. Analysis including additional years of data will be necessary to determine if the increase in the number of HIP members from 2017 to 2018 is a result of the payment tiers. This will be done for the Summative Evaluation Report.

Quantitative Methodology

We calculated the unique number of overall HIP Plus members and new HIP Plus members per year using February 2015 to December 2018 enrollment data as follows:

- **HIP Plus members:** Total unique members enrolled in HIP Plus based on the first enrollment month in the calendar year, using the **Goal 4** inclusion and exclusion criteria (refer to section *Definition of HIP Member Population Used in Goal 4*). This HIP Plus member cohort represents a subset of Goal 4 HIP Plus members (as described in **Exhibit F.4.1**) as we did not include HIP Plus members who were enrolled in HIP Basic prior to the HIP Plus enrollment within the same calendar year. For example, if a member had HIP Regular Basic from January to March and then moved to HIP Regular Plus in April, this member was not included in total HIP Plus member count for this outcome measure.
- **New HIP Plus members**: Total HIP Plus members (as defined for this research question above) who did not have HIP coverage in the last 12 months prior to the first HIP Plus enrollment month in a calendar year. We used the **Goal 4** inclusion and exclusion criteria described at the beginning of **Goal 4** and defined HIP coverage for the 12 month "look back" as one or more months with the following enrollment status:[98] HIP Basic (RB, SB), HIP Plus (RP, RP), Pregnant (MA), HIP Plus Copay (PC), and Native American (NA).[99] Members having only conditional enrollment (C) in the 12-month look back time period were considered as new enrollees.

[98] We considered members having Emergency Room services only in prior 12 months and meeting Goal 4 enrollment criteria as new enrollees for this research question.

[99] Members with an enrollment code of NA are exempt from HIP policies.

Quantitative Results

The total count of HIP Plus members (as defined for this research question) has steadily increased over time (**Exhibit F.4.5**). The proportion of HIP Plus members who are new enrollees was lower in 2017 and 2018 at 23% (approximately 81,000 each year) in comparison to 34% in 2016 (114,040). The Summative Evaluation Report will include analyses of enrollment in Medicaid among the likely eligible population (using publicly available data, e.g., ACS). This analyses will help assess if the decrease in the number and proportion of new HIP Plus members is related to the increasing maturity of HIP and a decline in the number of people that meet the new enrollee definition.

Approximately 77% of HIP Plus members were returning members in 2017 and 2018. Additionally, about 290,000 HIP Plus 2018 members had more than one year of HIP Plus coverage; approximately 152,000 members had a HIP Basic or Plus plan in all four years (**Exhibit F.4.4b**).

Exhibit F.4.5: Total and New HIP Plus Members as Defined for Research Question 2.1 (February 2015 – December 2018)

***Note**: Analyses use the **Goal 4** Research Question 1.2 HIP member exclusions and inclusions.*

Time Period	HIP Plus Members	New HIP Plus Members	% New HIP Plus Members
2015	240,554	n.a. (due to 12 month look back)	n.a. (due to 12 month look back)
2016	335,159	114,040	34.0%
2017	347,494	81,461	23.4%
2018	355,048	80,723	22.7%

Source: HIP monthly enrollment files, February 2015 – December 2018.

For a deeper look into member enrollment, we studied the member counts by FPL as observed in the first enrollment month in the calendar year (**Exhibit F.4.6**). Key observations include:

- For 2018, almost 50% of the HIP Plus members had income less than 22% of FPL while 79% had income less than 100% FPL (similar member income trend as discussed in **Section B**).
- Compared to 2016 and 2017, the number of members in 2018 having income less than 22% FPL was lower.
- The number of HIP Plus members with income between 101% and 138% FPL increased over time (54,355 in 2016 to 71,433 in 2018). However, the number (and proportion) of new HIP Plus members for this FPL category decreased (20,448 in 2016 to 15,472 in 2018) indicating most of the increase was due to returning members from previous enrollment years.
- The number of new HIP Plus members in 2017 and 2018 was similar across different FPL ranges (**Exhibit F.4.7**).

Exhibit F.4.6: HIP Plus Members by FPL at Time of HIP Plus Enrollment (February 2015 – December 2018)

***Notes**: Analyses use the **Goal 4** Research Question 1.2 HIP member exclusions and inclusions. FPL reflects FPL observed in first month of HIP Plus enrollment in the calendar year.*

Time Period	HIP Plus Members						
	<22% FPL	23-50% FPL	51-75% FPL	76-100% FPL	101-138% FPL	> 138% FPL	Total
2015	124,040 (51.6%)	19,670 (8.2%)	27,016 (11.2%)	30,235 (12.6%)	34,787 (14.5%)	4,806 (2.0%)	240,554
2016	181,511 (54.2%)	23,076 (6.9%)	32,214 (9.6%)	37,854 (11.3%)	54,355 (16.2%)	6,149 (1.8%)	335,159
2017	181,697 (52.3%)	24,194 (7.0%)	34,014 (9.8%)	40,648 (11.7%)	63,585 (18.3%)	3,356 (1.0%)	347,494
2018	168,436 (47.4%)	27,505 (7.7%)	37,992 (10.7%)	45,604 (12.8%)	71,433 (20.1%)	4,078 (1.1%)	355,048

Source: HIP enrollment data files, February 2015 – December 2018.

Exhibit F.4.7: New HIP Plus Members by FPL (January 2016 – December 2018)

***Notes**: Analyses use the **Goal 4** Research Question 1.2 HIP member exclusions and inclusions. FPL reflects FPL observed in first month of HIP Plus enrollment in the calendar year.*

Time Period	New Members By FPL and Year (Percent of HIP Plus Members)						
	<22% FPL	23-50% FPL	51-75% FPL	76-100% FPL	101-138% FPL	> 138% FPL	Total
2016	64,044 (35.3%)	6,683 (29%)	9,878 (30.7%)	12,319 (32.5%)	20,448 (37.6%)	668 (10.9%)	114,040 (34.0%)
2017	44,463 (24.5%)	4,725 (19.5%)	6,941 (20.4%)	9,134 (22.5%)	15,822 (24.9%)	376 (11.2%)	81,461 (23.4%)
2018	45,349 (26.9%)	4,462 (16.2%)	6,502 (17.1%)	8,562 (18.8%)	15,472 (21.7%)	376 (9.2%)	80,723 (22.7%)

Source: HIP monthly enrollment files, February 2015 – December 2018.

Note: 2015 was first year of HIP 2.0 program. Thus, all members in 2015 were new HIP enrollees. New HIP Plus members in 2016 were members not enrolled in 2015 (using definition outlined for this measure).

The number of members with previous HIP Plus enrollment who returned to receive HIP Plus coverage is high (approximately 77% for 2018 and 2017, 64% for 2016). However there is no indication of increase in the number of new HIP Plus member with the latest two years (2017 and 2018) having very similar proportion (and count) of new HIP Plus members overall and by income level. Given the observed trends across program years and timing of the POWER Account payment policy implementation, there is no conclusive finding for this research question for the Interim Evaluation Report. The Summative Evaluation Report will address this research question using two additional years of HIP enrollment data and a separate Medicaid uptake analysis for Medicaid eligible population.

Primary Research Question 2.2 – Is there a relationship between POWER Account payment tiers and continued enrollment in Medicaid?

The purpose of this research question is to assess whether POWER Account payment tier has an effect on continued member enrollment. The analyses presented in this section expand on the HIP coverage analyses performed for Research Question 1.2 and further explore disenrollment for non-payment, movement between HIP Plus and HIP Basic and the number of months with HIP coverage in a year.

Brief Summary: Overall, additional years of data are needed to assess if the change in payment tiers in 2018 affected disenrollment rates, movement between HIP Plus and HIP Basic, and continuity of coverage.

- *Probability of disenrollment due to non-payment:* Goal 4 HIP Plus member disenrollment with non-payment as reason (irrespective of member FPL) was low and decreased from 2016 (2.2%) to 2018 (1.4%). Controlling for various sociodemographic characteristics using logistic regression model, members in 2018 had higher likelihood of disenrollment overall but a lower likelihood of disenrollment with non-payment as reason compared to 2017. Additionally, Goal 4 HIP Plus members who were Black had a higher likelihood of disenrollment with non-payment as reason (as well as overall) compared to non-Hispanic White HIP Plus members (Odds Ratio[100] (OR)=1.8).
- *Probability of members moving from HIP Plus to Basic:* The proportion of Goal 4 HIP Plus members moving from HIP Plus to HIP Basic in a year has been variable between 6.4% and 7.9% from 2015 to 2018. In 2018, 25,157 Goal 4 HIP Plus members moved from HIP Plus to HIP Basic representing approximately 6.4% of the 393,059 HIP Plus individuals.[101] Controlling for various sociodemographic characteristics, Black Goal 4 HIP Plus members had a higher likelihood of moving to HIP Basic compared to non-Hispanic White members (OR=1.6) while members 40 years of age or older had a lower likelihood to move from HIP Plus to HIP Basic as compared to members 19 to 29 years of age (OR=0.8 for members age 40 to 49, 0.5 for members ages 50 to 59, 0.3 for members ages 60 to 66). Members having a frail indicator had a slightly higher likelihood of moving to HIP Basic from HIP Plus as compared to members without a frail indicator (OR=1.2).
- *Probability of members moving from HIP Basic to Plus:* The number of Goal 4 HIP members moving from HIP Basic to Plus has increased. In 2018, about 47,177 members moved from HIP Basic to HIP Plus representing 21.4% of the HIP Basic population (higher than in 2017 and 2016). Controlling for various sociodemographic characteristics, female members had a higher likelihood of moving from HIP Basic to HIP Plus compared to male members (OR=1.5) and members age 50 and older had a higher likelihood of moving to HIP Plus compared to members age 19 to 29 (OR=2.1).
- *Number of months with Medicaid coverage during year*: There was no observable difference in the number of months with HIP coverage across time for Goal 4 HIP Plus members.

[100] Odds Ratio (OR) is a measure of association; Agresti, A. (2007). *An Introduction to Categorical Data Analysis.* Hoboken, New Jersey: John Wiley & Sons, Inc. Retrieved from https://mregresion.files.wordpress.com/2012/08/agresti-introduction-to-categorical-data.pdf

[101] By HIP policy HIP Plus members with income at or less than 100% FPL may move to the HIP Basic plan upon non-payment of POWER Account Contribution (as discussed earlier in Goal 4). These members are sometimes referred as "eligible to move to Basic." As discussed earlier in this section, we have included all HIP Plus members instead of limiting the analysis to members having income at or less than 100% FPL.

Quantitative Methodology

We calculated the following four outcome measures to explore this research question:

- *Measure 1:* Probability of disenrollment due to non-payment
- *Measure 2:* Probability of members moving from HIP Plus to Basic
- *Measure 3:* Probability of members moving from HIP Basic to Plus
- *Measure 4:* Number of months with Medicaid coverage during year

As discussed in the *Summary of POWER Account and Enrollment* subsection, HIP Plus members can move to HIP Basic or be disenrolled if they do not make POWER Account Contributions. Additionally, HIP Basic members can move to HIP Plus.

Exhibit F.4.8 shows the specifications to calculate the outcome measures. Lewin used HIP enrollment and disenrollment data from February 2015 to December 2018 and applied the Goal 4 member inclusions and exclusions described in *Definition of HIP Member Population Used* in **Goal 4** subsection. Since member FPL can change across months and some members can have multiple disenrollments, for consistency, we identified the FPL using the first enrollment month in the calendar year when necessary for analysis. Based on analyses and feedback from the State, we included all HIP Plus members for analyses for all measures regardless of FPL in the enrollment data (*Identification of FPL* subsection at the beginning of **Goal 4** contains additional detail).

In addition to providing annual descriptive statistics for the outcome measures, Lewin also analyzed the impact of the POWER Account payment tier on the outcome measures adjusting for member characteristics using standard regression techniques. A summary of these analyses are available in **Attachment V**.

As the analyses reflect only one year of experience after implementation of the simplified payment tiers, the analyses developed and results presented in this report reflect Lewin's initial observations. We will expand on these observations using two additional years of data for purposes of the Summative Evaluation Report.

Exhibit F.4.8: Goal 4 Hypothesis 2 Research Question 2.2 Outcome Measure Calculation

Measure	Metric	Numerator	Denominator	Notes
Measure 1: Probability of disenrollment due to non-payment	Proportion of HIP Plus members who disenrolled – by reason ***Note**: While the metric in the Evaluation Plan was specific to disenrollment analyses for non-payment, we present analyses for all reasons.*	Number of unique Goal 4 HIP Plus members having disenrollment reason: • Non-payment[102] • Increase in income • Disability / pregnancy • Other administrative reasons	Number of unique Goal 4 HIP Plus members	• Members can have multiple disenrollments in a year and have multiple reasons for a single disenrollment. ○ A member is included one time in the count for a specific disenrollment reason if any of the member's disenrollments had the corresponding disenrollment reason code. ○ A member can be included in the counts for multiple disenrollment reasons. • Includes all income levels.
Measure 2: Probability of members moving from HIP Plus to Basic	Proportion of members who move from HIP Plus to Basic	Number of unique Goal 4 HIP Plus members that moved to HIP Basic in a later month within the calendar year	Number of unique Goal 4 HIP Plus members	• Members can switch plans multiple times during the year. This metric identifies unique members who moved from HIP Plus to HIP Basic at least once in the calendar year. • In the instance of members that had TMA or pregnant at any time during the year, this measure: ○ Did not include months of enrollment with TMA or pregnancy ○ Included months in which a member did not have TMA or pregnancy ○ Considered the benefit plan prior to TMA / pregnancy and the benefit plan post-TMA / pregnancy to identify the potential move between benefit plans

[102] Disenrollment reason 001 is "Non-payment of Initial POWER Account Contribution (i.e., never fully enrolled in HIP Plus)". Disenrollment reason 002 is "Non-payment of POWER Account Contribution (i.e., disenrolled from HIP Plus WITH 6 month lockout)." Disenrollment reason 003 is "Increased Income + Non-payment of POWER Account Contribution (i.e., disenrolled from HIP Basic WITHOUT 6 month lockout).

Measure	Metric	Numerator	Denominator	Notes
Measure 3: Probability of members moving from HIP Basic to Plus	Proportion of HIP Basic members who moved to HIP Plus	Number of unique Goal 4 members having HIP Basic for a particular month and moved to HIP Plus in a later month within the calendar year	Number of unique Goal 4 HIP Basic members	• Members can switch plans multiple times during the year. The metric identifies unique members who experienced a move from HIP Basic to HIP Plus at least once in a calendar year. • In the instance of members that had TMA or pregnant at any time during the year, this measure: o Did not include months of enrollment with TMA or pregnancy o Included months in which a member did not have TMA or pregnancy o Considered the benefit plan prior to TMA / pregnancy and the benefit plan post-TMA / pregnancy to identify the potential move between benefit plans
Measure 4: Number of months with Medicaid coverage	Number of months with HIP Plus or HIP Basic coverage	Total number of months Goal 4 HIP Plus members had HIP coverage in a calendar year	n.a., not a proportion	• Members can switch plans multiple times during the year. Coverage months include coverage under HIP Plus and HIP Basic. • If members had TMA at any time during the year or were pregnant, we did not include the associated months in this metric.

Quantitative Results

Measure 1: Probability of disenrollment due to non-payment[103]

As discussed earlier, the overall number of disenrollments and the disenrollment rate has increased across time while the disenrollment rate for members having non-payment as reason and the overall proportion of members having continued coverage has decreased across time (**Exhibit F.4.4a**). For this research question, we examined all reasons for disenrollment. **Exhibit F.4.9** shows the disenrollment rate for Goal 4 HIP Plus members overall as well as by disenrollment reason. Key observations include:

- The rate and number of disenrollments has significantly increased from 23% (79,667) in 2016 to 32% (125,495) in 2018.
- While the disenrollment rate resulting from non-payment has decreased, the proportion of disenrollments resulting from an increase in income or other administrative reasons has increased significantly across time.

[103] Disenrollment reason 001 is "Non-payment of Initial POWER Account Contribution (i.e., never fully enrolled in HIP Plus)". Disenrollment reason 002 is "Non-payment of POWER Account Contribution (i.e., disenrolled from HIP Plus WITH 6 month lockout)." Disenrollment reason 003 is "Increased Income + Non-payment of POWER Account Contribution (i.e., disenrolled from HIP Basic WITHOUT 6 month lockout).

- The proportion of members having income as a reason for disenrollment increased from 9% in 2016 to 13% in 2018, while disenrollment for other administrative reasons increased from 9.9% in 2016 to 15.9% in 2018.

State officials have indicated that the increase in members disenrolling for other administrative reasons is due to the alignment of the HIP verification policy with the Medicaid verification policy at the start of 2018. In 2015, the State requested verification on any known information including information entered into the system from SNAP and TANF determinations (a process in alignment with Medicaid rules). The Medicaid policy which requests ongoing verifications for known program data and applies verified information across programs (inclusive of SNAP/TANF) was put on hold for HIP in 2015 as it resulted in short benefit periods and additional POWER Accounts since individuals would churn off and on the program more frequently. In 2018, HIP changed to a calendar year benefit period and the Medicaid verification rules were reinstated in HIP. With the new verification process, any HIP member losing eligibility due to failure to verify during the calendar year could come back to the same health plan and POWER Account once the verification was resolved.

Exhibit F.4.9: Disenrollment Reason for Goal 4 HIP Plus Members (February 2015 – December 2018)

Note**: Analyses use the **Goal 4** definition of HIP member categories, as described in **Exhibit F.4.1

Time Period	All Goal 4 HIP Plus Members[a]	Goal 4 HIP Plus Members Disenrolled[a]		Goal 4 HIP Plus Members Disenrolled Due to Non-Payment		Goal 4 HIP Members Disenrolled Due to Income		Goal 4 HIP Plus Members Disenrolled Due to Disability or Pregnancy[c]		Goal 4 HIP Plus Members Disenrolled Due to Other Administrative Reasons[d]	
		Number	Percent[b]	Number	Percent	Number	Percent	Number	Percent	Number	Percent
2015	265,400	34,901	13.2%	2,133	0.8%	15,937	6.0%	5,173	1.9%	11,639	4.4%
2016	346,724	79,667	23.0%	7,662	2.2%	29,510	8.5%	9,302	2.7%	34,156	9.9%
2017	370,085	92,912	25.1%	6,781	1.8%	33,371	9.0%	9,700	2.6%	44,635	12.1%
2018	393,059	125,495	31.9%	5,500	1.4%	51,128	13.0%	8,940	2.3%	62,562	15.9%

[a] Unique count of members having disenrollment in the calendar year. Members can have multiple reasons for disenrollment. Additionally members can have multiple disenrollment in a year. Adding counts of members for different reasons for disenrollment is not recommended to obtain the number of disenrollment.

[b] Percent calculated as proportion of all Goal 4 HIP Plus members having disenrollment with specific reason.

[c] Approximately 2% of the members with disenrollment reason "Disability or Pregnancy" have HIP enrollment aid category of Plus Copay (PC) or Pregnant (MA) in the same calendar year. The majority of the HIP Plus members having PC or MA do not have disenrollment. Approximately 5% of the members with this disenrollment reason reenroll within next month and 25% reenroll within the same calendar year with Regular or State Basic or Plus benefit plan.

[d] Includes disenrollment codes 006 – Moved out-of-state, 007 – Did not submit paperwork for redetermination, 008 – Failure to verify information, and 009 – Other (e.g., "deceased," "incarcerated").

Source: HIP monthly enrollment files, February 2015 – December 2018.

Attachment V: Exhibit V.1 shows detailed Goal 4 HIP Plus member counts and disenrollment rates by FPL. The majority of the disenrollment due to non-payment in 2017 and 2018 are for members having greater than 100% FPL. As only individuals with income greater than 100% FPL can be disenrolled for non-payment, subsection *Identification of FPL* at the beginning of this goal provides a discussion of reasons why the FPL identified for analyses might not be consistent with HIP policy. The trend at the FPL level for all other disenrollment reason codes is similar to the yearly trend – irrespective of income level, there is an increase over time in the disenrollment rate due to an increase in income or other administrative reasons.

We developed a main effects logistic model to identify potential factors that can affect a member's chance of disenrollment due to non-payment (for details refer to **Attachment V: Exhibit V.4**). For the explanatory factors, we used member characteristics including year of membership, FPL, age, gender, race, income, medically frail indicator, marital status, and number of months with HIP coverage in the calendar year. We limited the analysis to Goal 4 HIP Plus members.

As observed previously, the prevalence of disenrollment having non-payment as reason is low (ranging between 0.8% and 2.2% annually from February 2015 to December 2018). Similar to the trend observed based on raw member counts, the initial regression model shows members had a lower likelihood to disenroll due to non-payment in 2017 compared to 2016, as well as 2018 compared to 2017. Interestingly, controlling for the different characteristics, members in 2018 appear to have higher likelihood (OR=1.4) of having disenrollment due to other reasons and lower odds of disenrollment due to non-payment (OR=0.8) compared to 2017.

Black HIP Plus members had a higher likelihood of disenrolling due to non-payment or other reasons compared to non-Hispanic White members (OR=1.8). HIP Plus members age 30 and older disenrolled less frequently due to non-payment compared to members younger than age 30. These findings are consistent with patterns observed in member enrollment and disenrollment data from 2016 to 2018, most notably:

- On average, 3.0% of Black members had non-payment as a reason for disenrollment as compared to 1.9% of non-Hispanic White members. Considering all reasons for disenrollment, on average, 33% of Black members had disenrollment as compared to 28% for non-Hispanic White members.
- On average, 2.6% of members age 19 to 29 had non-payment as a reason for disenrollment while, 1.9% of members age 30 and above had non-payment as reason for disenrolling. The pattern was similar considering all reasons for disenrollment. The average disenrollment rate for members age 19 to 29 was 34%. In comparison, approximately 28% of members age 30 and above had disenrollment in a year.

These initial observations provide a baseline view of the program and factors that impact member behavior. However, due to the timing of the analyses, these observations do not answer the hypotheses regarding whether POWER Account Contribution payment had an impact on member movement between HIP Basic and HIP Plus. An analysis of additional years of data is needed to fully address this measure, which Lewin will perform for the Summative Evaluation Report.

Measure 2: Probability of moving from HIP Plus to HIP Basic

As discussed in Research Question 1.2, Regular HIP Plus members with income at or less than 100% FPL can move to HIP Basic for not making POWER Account Contribution. These members will lose the more robust HIP Plus benefits. This outcome measure analyzes if the simplified POWER Account payment tier policy helped members maintain their HIP Plus coverage longer (instead of moving from HIP Plus to Basic). **Exhibit F.4.10** provides a summary of movement between HIP Basic and HIP Plus by observed FPL. The following are key observations from this summary:

- As discussed in Research Question 1.2, the proportion of Goal 4 HIP Plus members moving from HIP Plus to HIP Basic in a year varied between 5.9% and 7.9% from February 2015 to December 2018.

- In 2018, 25,157 Goal 4 HIP Plus members moved from HIP Plus to HIP Basic representing approximately 6.4% of the 393,059 HIP Plus individuals.[104]
- The number of members moving from HIP Plus to HIP Basic was highest in 2017 (29,174 Goal 4 HIP Plus members, representing 7.9% of the Goal 4 HIP Plus population).
- There was a small number of members with more than one move between HIP Plus and HIP Basic in a calendar year. For instance, in 2018 there were about 6,000 Goal 4 HIP members who moved from HIP Basic to HIP Plus and also moved from HIP Plus to HIP Basic.
- A proportion of Goal 4 HIP members having income over 100% FPL appear to move from HIP Plus to HIP Basic (based on enrollment data), which would not be expected as only members with incomes at or under 100% FPL should be able to make this transition. For example, in 2018, 2,079 Goal 4 HIP Plus members with incomes over 100% FPL moved from HIP Plus to HIP Basic (8% of all Goal 4 HIP Plus members that moved to HIP Basic). Subsection *Identification of FPL* provides a description of reasons for inconsistencies in FPL amounts as compared to HIP policy. We also conducted additional analyses on this subgroup for 2018 and observe the following:
- Most of the members appear to have 0% FPL in the month they moved from HIP Plus to HIP Basic; we observed a similar pattern for other years.
- The members had Regular or State Plan and moved between these plans: 581 members had State Plan benefits and moved between HIP Plus and HIP Basic; 660 members moved between Regular Plus and Regular Basic benefit plans; 838 members moved between State and Regular benefit plans. We observed similar pattern for other years.

We developed a main effects logistic model to identify potential factors that can affect members moving from HIP Plus to HIP Basic (for details refer to **Attachment V: Exhibit V.5**). For the explanatory factors, we used member characteristics including year of membership, FPL, age, gender, race, marital status, medically frail indicator (limiting to the Goal 4 HIP member population who had the HIP Plus plan at any time in the membership year). Key observations based on the estimated regression and February 2015 to December 2018 member enrollment and disenrollment data are:

- HIP Plus members age 40 and over were less likely to move from HIP Plus to HIP Basic compared to members aged below 30 (OR=0.8 for members age 40 to 49, 0.5 for members ages 50 to 59, 0.3 for members ages 60 to 66). Between February 2015 and December 2018, approximately 9% of HIP Plus members age 39 and below moved from HIP Plus to HIP Basic each year. In comparison, between 4% and 6% of HIP Plus members age 40 and above moved from HIP Plus to HIP Basic.
- Black HIP Plus members had higher likelihood of moving to HIP Basic compared to non-Hispanic White members (OR=1.6). During the four years used for analysis, between 9% and 11% of Black HIP Plus members had a change to HIP Basic compared to between 2% and 4% of non-Hispanic White HIP Plus members.
- Members identified as medically frail had a higher likelihood of moving from HIP Plus to HIP Basic (OR=1.2). The model estimate reflects the pattern observed in the recent years. Prior to 2017, the proportion of HIP Plus members identified as medically frail who moved from HIP

[104] By HIP policy HIP Plus members with income at or less than 100% FPL may move to the HIP Basic plan upon non-payment of POWER Account Contribution (as discussed earlier in Goal 4). These members are sometimes referred to as "eligible to move to Basic". As discussed earlier in this section, we have included all HIP Plus members instead of limiting the analysis to members having income at or less than 100% FPL.

Basic to HIP Plus was lower in comparison to members not medically frail (4.2% for medically frail and 6.3% for not medically frail in 2015). From 2017, a higher proportion of members identified as medically frail moved from HIP Basic to HIP Plus, compared to members not identified as medically frail (for 2018, 8.5% of medically frail members changed plans to HIP Basic, compared to 5.6% of the members not medically frail). The proportion of the member population identified as medically frail has increased over time (from 18% of HIP Plus members in 2015 to 28% in 2018).

These initial findings provide a baseline view of the program and factors that impact member behavior. However, due to timing of the analyses it does not answer the hypotheses on whether POWER Account payment tiers impacted member movement between HIP Plus and HIP Basic. An analysis of additional years of data is needed to fully address this measure; the Summative Evaluation Report will include these analyses.

Exhibit F.4.10: Goal 4 Member Movement Between Benefit Plans, by FPL (February 2015 – December 2018)

Note**: Analyses use the **Goal 4** definition of HIP member categories, as described in **Exhibit F.4.1

Time Period	FPL [a]	Goal 4 HIP Plus [b]	Goal 4 HIP Basic [b]	Moved from HIP Basic to HIP Plus[c]		Moved from HIP Plus to HIP Basic[c]	
				Number	Percent of Basic	Number	Percent of Plus
2015	0%-100% FPL	226,187	156,971	26,948	17.2%	15,306	6.8%
	> 100% FPL	39,213	4,183	59	1.4%	323	0.8%
	Total	**265,400**	**161,154**	**27,007**	**16.8%**	**15,629**	**5.9%**
2016	0%-100% FPL	287,427	191,245	19,758	10.3%	22,245	7.7%
	> 100% FPL	59,297	9,377	1,554	16.6%	795	1.3%
	Total	**346,724**	**200,622**	**21,312**	**10.6%**	**23,040**	**6.6%**
2017	0%-100% FPL	303,134	218,048	29,775	13.7%	27,606	9.1%
	> 100% FPL	66,951	13,620	2,594	19.0%	1,568	2.3%
	Total	**370,085**	**231,668**	**32,369**	**14.0%**	**29,174**	**7.9%**
2018	0%-100% FPL	316,731	204,532	43,301	21.2%	23,078	7.3%
	> 100% FPL	76,328	15,943	3,876	24.3%	2,079	2.7%
	Total	**393,059**	**220,475**	**47,177**	**21.4%**	**25,157**	**6.4%**

[a] FPL is based on the FPL observed in first month of enrollment in the calendar year

[b] Represents members having at least one month HIP Plus or HIP Basic in the calendar year regardless of other enrollment status (this is not the same as "HIP Plus Only" or "HIP Basic Only"). There are some members who are included in both the totals as they have switched between HIP Basic and HIP Plus. Adding the two columns is not recommended at it would overstate the total HIP membership population.

[c] Members can switch plans multiple times in a calendar year. Analyses of monthly enrollment data showed small number of members having more than two switches between HIP Basic and HIP Plus. Counts reported are unique member counts for each direction of the move between coverage plans and are not count of the number of moves (for members with multiple plan changes). Members with multiple movements between plans are counted in both columns; adding the two columns is not recommended as it will overstate the total number of members switching between HIP plans.

Source: HIP monthly enrollment files, February 2015 – December 2018.

Measure 3: Probability of moving from HIP Basic to HIP Plus

This outcome measure analyzes if the simplified POWER Account payment tier policy helped members move from HIP Basic to HIP Plus. **Exhibit F.4.10** provides a summary of movement between HIP Basic and HIP Plus by observed FPL for Goal 4 member population from February 2015 to December 2018. The following are key observations from this summary:

- The proportion of Goal 4 HIP Basic members moving from HIP Basic to HIP Plus annually has increased steadily since 2016 (10.6% in 2016, 14.0% in 2017, and 21.4% in 2018).
- Goal 4 HIP Basic members with income 100% FPL or less represent over 90% of all members transitioning to HIP Plus.
- There appears to be a small proportion of members having income over 100% FPL who moved from HIP Basic to HIP Plus. For example, in 2018, 3,876 Goal 4 members with incomes over 100% FPL moved from HIP Basic to HIP Plus (approximately 8% of all Goal 4 members that moved to HIP Plus—consistently from 2016 to 2018). This subgroup of members may reflect a variety of scenarios. For example, individuals transferring from another Medicaid category first enroll in HIP Basic and then have the opportunity to move to HIP Plus. Additionally, HIP Basic members who have income increase over 100% of the FPL remain in HIP Basic while assessing if they will move to HIP Plus. Subsection *Identification of FPL* also provides a description of reasons for variation in FPL amounts used for analysis. We conducted additional analyses on this subgroup and observed the following pattern:
    - Approximately 30% of these members had State and Regular plans; 50% of the members moved between Regular Basic and Regular Plus plans.
    - Among the members having a Regular Plan, there were some members who had multiple moves (started as HIP Plus then moved to HIP Basic and then later in the year moved back to HIP Plus), and a few members had MA (pregnancy) in the beginning months of the year followed by HIP Basic and then a move to HIP Plus.

An increase in the number of members moving from HIP Basic to HIP Plus could occur for a variety of reasons, including demand for the HIP Plus benefit package, decrease in POWER Account Contribution due to the new payment tier structure or new rollover process, and improved member affordability due to an increase in income.

We developed a main effects logistic model to identify potential factors that can affect a member's move from HIP Basic to HIP Plus (for details refer to **Attachment V: Exhibit V.6**). For the explanatory factors, we used member characteristics including year of membership, FPL, age, gender, race, marital status, income, and medically frail indicator. We limited the analysis to Goal 4 HIP Basic members. Key observations based on the estimated regression and February 2015 to December 2018 member enrollment and disenrollment data are:

- Female members had a higher likelihood (OR=1.5) of moving to HIP Plus compared to male members, controlling for other sociodemographic factors. The proportion of female members that moved to HIP Plus was higher compared to male HIP Basic members every year. In 2015, 18% of female HIP Basic members moved to HIP Plus compared to 14% male HIP members while in 2018, 24% of female HIP Basic members moved to HIP Plus compared to 17% of male HIP Basic members).

- Members age 50 and above have twice the likelihood (OR=2.1) of moving to HIP Plus compared to member age 19 to 29 controlling for other sociodemographic factors. The model estimate was consistent with member disenrollment data. For example, for 2015, 12% of members age 29 and below changed their plan from HIP Plus to Basic while 27% of members age 50 and above had a change in plan. This pattern was consistent across all years.

These initial findings provide a baseline view of the program and factors that impact member behavior. However, due to timing of the analyses it does not answer the hypotheses regarding whether the change in POWER Account Contribution payment tiers had an impact on member movement between HIP Basic and HIP Plus. An analysis of additional years of data is needed to fully address this measure, which we will perform for the Summative Evaluation Report.

Measure 4: Number of months with Medicaid coverage during year

In Research Question 1.2, we assess continuity of coverage in terms of members having continuous HIP Plus coverage through the calendar year once enrolled. For this research question, the measure of interest was the number of months of HIP coverage in a calendar year for Goal 4 HIP Plus members (coverage could be HIP Plus or HIP Basic).

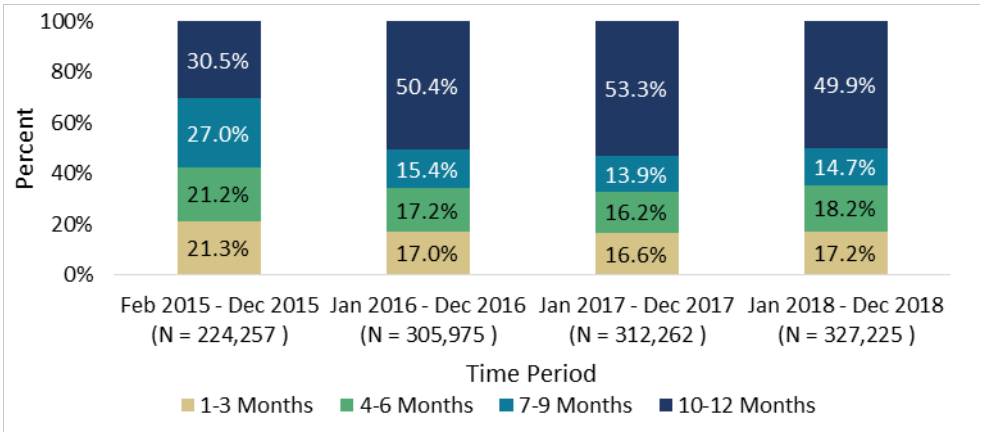
Goal 4 HIP Plus members include members who were only in HIP Plus during the year as well as members moving between HIP Plus and HIP Basic (HIP Switchers). We calculated the months covered (fully enrolled) for these two separate groups. **Exhibit F.4.11a** and **Exhibit F.4.11b** shows distribution of members by number of months with HIP coverage (HIP Basic or HIP Plus) in a calendar year. Key observations include:

- During most years, at least 50% of Goal 4 HIP Plus members (HIP Plus Only and HIP Switchers) had 10 to 12 months of coverage.
- In 2018, the proportion of Goal 4 HIP Switchers having 10 to 12 months coverage decreased slightly (from 62.7% in 2017 to 54.6% in 2018), while the proportion of switchers having 7 to 9 months of coverage increased (from 19.1% in 2017 to 24.3% in 2018). Approximately 80% of these members who change plans (HIP Basic/HIP Plus) have more than 7 months of coverage in a year (pattern is consistent across all 4 years)
- Members with Goal 4 HIP Plus Only coverage during a year appear to have had similar distribution of coverage months for 2016 to 2018:
- Approximately 50% of members had 10 to 12 months coverage.
- On average, 17% of members had 1 to 3 months coverage, 17% members have 4 to 6 months coverage and 15% members had 7 to 9 months coverage across all the years.

The HIP Evaluation Plan discussed potential development of regression-based analyses to assess the impact of POWER Account on number of months of coverage. These analyses will be developed for purposes of the Summative Evaluation Report as our analyses indicate that there is no observable difference in the number of months covered over time pre- and post-implementation of the POWER Account payment tiers (based on 12 months of data post-implementation).

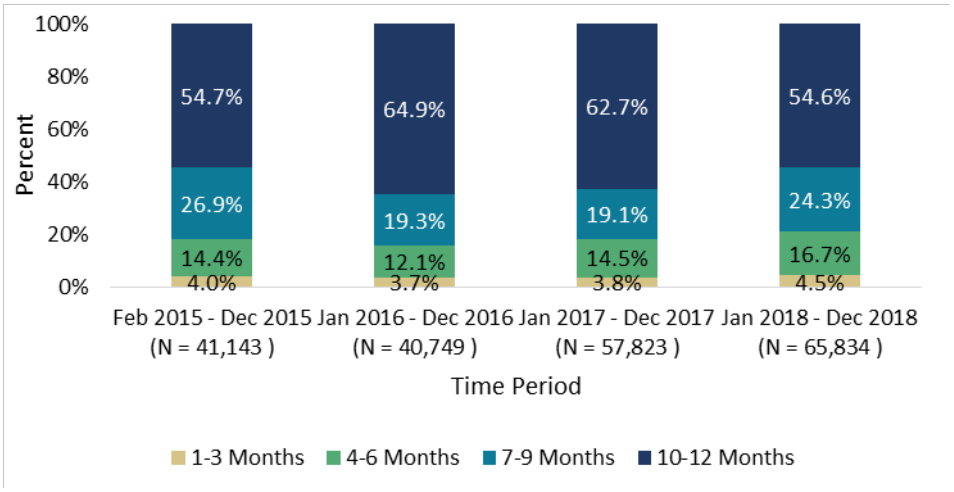
Exhibit F.4.11a: Number of Months with Medicaid Coverage – Goal 4 HIP Plus Only Population (February 2015 – December 2018)

Note**: Analyses use the **Goal 4** definition of HIP member categories, as described in **Exhibit F.4.1



Source: HIP monthly enrollment files, February 2015 – December 2018.

Exhibit F.4.11b: Number of Months with Medicaid Coverage – Goal 4 HIP Switchers Population[a] (February 2015 – December 2018)



[a] This population includes HIP Plus members who at some point in the calendar year had at least one month of HIP Basic enrollment.

Source: HIP monthly enrollment files, February 2015 – December 2018.

Primary Research Question 2.3 – Do HIP members who receive rollover have greater coverage continuity than members who do not receive rollover?

HIP members receiving qualifying preventive services can receive rollover in the following year. HIP Plus members having remaining funds at year-end that received qualifying preventive services can double the rollover amount (portion of unused POWER Account Contribution payments). Members may use these rollover funds to reduce / offset member POWER Account Contribution payments, which increases the affordability of HIP Plus coverage and potentially increases members maintaining coverage. **Section B: Summary of HIP Demonstration** provides additional detail on the State's rollover policy.

Starting in 2018, the State made all member benefit periods equal to the calendar year. Prior to 2017, members enrolling multiple times within a year had multiple POWER Accounts and the State applied rollover based on the individual member benefit period (based on the dates the member enrolled).

This research question assesses whether receipt of rollover supports greater continuity of coverage for HIP Plus members. Since the change to calendar year rollover and to the new POWER Account Contribution payment tier was implemented from 2018, Lewin presents initial observations from 2017 and 2018 in this report. The Summative Evaluation Report will include additional analyses with data through 2020. These analyses will include a regression model of outcomes to more rigorously test the effect of the POWER Account payment tiers on rollover and continuity of coverage.

Brief Summary: Overall, additional years of data are needed to assess if the change in payment tiers in 2018 affected continuity of coverages and rollover benefits. Approximately 42% of Goal 4 HIP Plus members in 2018 received rollover benefits; approximately 63% (104,083) had coverage between 10 and 12 months. Goal 4 HIP Plus members receiving rollover benefits had a higher disenrollment rate (36.2%) compared to members identified as not having earned rollover (28.8%). The primary reasons for disenrollment were increased income and other administrative reasons.

Quantitative Methodology

We calculated two outcome measures to address this research question:

- Number of months with Medicaid coverage
- Probability of disenrollment

Exhibit F.4.12 outlines the specifications we used to calculate the outcome measures. Both HIP Basic and Plus members can earn rollover (refer to **Exhibits B.6 and B.7**). For this analysis, we identified any member having earned rollover (irrespective of Basic or Plus membership) in the prior calendar year (i.e., 2017) and having enrollment in the year of analyses (i.e., 2018) as receiving rollover in the current year of analyses (i.e., 2018).[105]

Since this research question is associated with the impact of POWER Account payment tiers, we focused our analyses on Goal 4 HIP Plus members. Based on two years of available data, the majority of members earning rollover are enrolled in HIP Plus in the following year. For example, approximately 86% of 2018 HIP members (as defined for Goal 4) that had earned rollover in 2017 were enrolled in HIP Plus (165,284 members out of 192,000), approximately 12% of whom had changes between Basic and Plus; the remaining 14 percent of 2018 HIP members that had earned rollover in 2017 enrolled only in HIP Basic plan.

We present summary results for 2017 and 2018 only (based on enrollment data from 2016 to 2018) in this report due to the change in the benefit period definition effective in 2018 as described previously. We also note that the rollover results from 2017 and 2018 are not comparable due to this change. The Summative Evaluation Report will include analyses using additional years of data that will reflect the rollover process used in 2018.

[105] As earned rollover information was captured based on benefit period and some members could have multiple benefit periods, this approach may overstate members receiving rollover in 2017.

Exhibit F.4.12: Goal 4 Hypothesis 2 Research Question 2.3 Outcome Measure Calculation

Measure	Metric	Numerator	Denominator	Notes
Measure 1: Number of months with Medicaid coverage	Number of months with HIP coverage	Total number of months that Goal 4 HIP Plus members had HIP coverage in a calendar year	n.a., not a proportion	• Members can switch plans (HIP Plus / HIP Basic) multiple times during the year. Coverage months include coverage with either HIP Plus or Basic plan. • If members had TMA at any time during the year or were pregnant, we did not include the associated months in this metric.
Measure 2: Probability of Disenrollment	Proportion of HIP Plus members who disenrolled	Unique number of Goal 4 HIP Plus members by disenrollment reason: • Non-payment • Increase income • Disability / pregnancy • Other administrative reasons	Unique number of Goal 4 HIP Plus members	• Members can have multiple disenrollment in a year and multiple reasons for a disenrollment. ○ We counted members once if any of their disenrollment had a specific reason code. ○ Member can be included in the counts for multiple disenrollment reasons.

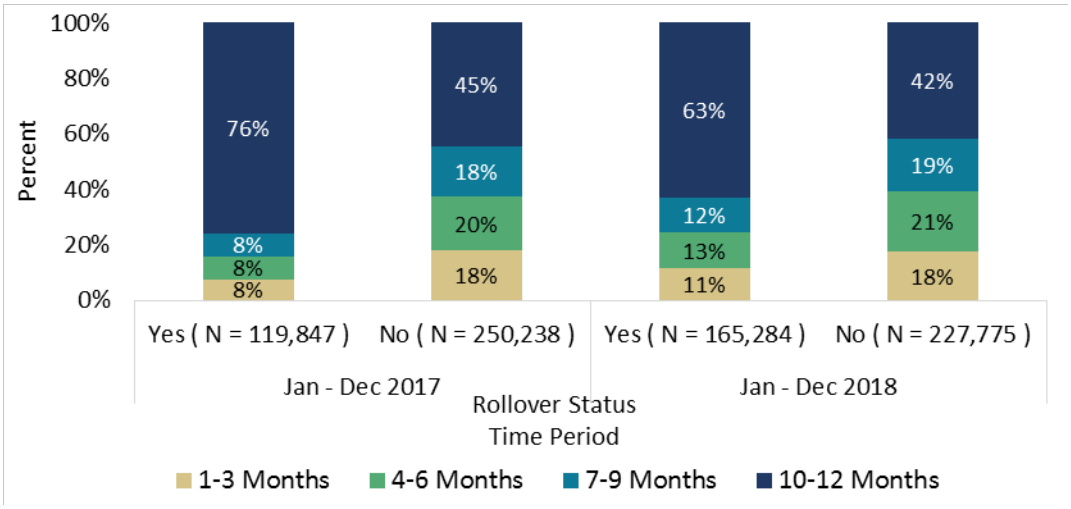
Quantitative Results

Exhibit: F.4.13 shows the distribution of Goal 4 HIP Plus members by the number of months of coverage, comparing the sub-populations receiving and not receiving rollover.

- About 42% (165,284) of Goal 4 HIP Plus members in 2018 (393,059) had earned rollover in the 2017 calendar year and were identified to receive rollover in 2018.
- Goal 4 HIP Plus members receiving rollover appear to have longer coverage compared to those not receiving rollover. In 2018, approximately 63% (104,083) of Goal 4 HIP Plus members receiving rollover and 42% (95,234) of Goal 4 HIP Plus members not receiving rollover had between 10 and 12 months of HIP coverage.

Exhibit F.4.13: Distribution of Goal 4 HIP Plus Members by Number of Coverage Month for Members Not Receiving / Receiving Rollover (January 2017 – December 2018)

Note**: Analyses use the **Goal 4** definition of HIP member categories, as described in **Exhibit F.4.1



Source: HIP monthly enrollment files, 2016 – 2018.

Note: The coverage months are HIP coverage (HIP Basic or HIP Plus). The rollover process prior to 2018 was different as described above. As such, comparisons between the 2017 and 2018 results are not appropriate. Analyses for this goal do not include any HIP Basic members in the analysis year, irrespective of whether member had earned rollover from previous year.

Exhibit: F.4.14 shows disenrollment for Goal 4 HIP members that received rollover and Goal 4 HIP members that did not receive rollover. For 2018, Goal 4 HIP Plus members receiving rollover had a higher disenrollment rate (59,898, 36.2%) as compared to Goal 4 HIP Plus members not receiving rollover (65,597, 28.8%). The disenrollment rate due to non-payment was low overall with Goal 4 HIP Plus members receiving rollover having a slightly lower rate (1.3%) than those not receiving rollover (1.4%). The majority of the disenrollment was due to increased income and other administrative reasons (consistent with results from Research Question 2.2 showing an overall increase in disenrollment rate for the HIP population in 2018 due to the same reasons).

Members flagged as receiving rollover in 2017 had a different disenrollment pattern than the disenrollment pattern observed in 2018. Specifically, members receiving rollover in 2017 had a lower disenrollment rate (22,780, 19.0%) compared to members not receiving rollover (70,132, 28.0%).

Additional years of data are necessary to draw conclusions regarding overall length of coverage and disenrollment trends related to rollover.

Exhibit F.4.14: HIP Plus Members Disenrollment Rate by Not Receiving / Receiving Rollover (2017 – 2018)

Note**: Analyses use the **Goal 4** definition of HIP member categories, as described in **Exhibit F.4.1

Time Period	Received Rollover	All Goal 4 HIP Plus Members	Goal 4 HIP Plus Members Disenrolled		Goal 4 HIP Plus Members Disenrolled Due to Non-Payment		Goal 4 HIP Members Disenrolled Due to Income		Goal 4 HIP Plus Members Disenrolled Due to Disability or Pregnancy		Goal 4 HIP Plus Members Disenrolled Due to Other Administrative Reasons	
		Number	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent
2017	Yes	119,847	22,780	19.0%	1,824	1.5%	8,761	7.3%	1,999	1.7%	10,528	8.8%
	No	250,238	70,132	28.0%	4,957	2.0%	24,610	9.8%	7,701	3.1%	34,107	13.6%
2018	Yes	165,284	59,898	36.2%	2,209	1.3%	23,971	14.5%	3,174	1.9%	31,782	19.2%
	No	227,775	65,597	28.8%	3,291	1.4%	27,157	11.9%	5,766	2.5%	30,780	13.5%

Source: HIP enrollment data files, 2016 – 2018.

Note: The rollover process prior to 2018 was different as described above. As such, comparisons between the 2017 and 2018 results are not appropriate. Analyses for this goal do not include any HIP Basic members in the analysis year, irrespective of whether member had earned rollover from previous year.

Goal 5 – Ensure HIP program policies align with commercial policies, are understood by members, and promote positive member experience and minimize coverage gaps

This goal tests whether HIP policies align with commercial policies, are understood by members, and result in a positive member experience for all HIP members including minimizing coverage gaps. The State designed its HIP policies to mirror a commercial market health insurance plan, including the use of copayments and monthly payment amounts (varying by benefit plan), offering members choices between benefit plans and MCEs, and including incentives to obtain preventive services and disincentives to continue tobacco use. **Section B: Summary of HIP Demonstration** provides a detailed description of the differences between the HIP Plus and the HIP Basic benefit plans, and the structure of the POWER Account and members' POWER Account Contributions.

The State and MCEs work together in distinct capacities to support member understanding of HIP policies. The State develops and distributes HIP resource materials to members and approves MCE member communications. The State's designated HIP communications team works with the MCEs, community partners, providers, and other stakeholders to disseminate information to the public, including HIP members and individuals eligible for HIP but not enrolled. The State has an in-house office dedicated to fielding HIP-related questions and concerns, including payment kiosks, call centers, and Gateway to Work reporting support. The MCEs train staff specifically on HIP who then support the member call centers and communication efforts. The State anticipates that the resources provided by the State and MCEs will promote a positive member experience, particularly through engagement with the customer service teams. Communications and customer service support are two major themes that State officials and MCE executives discussed at length during their key informant interviews including specific strategies for maximizing member understanding and satisfaction.

This Interim Evaluation Report addresses two of the three hypotheses associated with **Goal 5**—whether HIP members understand program policies and whether they are satisfied with the HIP program. The Summative Evaluation Report will address the third hypothesis—whether HIP members subject to non-eligibility periods are similar to commercial market populations.

Hypothesis 1 – Beneficiaries who are required to participate in HIP policies will understand program policies.

Lewin conducted analyses related to this hypothesis by analyzing feedback gathered during key informant interviews with State officials, MCE executives, and members. The Interim Evaluation Report includes findings from the preliminary discussions held in 2019. The Summative Evaluation Report results will reflect additional key informant interviews, a Member Survey, member focus groups, and analyses of program administrative data.

Primary Research Question 1.1 – Are HIP members knowledgeable about policies on payment of POWER Account Contributions, preventive care, and rollover?

HIP Basic and Plus members can rollover their unused POWER Account Contributions to the next year if their annual health care expenses are less than the annual $2,500 ceiling. When HIP members receive preventive care services, they are eligible for additional rollover. **Section B: Summary of HIP Demonstration** provides information about the rollover and preventive care policies affiliated with the POWER Account. Refer to **Goal 4** for additional information on member knowledge of POWER Accounts.

Brief Summary: Lewin found that members' knowledge differs on various HIP policies. Notably, several members reported not understanding the POWER Account and rollover, and MCE executives and providers cited the length and complexity of processes, such as reconciliation, as a source of confusion to members.

Results of Qualitative Analysis

Overall, MCE executives and State officials indicated that their collaboration around member communications has been critical in conveying HIP policies, particularly in regard to layered communication strategies. State officials described the State communications team's distinct focus on clarity, simplification, and standardization across all HIP materials, including digital and print. The State communications team's strategy also involves sharing their materials with MCEs and other partner organizations to support member understanding regardless of entry or access point.

MCE executives and State officials also indicated that rural members, as well as members who are less engaged (e.g., lower health literacy), are harder to reach, both in terms of physical location and access to resources such as community partners and the Internet, which affects access to online materials.

MCE executives indicated that some challenges members and staff reported include explaining the POWER Account Contribution (and its distinction from a premium) and rollover. Some MCEs noted that the long reconciliation process for POWER Account Contributions could be a source of confusion to members as it might impact the delivery and receipt of the rollover benefit.

For the eight members who responded to follow-up questions about POWER Account Contributions, only a few understood the policies. For example, two of the eight interviewees knew that they could rollover remaining balances, five of eight knew what happens if they did not make a payment, and three of eight knew that they could keep unused funds if they left HIP. Regarding rollover payments, two of the eight stated that they were aware that rollover was an option when health care expenses are less than the $2,500 per year, while six of the eight did not know, and nine did not respond. The low number of respondents does not allow for general conclusions and additional data collection and analysis will be conducted for the Summative Evaluation Report.

Given findings from the key informant interviews with State officials, MCE executives, and members, opportunities exist to further support member understanding of the policies related to POWER Account Contributions, rollover, and preventive care. The Summative Evaluation Report will reflect analyses based on data from a member survey and program administrative data used to identify rollover status.

Primary Research Question 1.2 – Do HIP members subject to non-eligibility periods understand program requirements and how to comply with them?

Primary Research Question 1.3 – Do HIP members subject to non-eligibility periods understand the non-eligibility period consequence for non-compliance with program requirements?

Primary Research Question 1.2 and 1.3 address whether HIP members who are subject to non-eligibility[106] or lockout periods understand the program requirements and the consequences for non-compliance. Lockout periods in HIP refer to the six-month disenrollment period that HIP Plus members are subjected to if they do not pay their HIP POWER Account Contribution.

[106] STCs also authorize a redetermination non-compliance lockout that is not currently in effect.

Brief Summary: There appears to be limited member understanding of the lockout period for non-payment of POWER Account Contributions, although more surveying of members is needed.

Results of Qualitative Analysis

Lewin asked members during key informant interviews if they knew what would happen to their HIP coverage if they did not make a payment. Of the 17 respondents making a HIP payment, five responded yes, they did know what would happen if they were noncompliant with payment requirements, three responded they did not know what would happen, and nine did not respond.

The Summative Evaluation Report will reflect additional analyses based on data from a member survey and feedback from upcoming key informant interviews with State officials, providers, and members.

Primary Research Question 1.4 – What are common barriers to compliance with program requirements that have non-eligibility period consequences for non-compliance?

Lockout periods in HIP refer to the six-month disenrollment period that individuals are subjected to if they do not pay their HIP POWER Account Contribution.

Brief Summary: Common barriers to compliance with POWER Account Contributions include navigating the online payment system, inaccurate statements, and the financial burden of the payment amount. Some interviewees noted the variety of avenues to make a payment (e.g., phone, in-person, online) as supporting compliance.

Results of Qualitative Analysis

According to the interviews, one member stated that he or she encountered challenges with the POWER Account online payments and had issues on the payment website and on the phone. Another member said that the payments were a source of financial strain. When asked if they had any issues making a payment, of the 17 respondents making a payment, three responded yes, they had issues making a payment, five said no, and nine did not respond.

According to State officials and MCE executives, members faced some barriers to making POWER Account Contributions, such as inaccurate statements, bills not arriving on time, and members' inability to see account balances online. The State also shared that sometimes there are challenges reaching members and delays with POWER Account reconciliation. However, both entities stated that members appreciate newly rolled out mechanisms for payment, including over the phone, in State offices, online, via mail, and at a storefront.

The Summative Evaluation will provide additional information based on data from the Member Survey and more feedback from upcoming key informant interviews with members.

Hypothesis 2 – Beneficiaries will be satisfied with the HIP program.

Lewin conducted analyses related to this hypothesis by analyzing feedback received during key informant interviews. These analyses will be continued for purposes of the Summative Evaluation Report, including additional key informant interviews, a Member Survey, member focus groups, and analyses of ACS data.

Primary Research Question 2.1 – What is the level of satisfaction with HIP among HIP members?

Satisfaction among HIP members with the HIP program is important to HIP's continued development and implementation across the State. Satisfaction is not specifically defined for the purposes of this evaluation, but members may consider overarching themes of access to care and support, HIP policies, and processes for payment, eligibility, and enrollment in their responses. Key informant interviews with State officials, MCE executives, and providers likely also reflect these themes in their responses related to their understanding of member satisfaction.

Brief Summary: The majority of members interviewed reported that they were satisfied with the program, citing affordability, enrollment processes including Fast Track and presumptive eligibility, and online capabilities for things such as payments and Gateway to Work reporting as top reasons for satisfaction. Reasons for dissatisfaction reported by members and providers include loss of coverage from HIP as a result of non-payment, documentation and time required for enrollment, confusing language in outreach materials, timeliness of communications, lack of coverage for some services or medications, poor provider selection in some areas of Indiana, lack of adequate transportation resources, problems related to switching MCEs, and the misplacement of paperwork between members and the State. Most certified navigators interviewed specifically highlighted the "very effective" enrollment process.

Results of Qualitative Analysis

The MCE executives interviewed indicated that they regularly survey members through follow-up calls; some even have multilingual surveys following phone calls. MCE executives have indicated member satisfaction with HIP in the following areas:

- HIP's enhanced benefit package
- Robust provider network
- Quick access to care
- Access to routine care
- Care management support
- Coverage of services and empowerment when making monthly payments
- Face-to-face education opportunities
- Well-trained customer service and member services teams
- Effective and respectful communications with providers

MCE executives and State officials have identified simplification and streamlining as two of the main areas for improvement, both for their own staff and for members, as HIP implementation continues. This streamlining and simplification has to do with consistency in language used in various materials, simplified language, multilingual materials for members, and enhanced internal communications (within MCE plans and between MCEs and FSSA).

Information from the member key informant interviews revealed that 24 of the 27 interviewees had some level of satisfaction with the program, with 16 identifying as "very satisfied" and eight as "somewhat satisfied." The remaining responses included two that were "somewhat dissatisfied" and seven that did not know or did not respond. While members responding as very satisfied shared positive experiences with level of coverage, payment options, available physicians, and ease of use, members responding as somewhat satisfied focused on their negative experiences. The top reasons for a somewhat satisfied rating included negative feedback related to process breaks such as miscommunication of information and lost documentation. The top reasons for a somewhat dissatisfied response included plan requirements, the number of available physicians, and the location options available.

Additionally, interviews with 36 providers offered insights to provider understanding of member perceptions on HIP. These interviews included physicians, nurses, navigators, and administrators. Most of the providers interviewed reported that HIP members are satisfied with their plan. Of the 21 providers who answered the question about overall member satisfaction, five said they are "very satisfied" and 12 said they are "somewhat satisfied." One of the 36 providers said that HIP members are "somewhat dissatisfied." The most common theme from the provider interviews was their agreement on access to coverage as the top area for member satisfaction. Many of these members did not have coverage prior to HIP, so providers stated the access to coverage had the largest impact on members' satisfaction, as was added coverage for dental and vision services. Other reasons for HIP member satisfaction included:

- Affordability of HIP
- Speed at which members are able to join HIP
- Presumptive eligibility and Fast Track as a means for enrollment and full coverage
- POWER Accounts that instill a sense of accountability and ownership of coverage
- Ability to complete forms and other requirements online

According to the providers, the top reasons for dissatisfaction among members included:

- Loss of coverage from the plan as a result of non-payment
- Documentation and time required for enrollment
- Confusing language in outreach materials
- Timeliness of communications that impact service authorizations and medication approvals
- Lack of coverage for things such as dentures and some newer medications
- Poor provider selection in some areas of the State
- Lack of adequate transportation resources
- Problems related to switching MCEs
- Misplacement of paperwork between members and the State

Interviews with the 15 navigators indicated that members are satisfied with their enrollment process, with most navigators reporting that members say their enrollment experience is "very effective." The navigators specifically noted that some rural members reported dissatisfaction with dental coverage. Providers also noted that there is some recent dissatisfaction among members and navigators related to the process of designating a member as "medically frail." The providers also discussed the satisfaction that members have expressed in working with a navigator throughout various HIP processes and that members appreciate their questions being answered in a more personal setting. One area of dissatisfaction that concerned a navigator was the change to a new computer system. According to the navigator, the switch has been their top fielded complaint from members who are turning in the same document multiple times as a result of the system change which is causing some missing documentation.

Data from a 2019 email survey administered by FSSA with 883 respondents found that 61% of members are "very satisfied" with HIP and 26% are "satisfied."[107] The survey also found that older members are more satisfied with HIP compared to younger members. Over half of the responding members who left the plan left because they obtained a new job and/or were no longer eligible for HIP.

Given the data across key informant interviews, members seem generally satisfied with the HIP program overall. Satisfaction varies across aspects of the program and further data related to this research question is forthcoming for the Summative Evaluation Report. The Summative Evaluation Report will include member focus groups, member surveys, and key informant interviews with MCE executives, State officials, providers, and members.

Hypothesis 3 – Individuals subject to the non-eligibility periods (payment and redetermination) and retroactive eligibility are no different from commercial market populations.

The research questions associated with these hypotheses rely on data from 2015 to 2020, including ACS data and program administrative data. As such, we will address this hypothesis and related research questions in the Summative Evaluation Report.

Primary Research Question 3.1 – Do HIP members have similar demographic characteristics as the commercial market population?

Primary Research Question 3.2 – Do HIP members that are not retroactively eligible have similar demographic characteristics as the commercial market population?

[107] This survey was distributed via email by FSSA and yielded a 2.2% response rate (883 responses). The contractor conducting the survey indicated that this response was a statistically significant representation of the approximately 400,000 HIP members within ±3% and reflected a "good representation" across all 10 districts of the state. Lewin notes that the survey's function was limited to informing the State's communications strategy, and that its reliance on email to distribute the survey introduced notable selection bias inconsistent with surveys conducted for quantitative evaluation purposes.

Goal 6 – Assess the costs to implement and operate HIP and other non-cost outcomes of the demonstration.

The research questions associated with these hypotheses rely on data from 2015 to 2020, including Healthcare Provider Cost Reporting Information System (HCRIS) data and program administrative data. Medicare cost report data include information on uncompensated care, bad debt and charity care. As such, **Goal 6** and its corresponding hypotheses and research questions will be addressed in the Summative Evaluation Report based on analysis completed by Indiana's actuary, Milliman, Inc.[108]

Hypothesis 1 – Costs and non-costs to implement and operate HIP are sustainable.

Primary Research Question 1 – What are the administrative costs incurred by the State to implement and operate the HIP demonstration?

Primary Research Question 2 – What are the short- and long-term effects of eligibility and coverage policies on Medicaid health care expenditures?

Primary Research Question 3 – What are the impacts of eligibility and coverage policies on provider uncompensated care costs?

[108] To reduce the duplication of efforts, and thus cost, this analysis will completed by Indiana's actuary, Milliman, Inc. and appended to the summative evaluation. The results will be incorporated into the overall evaluation analysis where relevant and as appropriate.

G. Conclusions

This section provides high-level observations for each goal of the Indiana HIP program under evaluation, along with our recommended key areas of focus for the State going forward. **Section F: Results by Demonstration Goal** provides additional detail by hypothesis and research question, including indicating which research questions we will address in the Summative Evaluation Report due to the timeframe required for analysis.

For Indiana and other states testing new approaches and flexibilities in their Medicaid programs through Section 1115 waiver demonstrations, evaluations allow states to build on successes and make adjustments based on lessons learned. This Interim Evaluation Report encompasses the first 17 months of the HIP waiver renewal period. As the State only recently implemented some of the program policies under the waiver renewal, this report primarily provides observations that will help inform the full set of analyses and related conclusions for the Summative Evaluation Report (due in 2022).

Overall, the complexity of HIP creates challenges for the State and MCEs to support member and provider understanding of key policies, in particular, POWER Accounts and community engagement reporting requirements. Although the State and MCEs have dedicated resources to communicating key policies and related changes, information gathered during key informant interviews with State officials, MCE executives, members, and providers suggest opportunities for improvement in member and provider understanding of HIP policies. Additionally, maintaining current and accurate member contact information has been a long-standing challenge for the State and MCEs, presenting a barrier to member communications. As such, we recommend the following areas of focus for the State going forward:

- Identify new opportunities to update member contact information, for example, through increased public outreach and support for MCEs in establishing member incentive programs to update contact information to help members understand the steps or pathway to updating their contact information.
- Continue to work with MCEs to carefully test and further streamline communications to support member understanding of POWER Account policies and community engagement reporting requirements, along with other HIP policies such as rollover, Fast Track, and presumptive eligibility, including continuing a layered communication approach (e.g., social media, text message, email, mail) and multiple communication releases reframing the same message to reinforce the policies; and
- Explore additional opportunities to increase engagement of providers, community organizations, and certified navigators in communications about HIP policies.

Goal 1 – Improve health care access, appropriate utilization, and health outcomes among HIP members

State officials, MCEs, providers, and members recognize HIP as critical for supporting health care access to individuals at or under 138% of the FPL. The quantitative and qualitative analyses performed for the Interim Evaluation Report (described in **Section F: Results by Demonstration Goal**) provide observations related to member utilization of services and the ability to access services. Our analyses relied on data from February 2015 to December 2018, and we note that service utilization over this time period encompassed a variety of waiver and non-waiver developments. These include the maturation of the HIP program since 2015, recent improvement in the state economy, case-mix changes over time,

implementation of a new Medicaid Management Information System, removal of a graduated ED copayment, updates to HIP verification processes, and new processes for reporting and tracking community engagement activities. Lewin will continue the analysis of service utilization using 2019 and 2020 data to fully evaluate the impact of programmatic and policy changes included under the waiver renewal for purposes of the Summative Evaluation Report.

Lewin's key observations for **Goal 1** include:[109]

- Based on findings from member key informant interviews, 23 of 27 respondents received needed health care services through HIP. MCE executives, providers, and State officials conveyed that provider network and member access to services continue to improve.
- An analysis of the use of any HIP-covered service from February 2015 to December 2018 indicated that the majority of continuously enrolled HIP members received one or more HIP-covered services, with HIP Plus and HIP Switcher members more likely to receive one or more services as compared to HIP Basic members.
- Participation and utilization rates (percentage of continuously enrolled members participating in the services and the number of services or visits per 1,000 member years, respectively) for CDC-defined preventive services increased from February 2015 to December 2018 while the rates for dental and vision services decreased.
- The percentage of continuously enrolled members accessing a primary care provider increased from 2015 to 2018, while the utilization rate remained approximately the same.
- Participation and utilization rates for specialty care services decreased from February 2015 to December 2018.
- HIP members' adherence to their prescription drug regimens remained relatively the same from 2015 to 2018.
- The percentage of continuously enrolled members accessing health care at urgent care centers increased from 2015 to 2018 while the percent accessing health care at EDs decreased. Despite this decrease, approximately 45% of ED visits in the HIP program in 2018 were "avoidable," classified as either "non-emergent," or "emergent—primary care treatable."
- HIP Basic members had lower participation and utilization rates for preventive services, primary care, specialty services, and urgent care centers from 2015 to 2018 as compared to HIP Plus members. Many factors could contribute to this difference between benefit plan groups, including case mix (10% of HIP Basic members are medically frail as compared to 17% of HIP Plus members), health literacy, lack of transportation to providers, among others.
- Overall, HIP enrollment in MCE disease management programs continued to increase from 2015 to 2018. Programs for depression had the highest enrollment and grew the fastest at an average annual growth rate of 62%.
- HIP enrollment in pregnancy management programs increased at an average annual growth rate of 41% from 2015 to 2018.

[109] Section F: Results by Demonstration Goal provides a detailed description of the HIP members included in analyses for Goal 1.

- MCE performance varied on selected HEDIS® measures. From 2015 to 2017, two of the three MCEs performed lower than the national Medicaid HMO average on two of the six selected measures (controlling high blood pressure and cervical cancer screening). In 2017, the three MCEs performed above the national Medicaid HMO average on at least four of the six selected measures (adult BMI assessment, diabetes care: HbA1c testing, breast cancer screening, and medication management for people with asthma).

- Presumptive eligibility and Fast Track processes have supported new enrollment. Approximately 30.3% and 33.7% of Fast Track and presumptive eligibility members enrolled for six months or more in 2018, respectively. However, the percentage of new members using the presumptive eligibility process and Fast Track decreased. Specifically, the percentage of new HIP Plus members enrolling via Fast Track decreased from 9.9% of all new members in 2017 to 7.4% of all new members in 2018. The percentage of new HIP members enrolling in HIP Plus or HIP Basic using presumptive eligibility decreased from 17.3% to 14.4% from 2016 to 2018.

Lewin recommends the following key areas of focus for Indiana's consideration concerning **Goal 1**:

- Collaborate with the MCEs to tailor outreach to engage HIP Basic members in their care as appropriate and support HIP Basic members in understanding how to enroll in HIP Plus and successfully maintain that enrollment.
- Develop policies to further decrease avoidable ED use.
- Conduct analyses and gather additional member and certified navigator feedback to better understand the decrease in the percentage of new enrollees using presumptive eligibility and Fast Track options.
- Explore opportunities to conduct additional outreach with providers and potential enrollees related to using presumptive eligibility and Fast Track options.

Goal 2 – Increase community engagement leading to sustainable employment and improved health outcomes among HIP members.

Due to the phase-in of the new community engagement reporting requirements under the waiver renewal, the period of analysis for Gateway to Work only included voluntary reporting of community engagement activities. As a result, we cannot fully evaluate this goal until the Summative Evaluation Report. Effective October 31, 2019, the State temporarily removed the enrollment suspension for members who do not meet their reporting requirements pending the results of the federal lawsuit regarding CMS approval of HIP.

Qualitative and quantitative analyses performed for the Interim Evaluation Report (described in **Section F: Results by Demonstration Goal**) provide context on the first six months (January to June 2019) of the State's phase-in of the new reporting requirements (voluntary basis only). Specifically:[110]

- The majority of HIP members—74.6% in June 2019—did not have to report while 18.0% had a reporting requirement (voluntary basis only) and 7.4% prequalified due to existing employment of 20 hours or more per week. This distribution remained constant during the first six months of 2019.

[110] "Section F: Results by Demonstration Goal" provides a detailed description of the HIP members included in analyses for Goal 2.

- Medical frailty, caretaking of children under seven years of age, and "other" emerged as the most common exemption reasons during the first six months of 2019. The "other" category includes SNAP and TANF recipients and other reasons, such as domestic violence.
- In June 2019, less than 1% of the approximately 70,000 members identified as required to report qualifying activities (voluntary basis only) did so. While the low percentage of members reporting reflects the voluntary nature of reporting during the analysis period, it also highlights the reporting behavior change that will need to occur before the end of the calendar year for members to maintain their active HIP coverage status.
- The majority of members required to report qualifying activities (voluntary basis only) indicated employment as the qualifying activity (64.3%); the next highest qualifying activity categories were volunteer work (16.1%) and caregiving (15.6%).
- Members required to report qualifying activities disenrolled for similar reasons as members not required to report, most notably: increase in income above the qualifying threshold for HIP Plus (>138% FPL); failure to verify information; and failure to submit paperwork for redetermination.
- Feedback from members, providers, State officials, and MCE executives indicates that many HIP members have some level of understanding of the Gateway to Work program, their reporting status, and the consequences of not reporting. This understanding has been built through various layered communication methods and a variety of initiatives employed by the State, the MCEs, and providers. However, a portion of members still do not know their community engagement requirements, do not know how to report, or do not know the consequences of not reporting qualifying activities.
- Barriers to complying with reporting requirements noted in key informant interviews included time and paperwork, adequate and accurate member contact information, location of members in rural areas, access to the internet, and the scope of the "good cause" exemption.
- MCE executives and State officials reported working closely on a variety of initiatives to reduce member reporting burden. The State also expanded the ways in which members can report their hours and made reporting timeframes more flexible.

Lewin recommends the following key area of focus for the State's consideration in relation to **Goal 2**:

- The State should increase efforts to obtain updated member contact information (as described above) so that communications regarding how to report community engagement activities can reach all members that are required to report;
- The State should continue its focus on ongoing, tailored communications for individuals required to report qualifying activities, and work closely with MCEs to ensure similar tailored communications. These communications should emphasize the variety of ways that members can report their hours (e.g., online, calling the MCEs, in-person);
- MCEs should increase efforts to partner with community-based organizations to reach members required to report; and
- The State should consider using the "good cause exemption" category to provide exemptions for members that have encountered barriers to reporting (for example, lack of a reliable street address or email).

Goal 3 – Discourage tobacco use among HIP members through a premium surcharge and the utilization of tobacco cessation benefits.

While the analyses for the evaluation of **Goal 3** will not occur until the Summative Evaluation Report, this Interim Evaluation Report provides baseline analyses of member tobacco use (based on a subset of new enrollees) and member tobacco cessation use. The Summative Evaluation Report will include additional analyses to understand the impact of this policy.

Qualitative and quantitative analyses performed for the Interim Evaluation Report (described in **Section F: Results by Demonstration Goal**) provide the following context on the tobacco surcharge:

- MCEs face significant limitations in collecting information about member tobacco use over time. While MCE health needs assessments include questions about tobacco use, the MCEs do not use these responses to determine the tobacco surcharge due to concerns about members underreporting tobacco use during an assessment performed for clinical purposes. The subgroup of members that MCEs evaluated for continued tobacco use included those that voluntarily contacted their MCE to report their tobacco use status after one year, or were continuously enrolled with the same MCE. If members changed MCEs during the annual enrollment, the MCEs did not use member tobacco usage reported from the first MCE for purposes of surcharge determination. If a member switched MCEs or disenrolled from HIP, the period for the tobacco surcharge reset.
- Approximately 29% to 31% of new HIP members or members reporting during the MCE selection period use tobacco.[111] This is somewhat lower than low income/Medicaid estimates for Indiana from other sources which range from 35% to 37%.[112,113] These new applications represent approximately 10% to 15% of the overall HIP population but do not represent all HIP members. Compared to members in metro areas, non-metro and rural members had the highest prevalence, ranging from 36.3% to 46.1%.
- MCEs reported applying the tobacco surcharge to 2,662 members in 2019, representing less than 1% of the 569,971 HIP members in 2018.
- From 2015 to 2018, 5.8% to 8.7% of HIP members utilized a tobacco cessation service annually (based on encounter data).[114]
- Among members using tobacco cessation in 2018, most (88.5%) chose medications; of those approximately 50% of members used bupropion and 31.6% used a nicotine replacement.
- Cessation services were most common among members 51 years of age or older, females, non-Hispanic Whites, and rural residents.

[111] Analysis is based on data collected by the State from new HIP applications beginning in 2017 (new enrollees or enrollees switching MCEs) and other self-reported member tobacco use collected during enrollment.

[112] Ku, L., Bruen, B., Steinmetz, E., & Bysshe, T. (2016). Medicaid Tobacco Cessation: Big Gaps Remain In Efforts To Get Smokers To Quit. Health Affairs. Retrieved from https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2015.0756#EX4FN1

[113] UnitedHealth Foundation. (2019). America's Health Rankings Annual Report. Retrieved from https://www.americashealthrankings.org/explore/annual/measure/Smoking/state/IN

[114] Enrollment status values of Regular Basic (RB), Regular Plus (RP), State Basic (SB), State Plus (SP), pregnant (MA), and HIP Plus Copay (PC). Months when an individual has conditional eligibility were not included.

- Results from the member interviews suggest that HIP members generally know about HIP policies, including the tobacco surcharge and available cessation services. MCE executives indicated that they had provided members, in particular those identified as tobacco users and/or being assessed the surcharge, with multiple communications regarding the tobacco surcharge and the availability of tobacco cessation services.
- Results from the member interviews suggest that individuals know about available cessation services (counseling and medication), although few reported actually using services.
- Results from member and provider interviews suggest that some members would like to access tobacco cessation services not currently covered, specifically group therapy services and a new type of nicotine patch.
- MCE executives reported receiving few complaints or disputes related to the new tobacco surcharge. The number of members reporting the use of tobacco cessation services in the member interviews did not allow us to report on overall satisfaction with these services.

Lewin recommends the following key areas of focus for FSSA's consideration in relation to **Goal 3**:

- The State should re-evaluate the process used by the MCEs to identify to which members the surcharge applies. MCEs currently base their surcharge decision primarily on self-reported tobacco use that is not tracked consistently for all members;
- Consider a regular review of HIP-covered tobacco cessation services to identify if additional services should be covered, such as group therapy services and newer nicotine patches; and
- Consider targeted outreach to HIP members in rural and non-metro areas given the relatively higher prevalence of tobacco use for these members.

Goal 4 – Promote member understanding and increase compliance with payment requirements by changing the monthly POWER Account payment requirement to a tiered structure.

The State's transition from a percent of income POWER Account Contribution structure to a simplified tiered structure in 2018 intended to reduce administrative burden, support initial and sustained enrollment in HIP, and reduce disenrollments due to members misunderstanding their POWER Account Contribution payment amounts. As the related analyses reflect only 12 months of experience after implementation of the simplified payment tiers, the results presented here reflect Lewin's initial observations. The Summative Evaluation Report will incorporate two additional years of enrollment data and reflect additional key informant interviews and member surveys. Our initial observations include:[115]

- Feedback from MCE and State officials indicates that the transition of the monthly POWER Account payment to a tiered structure has supported sustained member enrollment and reduced MCE administrative burden. Regardless, some members interviewed did not understand the POWER Account Contribution policies. Providers reported affordability of the actual payment amount as less of a challenge for HIP members than knowing the payment amount and when to make those payments.

[115] Section F provides a detailed description of the HIP members included in the Goal 4 analyses; the identification of these members is different than those identified for Goal 1 and 2 analyses.

- HIP Plus enrollment increased and the rate of disenrollment decreased with non-payment as a reason from 2017 to 2018. This might indicate potential member interest in HIP Plus coverage and improved member understanding of POWER Account Contribution payments. However, given that the State implemented the new POWER Account payment tiers in 2018 and HIP Plus disenrollment due to non-payment declined prior to 2018, any impact of the change in payment tiers on disenrollment requires additional analysis over time.
- In 2017 and 2018, fewer new HIP Plus members enrolled (both in terms of absolute numbers and the proportion) compared to 2016, even as the total number of HIP Plus members increased between 2015 and 2018.
- The proportion of HIP Plus members having continuous HIP Plus coverage upon enrolling in the benefit plan decreased from 2015 to 2018.
- Although the program experienced an increase in the HIP Plus member population, the proportion of members having at least one disenrollment in a calendar year also increased. The proportion of HIP Plus members having non-payment as reason for disenrollment has been low with a slight declining trend from 2017 to 2018. Administrative reasons and increased income represent the two primary reasons for member disenrollment. Black HIP Plus members had a higher likelihood of disenrolling due to non-payment or other reasons compared to non-Hispanic White members. HIP Plus members age 30 and older disenrolled due to non-payment less frequently than members younger than age 30.
- The proportion of HIP Plus members moving from HIP Plus to HIP Basic in a year has been variable between 5.9% and 7.9% from 2015 to 2018. In 2018, 25,157 members moved from HIP Plus to HIP Basic representing approximately 6.4% of the 393,059 HIP Plus individuals.[116]
- Controlling for various sociodemographic characteristics, Black HIP Plus members had a higher likelihood of moving to HIP Basic compared to non-Hispanic White HIP Plus members (OR=1.6). Members 40 years of age or older had a lower likelihood of moving from HIP Plus to HIP Basic as compared to members 19 to 29 years of age (OR=0.8 for members age 40 to 49, 0.5 for members ages 50 to 59, 0.3 for members ages 60 to 66). Members having a medically frail indicator had a slightly higher likelihood of moving to HIP Basic from HIP Plus than members without a frail indicator (OR=1.2).
- The number of HIP Basic members moving to HIP Plus has increased across time. In 2018, 47,717 members moved from HIP Basic to HIP Plus representing 21% of HIP Basic members. Female members had a higher likelihood of moving to HIP Plus than male members; members over age 50 had a higher likelihood than members 19 to 29 years of age.
- Approximately 42% of HIP Plus members in 2018 received rollover benefits; approximately 63% (104,083) had coverage between 10 and 12 months. Members receiving rollover benefits had a higher disenrollment rate (36.2%) than members identified as not having earned rollover (28.8%). The primary reasons for disenrollment were increased income and other administrative reasons.

[116] By HIP policy HIP Plus members with income at or less than 100% FPL may move to the HIP Basic plan upon non-payment of POWER Account Contribution (as discussed earlier in Goal 4). These members are sometimes referred to as "eligible to move to Basic." As discussed earlier in this section, we have included all HIP Plus members instead of limiting the analysis to members having income at or less than 100% FPL.

As discussed earlier in this section, we recommend the State consider focusing on enhancing existing efforts to carefully test and further streamline communications to support member understanding of POWER Account Contribution policies.

Lewin recommends the following key areas of focus for the State to consider related to **Goal 4**:

- Focus on improving member contact information and supporting additional communications to members, as described earlier in this subsection.
- Investigate underlying causes of the increased disenrollment rate and movement from HIP Plus to HIP Basic for Black HIP members; consider a targeted and culturally appropriate communication strategy to more fully engage all subpopulations and providers.

Goal 5 – Ensure HIP program policies align with commercial policies, are understood by members, and promote positive member experience and minimize gaps in coverage.

Similar to most commercial insurance plans, the HIP structure follows a cost-sharing model with deductibles, copayments, and monthly contributions or premiums. The State and MCEs work together in distinct capacities to convey information to members. The two major themes that emerged from the key informant interviews were the importance of communication and customer service support. The State and MCEs use a layered communication strategy (e.g., text message, email, mail, social media) to maximize member understanding and satisfaction. For the Interim Evaluation Report, analysis included program administrative data and key informant interviews. The Summative Evaluation Report will reflect additional key informant interviews, a member survey, and analysis of ACS data.

The results of our member key informant interviews provided the following key observations:

- The majority of members interviewed reported satisfaction with the program, citing the following as top reasons: affordability, enrollment processes (including Fast Track and presumptive eligibility), and online capabilities for POWER Account Contribution payments and reporting of qualifying activities. Most certified navigators interviewed highlighted the "very effective" enrollment process.
- Reasons for dissatisfaction reported by members and providers included: loss of coverage from HIP as a result of non-payment, documentation and time required for enrollment, confusing language in outreach materials, timeliness of communications, lack of coverage for some services or medications, poor provider selection in some areas of the State, lack of adequate transportation resources, problems related to switching MCEs, and the misplacement of paperwork between members and the State.
- Members' knowledge differed on various HIP policies. Notably, several members reported not understanding the POWER Account and rollover, and MCE executives and providers cited the length and complexity of processes, such as POWER Account reconciliation, as a source of confusion to members. Some members indicated a limited understanding of the lockout period for non-payment of the POWER Account Contributions.
- Common barriers to compliance with POWER Account Contributions include navigating the online payment system, inaccurate statements, and the financial burden of the payment amount. Some interviewees noted the variety of avenues to make a payment (e.g., phone, in-person, online) as supporting compliance.

Lewin identified the key areas of focus for the State to consider related to **Goal 5** at the beginning of this section regarding strengthening communications to members to explain the HIP program, most notably POWER Account Contributions and community engagement reporting requirements.

Goal 6 – Assess the costs to implement and operate HIP and other non-cost outcomes of the demonstration.

The Summative Evaluation will address this goal.

H. Interpretations, Policy Implications, and Interactions with Other State Initiatives

Indiana's 2018 waiver renewal allowed Indiana to continue offering individuals up to 138% of the FPL coverage through the HIP Plus and HIP Basic benefit plans, in effect since 2015. The new policies implemented under HIP – tobacco surcharge, community engagement reporting requirements (via the Gateway to Work Program), and simplified POWER Account tiers – aimed to increase member engagement in community activities and in their health. The POWER Account Contributions, differences between HIP Plus and Basic benefit plans (benefits and costs), and tobacco surcharge seek to help members prepare for commercial coverage; individuals participating in the commercial market must typically pay monthly premium amounts and copayments, make decisions between benefit packages based on costs and covered benefits, and may be assessed a tobacco surcharge.

Our analyses identified effective communication and ongoing feedback loops to ensure member understanding of key policies as critical (particularly related to POWER Account Contributions, community engagement reporting requirements, and the potential "lock out" from HIP coverage for non-payment for HIP members over 100% of the FPL). We will further explore these issues as part of the Summative Evaluation Report.

For Indiana and for states considering similar policies, adopting a multifaceted program like HIP requires a significant commitment to member understanding of monthly payment requirements and community engagement reporting requirements. This must occur throughout the member's enrollment in HIP since policy adjustments or changes occur over time. Additionally, members transitioning out of a program like HIP—most notably due to non-payment of POWER Account Contributions, increased income, or, in the future, not meeting community engagement reporting requirements—require a different set of supports.

Indiana introduced two initiatives, one in 2019 to support individuals transitioning from HIP—the HIP Workforce Bridge—and one in 2017 to help individuals in Indiana access trainings and connect residents with jobs—Workforce Training Initiative (**Section B: Summary of HIP Demonstration**). The State is testing whether the use of the community engagement reporting requirements will support higher rates of employment among HIP members during the 2018 waiver renewal (February 2018 to December 2020). Indiana's Workforce Training Initiative, Next Level Jobs, focuses on connecting Indiana residents with jobs. The program provides free trainings to individuals and reimbursements for Indiana employers when they train employees in high-demand fields. Next Level Jobs can support members in achieving compliance with their Gateway to Work requirements. As members gain employment, their eligibility in HIP may change; members who earn income over the HIP income limit may lose their HIP coverage and potentially transition to commercial coverage. The HIP Workforce Bridge account seeks to alleviate the potential gap in coverage between the time members leave HIP and transition to their commercial plan.

State officials interviewed for this evaluation indicated that they would expect that HIP's Gateway to Work program, Next Level Jobs, and the pending HIP Workforce Bridge program will work in concert to strengthen workforce participation throughout Indiana. HIP members can leverage participation in Next Level Jobs trainings to satisfy HIP community engagement reporting requirements, and the HIP Workforce Bridge will help individuals make the transition from HIP to commercial coverage when appropriate. Moving forward, we will focus on the combination of these initiatives to effectively support HIP members that transition due to increased income from participating in the Gateway to Work program. The Summative Evaluation Report will provide findings that reflect the full implementation of the changes under the demonstration and implications of findings at both the state and national levels.

I. Lessons Learned and Recommendations

This section describes initial lessons learned and recommendations from the first year of the three-year HIP waiver renewal for other states considering similar approaches. We will identify additional lessons learned and recommendations for the remaining two years of the HIP waiver renewal in the Summative Evaluation Report. **Exhibit I.1** summarizes each lesson learned from the first year of the HIP waiver renewal and the related recommendation(s) for other states considering a similar approach.

Exhibit I.1: Lessons Learned from HIP and Recommendations for Other States

Lessons Learned from HIP	Recommendations for Other States Considering a Similar Approach
Effective member communication remains key to implementing Medicaid programs with similar complexities to HIP. The State focuses on developing clear messaging for HIP policies, such as investing in a dedicated State communications team and outside marketing firm. The State also works closely with MCEs to review all materials and ensure consistent messaging. However, given the complexities of the policies and some of the feedback received during key informant interviews regarding POWER Accounts, Gateway to Work, and tobacco surcharge policies, communications must remain a continued area of focus.	• Maintain a dedicated communications team and consider using an outside marketing firm to perform targeted analyses to improve messaging • Continually develop and refine materials based on an interactive feedback loop including, for example, member surveys and provider focus groups • Identify opportunities to simplify and standardize the eligibility process
Closely collaborating with MCEs responsible for implementing key policies reduces the "disconnect" between what members may hear from the State versus their health plans. Indiana contracts with four MCEs to implement and provide HIP services. The State has outlined clear responsibilities for the MCEs related to member communications and administrative tasks for policies, such as POWER Account Contributions, Gateway to Work reporting, and the tobacco surcharge. Clearly defined roles for the State and MCE have been critical to the implementation of HIP in Indiana. It has also been important that the State and MCEs meet regularly to discuss successes and challenges.	For states working with MCEs or health plans to implement unique demonstrations (e.g., community engagement): • Carefully define MCE/health plan roles • Meet regularly with the MCEs/health plans • Spend time and resources on MCE/health plan and state staff training
Implementing a phase-in period for mandatory community engagement policies helps support members and MCEs. HIP 2.0 members had the opportunity to participate in Gateway to Work and current HIP members have a phase-in period with hours increasing from 0 to 20 hours per week over 18 months. This phase-in period gives members time to adjust to new policies and allows MCEs to develop supports. Members joining HIP after July 1, 2019, will not have the opportunity to participate in the voluntary phase-in period, but will still benefit from the gradual increase of 5 to 20 hours per week over 12 months. Members joining HIP after July 1, 2020 required to report will not benefit from any phase-in period and will need to report the full 20 hours per week to comply with requirements.	• Consider phase-in period for new and complex policies and tailor communications to the specific stage of the phase-in • Use the phase-in period to address identified administrative and other barriers to reporting community engagement activities and determining exempt status • Continue to revisit barriers to reporting after the phase-in period

Lessons Learned from HIP	Recommendations for Other States Considering a Similar Approach
Effective member communications requires maintaining updated member contact information. Feedback from State officials and MCE executives indicate that State and MCE communications regarding HIP do not always reach members due to difficulties in maintaining current member contact information. These gaps in communication can contribute to a lack of understanding of key policies.	• Carefully review processes and strategies for updating member contact information • Use a layered approach for outreach to minimize gaps in communication due to outdated or inaccurate contact information (e.g., social media, email, text message, phone, mail, state, MCE, or community partner websites)
Collaboration across stakeholders (e.g., FSSA staff, MCEs, providers, and certified navigators) supports program implementation. The ongoing collaboration across stakeholders has evolved as HIP evolved. The State and MCEs meet regularly to discuss HIP implementation. The State and MCEs also engage members through advisory boards, focus groups, and surveys to gather input and feedback on the program design. These processes allow members to have a voice in the services important to them.	• Provide opportunities to gather feedback from members and other stakeholders • Set up regular meetings between the state and MCEs (or other health plan) • Streamline and refine reporting processes for community engagement hours based on member feedback • Review covered services on a regular basis, particularly if there are differences in covered services between benefit plans • Alleviate administrative burden and time lag for account reconciliation
Understanding the member population in-depth and having a continual feedback loop contributes to developing appropriate exemptions from mandatory community engagement reporting policies. Indiana gathers feedback from stakeholders and allows members to submit exemption requests. While reviewing these exemptions, the State identified additional populations to include for good cause exemptions and proposed increasing the caregiver exemption age from seven years old to 12 years old.	• Regularly review and update exempt populations • Provide a clear process for members to request exemptions and for the state to review and approve/deny requests
Simplifying payment tiers for POWER Accounts eased administrative burden. The State and MCEs reported the simplified payment tiers helped with administrative processes and member understanding.	• Simplify eligibility categories and tiered payment categories • Use a phase-in period for complex policies to support member and stakeholder understanding

In the Summative Evaluation Report, we will identify and refine the lessons learned and recommendations for other states based on all three years of the HIP renewal period.

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Healthy Indiana Plan Interim Evaluation Report – Section J. Attachments

Prepared for: Indiana Family and Social Services Administration

Submitted by: The Lewin Group, Inc.

December 18, 2019

Final for CMS Review

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J. Attachments

Attachment I: Evaluation Plan

Healthy Indiana Plan Evaluation Plan

Addresses All Feedback Received from CMS as of December 18, 2019

HEALTH CARE AND HUMAN SERVICES POLICY, RESEARCH, AND ANALYTICS—WITH REAL-WORLD PERSPECTIVE.

Prepared for: Indiana Family and Social Services Administration

Submitted by: The Lewin Group, Inc.

December 18, 2019

Healthy Indiana Plan
Evaluation Plan

Prepared for: Indiana Family and Social Services Administration

Submitted by: The Lewin Group, Inc.

Addresses All Feedback Received from CMS as of December 18, 2019

Note: This Evaluation Plan does not include adjustments to reflect the State's decision to temporarily remove the suspension of enrollment for HIP members that do not comply with community engagement reporting requirements (effective October 31, 2019), pending the results of the federal lawsuit.

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A. General Background Information

The Centers for Medicare & Medicaid Services (CMS) renewed the Indiana Family and Social Services Administration's (FSSA) Healthy Indiana Plan (HIP) Section 1115(a) demonstration waiver for three years from February 1, 2018 through December 31, 2020. First passed by the Indiana General Assembly in 2007, and implemented in 2008, HIP represents the nation's first consumer-driven health plan for Medicaid beneficiaries, and in 2015, became an alternative to traditional Medicaid expansion under the Patient Protection and Affordable Care Act.

Through the Section 1115(a) demonstrations and waiver authorities in the Social Security Act, states can test and evaluate innovative solutions to improve quality, accessibility, and health outcomes in a budget-neutral manner. Indiana's approved 1115 waiver Specific Terms and Conditions (STCs) to implement HIP require an evaluation of this program's ability to meet its intended goals. This Evaluation Plan will guide the federally-required independent evaluation of this program, and is organized as follows:

- Section A: General Background Information
- Section B: Evaluation Questions and Hypotheses
- Section C: Methodology
- Section D: Methodological Limitations
- Section E: Attachments
    - Attachment E.1: Summary of Independent Evaluator Approach
    - Attachment E.2: Evaluation Budget
    - Attachment E.3: Timeline and Major Milestones
    - Attachment E.4: Variable Descriptions for Federal Survey Data to be Used in this Evaluation
- Section F: Analytic Plans by Goal

In addition to the demonstration's STCs, this Evaluation Plan reflects, as feasible and appropriate, CMS Evaluation Plan feedback received in February 2019, the CMS evaluation guidance released in March 2019,[1] CMS Evaluation Plan feedback received in June 2019, and additional feedback received during calls with CMS and the State. With regard to CMS' evaluation guidance, this plan addresses the general guidance, the appendix on community engagement, and the appendix on sustainability. Due to state-specific requirements outlined in the STCs, this plan addresses the appendices on non-eligibility periods, premiums or account payments, and retroactivity as feasible and appropriate in the context of the demonstration.

[1] CMS. 1115 Demonstration State Monitoring & Evaluation Resources. Released and Accessed March 13, 2019 at https://www.medicaid.gov/medicaid/section-1115-demo/evaluation-reports/evaluation-designs-and-reports/index.html

1. Demonstration Goals

Building on the successes and lessons learned from Original HIP implemented in 2008 and HIP 2.0 implemented in 2015, the State used the 2018 HIP waiver renewal to test new approaches and flexibilities in Indiana's Medicaid program to provide incentives for members to take personal responsibility for their health. Over the current demonstration period (February 2018 through December 2020), the State seeks to achieve several demonstration goals (**Exhibit A.1**). These goals inform the State's evaluation of the HIP program, and include, but are not limited to, the following:

1. Improve health care access, appropriate utilization, and health outcomes among HIP members.
2. Increase community engagement leading to sustainable employment and improved health outcomes among HIP members.
3. Discourage tobacco use among HIP members through a premium surcharge and the utilization of tobacco cessation benefits.
4. Promote member understanding and increase compliance with payment requirements by changing the monthly POWER Account payment requirement to a tiered structure.
5. Ensure HIP program policies align with commercial policies, encourage members understanding, and promote positive member experience and minimize gaps in coverage.
6. Assess the costs to implement and operate HIP and other non-cost outcomes for the demonstration.

Exhibit A.1: Indiana 1115(a) Demonstration

Name of Demonstration:
Healthy Indiana Plan

Approval Date of Demonstration:
February 1, 2018

Demonstration Renewal Period: February 1, 2018 - December 31, 2020

The above goals address key objectives of Section 1115(a) demonstrations, including improving access to high-quality services that produce positive health outcomes for individuals; strengthening beneficiary engagement in their personal health care plan, including incentive structures that promote responsible decision-making; and enhancing alignment between Medicaid policies and commercial health insurance products to facilitate smoother beneficiary transition.[2]

[2] CMS. About Section 1115 Demonstration Waivers. Accessed March 29, 2018 at https://www.medicaid.gov/medicaid/section-1115-demo/about-1115/index.html

2. Description of the Demonstration and Implementation Plan

First passed by the Indiana General Assembly in 2007, HIP provides Medicaid health-insurance coverage for qualified low-income, non-disabled adults ages 19 to 64. HIP offers its members a high deductible health plan paired with a Personal Wellness and Responsibility (POWER) Account, which operates similarly to a health savings account.

The current HIP 1115 waiver renewal, approved in February 2018, continues most components of HIP 2.0 (**Exhibit A.2**) and adds some new provisions. Changes for HIP, summarized from the State's amended waiver application, include:[3]

- Adding a tobacco use surcharge by increasing users' POWER Account Contributions by 50% beginning in their second year of continuous enrollment
- Expanding the Gateway to Work program by adding a community engagement reporting requirement for non-disabled working-age members beginning in 2019
- Changing Personal Wellness and Responsibility (POWER) Account Contributions to a tiered structure instead of a flat 2% of income
- Adding a new HIP Plus chiropractic benefit
- Facilitating enrollment in HIP Maternity (MA) coverage for pregnant women
- Enhancing the managed care entity (MCE) member incentive program by increasing available healthy incentives to a maximum of $200 per initiative
- Reestablishing an open enrollment period
- Waiving the "institution for mental disease" payment exclusion for short-term substance use disorder (SUD) treatment services for all Medicaid adults ages 21 to 64 (Note: this provision will be the subject of a separate evaluation)
- Discontinuing the graduated copayments for non-emergency use of the emergency department (ED) and the HIP Link premium assistance program for those with employer-sponsored insurance

Exhibit A.2: Program History

2007: HIP passed in the Indiana General Assembly.
2008: With CMS approval, HIP began enrolling working-age, uninsured adults in coverage.
2011: State legislature passed Senate Enrolled Act 461 that called on HIP to be the program used for the eventual expansion of Medicaid through the Patient Protection and Affordable Care Act.
2014: State requested permission from CMS to expand its existing demonstration waiver via HIP 2.0.
2015: CMS approved HIP 2.0, which included Indiana's Medicaid expansion, through a three-year waiver renewal expiring January 2018.
2017: State requested permission from CMS to expand its existing demonstration waiver via HIP.
2018: CMS approved the current HIP through a three-year waiver renewal expiring December 2020.

[3] Indiana Family and Social Services Administration. (2018). HIP Waiver Application. Retrieved from https://www.in.gov/fssa/hip/files/IN-HIP-1115-Approval-Package_2-1-2018.pdf

Healthy Indiana Plan

In 2015, HIP's target population changed to all non-disabled, low-income adults between 19 and 64 years old with household income at or below 138% of the FPL. HIP covers the adult group, low-income parents and caretakers, Transitional Medical Assistance (TMA), and pregnant women. HIP offers distinct benefit packages to its eligible members: HIP Plus, HIP Basic, HIP State Plan Plus, HIP State Plan Basic, HIP Maternity, and HIP Plus Copay. The State uses a managed care delivery system for HIP. Four MCEs, contracted under HIP at the time of this Evaluation Plan, provide health care coverage to HIP members.

HIP Benefit Plans

Indiana's current section 1115(a) demonstration provides authority for the State to continue to offer HIP with different benefit plans—HIP Plus and HIP Basic:

- **HIP Plus:** HIP members with income at or below 138% of the federal poverty level (FPL) who make required POWER Account Contributions maintain access to HIP Plus, an enhanced benefit plan, which includes additional health care benefits such as coverage for dental, vision, and chiropractic services.[4] HIP Plus members pay a monthly POWER Account Contribution based on income tiers but do not pay copayments for health care services.
- **HIP Basic:** HIP members with income at or below 100% of the FPL who do not make monthly POWER Account Contributions for HIP Plus coverage enroll in HIP Basic. This benefit plan provides more limited coverage than HIP Plus (i.e., not covering vision or dental services) and includes copayments for doctor visits, hospitals stays, non-emergency ED visits, and prescriptions.[5] These payments are consistent with traditional Medicaid copayments, and can range from $4 to $8 per doctor visit or prescription filled and can be as high as $75 per hospital stay. Pregnant members have no cost sharing and there is a 5% of income quarterly cost sharing limit for all members. HIP Basic members can enroll in HIP Plus during their annual redetermination if they choose to begin paying their POWER Account Contribution.
- **HIP State Plan Plus:** Members have the same cost-sharing requirements as HIP Plus and do not pay copayments for services. State Plan Plus members, similarly to regular HIP Plus members, make POWER Account Contributions. Enrollment in this plan provides certain members[6] with access to the Medicaid State Plan benefits in place of the approved Alternative Benefit Plan.
- **HIP State Plan Basic:** Members have the same cost-sharing requirements and copayments for services as HIP Basic. Enrollment in this plan provides certain members[7] with access to the Medicaid State Plan benefits in place of the approved Alternative Benefit Plan.

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4 On June 10, 2015, the State submitted an approved copy of the Alternative Benefit Package (ABP) for HIP Plus as a State Plan Amendment to the Centers for Medicare and Medicaid Services. These benefits for the ABP were aligned using Essential Health Benefits. Indiana Family and Social Services Administration. (2014). Alternative Benefit Plan: Healthy Indiana Plan (HIP) 2.0 Plus. Retrieved from https://www.in.gov/fssa/hip/files/DraftPlusABP.pdf

5 On June 10, 2015, the State submitted an approved copy of the Alternative Benefit Package (ABP) for HIP Basic as a State Plan Amendment to the Centers for Medicare and Medicaid Services. These benefits for the ABP were aligned using Essential Health Benefits. Indiana Family and Social Services Administration. (2014). Alternative Benefit Plan: Healthy Indiana Plan (HIP) 2.0 Basic. Retrieved from https://www.in.gov/fssa/hip/files/DraftBasicABP.pdf

6 Medically frail, TMA participants, Section 1931 low-income (< 19% of the FPL) parents and caretakers, and low-income (< 19% of the FPL) 19 – 20 year olds.

7 Medically frail, TMA participants, Section 1931 low-income (< 19% of the FPL) parents and caretakers, and low-income (< 19% of the FPL) 19 – 20 year olds.

- **HIP Maternity:** HIP members who become pregnant while enrolled in a HIP plan transition to HIP Maternity (MA). HIP Maternity covers HIP members throughout their pregnancy and 60 days postpartum. HIP Maternity enrollees do not have cost-sharing requirements and have access to the Medicaid State Plan benefits.
- **HIP Plus Copay:** HIP members above 100% of the FPL identified as medically frail[8] by the State or an MCE and have not been able to meet their HIP Plus POWER Account Contribution obligations. These members have copayments assigned to them, consistent with the HIP Basic Plan and have access to HIP Plus benefits.

Members can switch between benefit plans as policies allow. Adults that meet all the eligibility requirements for HIP, but who are not a U.S. citizen and not a lawful permanent resident in the U.S. for at least five years or are not qualified aliens, are entitled to "emergency services only" under HIP. Lewin did not include this enrollment category in this evaluation due to the limited nature of covered services.

Eligibility Determination Process

Individuals apply for HIP services through the Division of Family Resources, which determines eligibility for Indiana Health Coverage Programs. Members can also complete a presumptive eligibility application with qualified providers to receive temporary health coverage.

To start coverage, HIP members must wait 60 days or make an initial Fast Track payment to their POWER Account. Individuals with income greater than 100% FPL must make a payment within 60 days to obtain coverage. New HIP members in the waiting period who have not made a Fast Track payment are determined conditionally eligible by the Division of Family Resources. Conditionally eligible members do not receive full eligibility and cannot enroll as members until one of the following occurs within the 60-day payment period:

- Enrollee makes a payment of their first POWER Account Contribution for HIP Plus
- Enrollee makes a Fast Track $10 prepayment for HIP Plus
- Enrollee at or below 100% of the FPL does not make a first payment before the 60-day payment period expires and, therefore, enrolls in HIP Basic

Members have the opportunity to select an MCE on their application. However, if an individual determined to be conditionally eligible for HIP by the Division of Family Resources does not select an MCE, the State auto-assigns the member to an MCE. Member eligibility is effective the first day of the month; coverage end dates fall on the last day of a month unless a member dies.

Presumptive Eligibility

With HIP 2.0, the State introduced a Fast Track prepayment option for POWER Account Contributions and enhancements to the presumptive eligibility (PE) process. The PE process allows qualified providers to determine eligibility for certain groups to receive temporary health coverage under the Indiana Health Coverage Programs, which includes HIP. As of April 1, 2015, the State expanded qualified PE providers to

[8] Medically frail refers to a federally required designation of members who have disabling mental disorders, including serious mental illness; chronic substance use disorders; serious or complex medical conditions; physical, intellectual or developmental disabilities that significantly impair the ability to perform one or more activities of daily living; or a disability determination based on Social Security Administration criteria. These members have a medically frail flag of Y in the monthly enrollment data.

include Federally Qualified Health Centers (FQHCs), Rural Health Centers (RHCs), Community Mental Health Centers, and local County Health Departments. Qualified providers work with individuals to complete a PE application. Using an online system and member self-reported responses, qualified providers receive real-time PE determinations for individuals seeking health care services. An individual can receive presumptive eligibility coverage only once during a 12-month rolling period, and only once per pregnancy.[9]

Individuals determined presumptively eligible can receive temporary coverage and receive services immediately until the end of the following month. Members must complete the full application by the last day of the next month to maintain PE coverage. Before January 1, 2019, members determined presumptively eligible received coverage under the managed care delivery system. State applicants determined presumptively eligible for the adult category (PE Adult) before 2019 enrolled with a MCE and received coverage similar to HIP Basic with copayment obligations. As of January 1, 2019, applicants determined presumptively eligible receive coverage under a fee-for-service delivery system.[10]

Starting in 2018, PE members determined to be conditionally eligible for HIP move directly to HIP Basic with an opportunity to pay for HIP Plus. The State refers to this population as "Potential Plus." This extension allows members to avoid a gap in coverage as long as they meet the required application and payment deadlines. Applicants have 60 days to pay any required POWER Account Contribution to be eligible for HIP Plus.[11]

Fast Track

The Fast Track option expedites HIP enrollment by allowing applicants to make a prepayment of $10 towards their POWER Account Contribution. Using Fast Track, applicants can pay a POWER Account Contribution at the time of application or any time before the State's eligibility determination. Once the State determines an applicant eligible for Medicaid, the individual's Medicaid eligibility dates back to the first day of the month in which the member made the Fast Track payment. Individuals approved for HIP with income less than 100% of the FPL who do not make a POWER Account Contribution within the 60 days enroll in HIP Basic. Individuals with income over 100% of the FPL who do not make a POWER Account payment or Fast Track pre-payment in the required 60-day period do not receive coverage and must reapply.[12]

POWER Accounts

To help members prepare for participation in the commercial marketplace, the State offers all HIP members a POWER Account, similar to a health savings account. POWER Accounts provide incentives for members to stay healthy, be value and cost conscious, and use services in a cost-efficient manner. HIP Plus, HIP Basic, or HIP State Plan members use their POWER Accounts to pay for covered services up to their $2,500 deductible. MCEs establish and administer each member's POWER Account and pay the claims for all covered services when a member exhausts their POWER Account.

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9 Indiana Health Coverage Programs. (2019). Presumptive Eligibility Provider Reference Model. Retrieved from https://www.in.gov/medicaid/files/presumptive%20eligibility.pdf

10 Ibid.

11 Ibid.

12 Indiana Family & Social Services Administration. (2019). MCE Reporting Manual HIP 2.0, Office of Medicaid Policy and Planning Version 4.0.

POWER Account Contributions

While all members have a POWER Account, HIP Plus members have a POWER Account Contribution. The State funds POWER Accounts up to a ceiling of $2,500 per year, contributing an amount annually for each member that is equal to the difference between the required member contribution and the $2,500 ceiling. For HIP Plus members, this monthly amount represents a combination of member, employer or not-for-profit, and State contributions. Members may also apply earned MCE incentives as offered by their plan. For HIP Basic members, the State fully funds the POWER Accounts and covers the member's $2,500 annual deductible. All HIP members pay $8 for a non-emergency ED visit.

MCEs bill for and collect HIP Plus POWER Account Contributions and send monthly statements to members. HIP Basic members also receive monthly account statements to assist them in managing the POWER Account and copayments and to increase awareness of the cost of the health care services received.

Determination of POWER Account Contribution Amounts

Effective with CMS' waiver approval in 2018, the State changed the determination of member POWER Account Contribution amounts from 2% of income to a tiered structure based on income level (**Exhibit A.3**). The previous monthly POWER Account Contribution amounts ranged from a maximum amount of $4.28 for members with incomes less than 22% of the FPL to a maximum amount of $27.17 for those at 100% of the FPL or higher. Fluctuations in a member's income required a recalculation of the member's 2% of income and changed the monthly amount due. This change could happen as frequently as every month for members with monthly income fluctuations. This ongoing variability of the POWER Account Contribution amounts created confusion among members regarding the amount owed and increased the overall administrative burden for the State and MCEs related to Power Account Contributions.

The new tiered monthly contribution amounts range from $1.00 for members with income less than 22% of the FPL to $20.00 for those at 100% of the FPL or higher. The State anticipates that moving to this simplified tiered structure will result in greater member understanding, increased member compliance with payments, and will minimize gaps in coverage.

The State calculates the household's POWER Account Contribution based on a tiered contribution structure for individuals. For two HIP-eligible married adults, the State divides the monthly contribution, and each member pays half of the calculated amount on a monthly basis. Married members with household income less than 22% both pay a $1 POWER Account Contribution. Other income tiers split the amount; for example, two married adults with household income of 51% to 75% FPL each pay $5.00. Beginning in January 2019, members may pay a 50% tobacco use surcharge in addition to the POWER Account tier amounts.

Exhibit A.3: Comparison of HIP Plus Previous and Current POWER Account Contribution Amounts for Single Members (2015 and 2018)

FPL	HIP 2.0 POWER Account Contribution (Previous)[a]		HIP POWER Account Contribution (Current)[b]		
	2015 Monthly Income, Single Individual	Maximum Monthly POWER Account Contribution, Single Individual	2018 Monthly Income, Single Individual	Monthly POWER Account Contribution, Single Individual	Tobacco Use Surcharge
<22%	**Less than $214**	$4.28	**Less than $222**	$1.00	$1.50
23-50%	**$214.01 to $487**	$9.74	**$222.01 to $505**	$5.00	$7.50
51-75%	**$487.01 to $730**	$14.60	**$505.01 to $758**	$10.00	$15.00
76-100%	**$730.01 to $973**	$19.46	**$758.01 to $1,011**	$15.00	$22.50
101-138%	**$973.01 to $1,358**	$27.17	**$1,011.01 to $1,396**	$20.00	$30.00

[a] FSSA. HIP 2.0 Introduction, Plan options, Cost sharing, and Benefits. Accessed May 6, 2019 at https://www.in.gov/idoi/files/HIP_2_0_Training_-_Introduction_Plans_Cost-Sharing_Benefits_-_1_21_15.pdf
[b] FSSA. POWER Accounts. Accessed May 6, 2019 at https://www.in.gov/fssa/hip/2590.htm
Note: For HIP 2.0, the monthly income amounts shown here reflect 2015 FPL and the monthly POWER Account Contribution amounts represent a percentage of income. For current HIP, the POWER Account Contribution amounts reflect the tiered contribution structure.

Loss of Coverage Due to Non-Payment of POWER Account Contributions

HIP Plus members with incomes from 101% to 138% of the FPL that do not make monthly POWER Account Contribution payments are disenrolled from HIP and are not allowed to re-enroll for six months (also referred to as the six-month lockout or non-eligibility period). The State exempts members determined medically frail from non-payment penalties regardless of income; these members do not lose benefits due to non-payment of POWER Account Contributions. The enrollment lockout period also does not apply for members residing in a domestic violence shelter or in a state-declared disaster area. Members subject to a lockout period can request a waiver to reenter the program.

Tobacco Cessation Initiative

As indicated previously, all HIP members must contribute to their POWER Account to maintain access to the enhanced HIP Plus benefit plan. To discourage tobacco use and to align with commercial market coverage policies, HIP includes a surcharge on top of the POWER Account Contribution for HIP Plus members who self-identify as tobacco users.[13] Tobacco use means the use of tobacco four or more times a week in the last six months, including use of chewing tobacco, cigarettes, electronic cigarettes (including vaping), cigars, pipes, hookah, and snuff. The HIP tobacco initiative began in January 2018, with surcharges taking effect in January 2019.

The State assesses a surcharge on top of the POWER Account Contribution for members who continuously enroll for 12 months with the same MCE and self-identify as tobacco users during this period. If the member continues to self-identify as using tobacco, the State increases their monthly contributions by 50% beginning in the first month of their new benefit period. For example, the POWER Account Contribution for an individual with income less than 22% of the FPL would increase from $1.00

[13] Members may self-identify as tobacco users during their initial application, during MCE selection, or when a member notifies their MCE.

to $1.50 per month with the application of the tobacco surcharge. For married HIP members, only the tobacco user receives the tobacco surcharge.

MCEs separate the surcharge on the monthly POWER Account statements to highlight the additional cost due to tobacco use for members. Some MCEs offer members MCE-specific incentives to participate in tobacco cessation services. Two of these tobacco cessation services include:

- **Indiana Tobacco Quitline:** Free phone-based counseling service administered by the State. Users can access services every day of the week in over 170 languages. The Quitline includes access to one-on-one coaching, resources for health care providers, and tools for other stakeholders to use for smoke-free and other smoking cessation programming.[14]
- **Baby and Me Tobacco Free:** Smoking cessation program for pregnant and postpartum women (up until 12 months postpartum). This program includes individualized education sessions, biochemical testing at visits, and several diaper vouchers.[15]

The State collects information on HIP member tobacco use during the HIP enrollment process (i.e., initial enrollment and when changing plans during open enrollment); members can also report changes in their tobacco use by calling their MCE or the State. While there are questions about tobacco use on the health needs assessment performed by the MCEs, these responses are not used to determine the tobacco surcharge due to concerns about members underreporting tobacco use during an assessment performed for clinical purposes. When a member changes MCEs during the MCE selection period or the middle of the year, the tobacco indicator passes to the new MCE. However, the surcharge is based on 12 months of full eligibility and tracking of tobacco use, so the new MCE will not know the member's previous tobacco use indicator or be expected to apply a surcharge.

Preventive Service Incentive and Rollover

The State provides all HIP members with incentives to receive preventive services and to manage their POWER Accounts via direct financial investment. Members have an opportunity to rollover any funds remaining in their POWER Account and apply the rollover as a credit toward their POWER Account Contribution in the next benefit period. For members that contribute to a POWER Account and use services, claims are paid from the account proportionally from State and member funds. If the member contributes $240 over the year out of the $2,500 limit, then 9.6% of every claim paid by the account is paid with member dollars; the rest is covered with State dollars. If the entire account is not spent, then the member's remaining dollars can be rolled over to the next year or refunded if the member leaves the program.

The amount rolled over or discounted depends on whether the member received preventive care services and what program the member enrolled in on the last day of the benefit period:

- If HIP Plus members have funds remaining at year-end and received preventive services, the State matches the members rollover amount and provides extra funds to their POWER Account. These funds further reduce the amount owed for the current benefit period, but only after members use rollover funds.

[14] Indiana.gov Quitline. (2019). Indiana's Tobacco Quitline. Retrieved from https://www.in.gov/quitline/

[15] Indiana State Department of Health: Maternal and Child Health Epidemiology Division. (2016). Infant Mortality: Year in Review. Retrieved from https://www.in.gov/fssa/files/Medicaid%20Advisory%20Board%208.16.pdf

- If HIP Basic members receive preventive services, they can offset the required contribution for HIP Plus by up to 50% the following year. However, members may not double their rollover as in HIP Plus. Members who choose to remain in HIP Basic will incur a penalty on any unused member rollover funds. HIP Basic members who do not receive preventive services will not earn the rollover discount. Members who choose to remain in HIP Basic will incur a penalty on any unused member rollover funds.

Exhibits A.4 and A.5 illustrate the rollover for HIP Plus and HIP Basic.

Exhibit A.4: HIP Rollover for HIP Plus Members

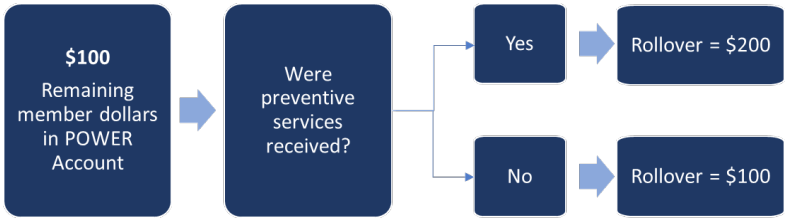
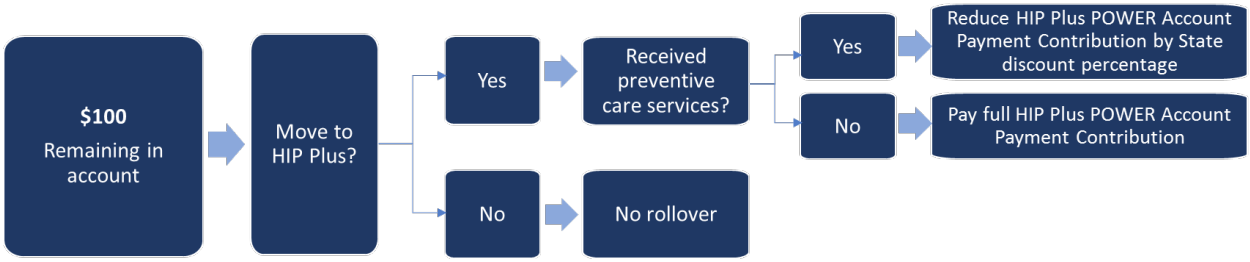


Exhibit A.5: HIP Rollover for HIP Basic Members



The MCEs calculate the rollover 121 calendar days after the end of the benefit period to allow for a claims run-out period. The MCEs then submit this information to the State. For member rollover, members can reuse these funds to reduce the amount owed for their current benefit period. HIP members who leave the program remain eligible to receive a refund for the unused portion of their contributions and rollover following the reconciliation of their POWER Account. State rollover funds never pay tobacco surcharge amounts, and unused funds return to the State at the end of the current benefit period.

Employment, Education, and Gateway to Work Policy

Indiana's community engagement reporting requirement went into effect in 2019 with a six-month voluntary reporting period. This policy evolved from Indiana's existing HIP 2.0 voluntary Gateway to Work program and provides an incentive for HIP members to attain employment or engage in other community activities correlated with improved health and wellness (e.g., employment, volunteer work, education, and training). Under this new policy, all able-bodied HIP participants, not otherwise meeting an exemption or already working at least 20 hours per week, must engage in and report on qualifying activities monthly.

The Gateway to Work program provides three possible reporting statuses for members, reflecting that some members may already work a substantial amount, and others may encounter circumstances that create significant barriers to participation. **Exhibit A.6** provides a summary of each status.

Exhibit A.6: Gateway to Work Reporting Status Definitions

Reporting Status	Definition
Exempt	Member has an exemption from reporting requirements and does not have to report qualifying activities during exemption months. The member still has the option of using Gateway to Work resources.
Reporting Met (i.e., pre-qualified)	Member already works at least 20 hours per week. The member can still use Gateway to Work resources.
Required to Report (i.e., non-exempt)	Member needs to report qualifying activities for a certain number of hours each month (e.g., FSSA Benefits portal or by calling the MCE). Note: January to June 2019 reporting is on a voluntary basis only.

Exhibit A.7 provides a summary of qualifying activities and exempt populations. The list of possible exemptions includes a "good cause" exemption, which members report to their MCE for further review by the State and which does not specify any one circumstance or condition. The good cause exemption applies to individuals who do not fit into the other designated exemption categories that may affect their ability to meet reporting hours (e.g., restrictions due to religious affiliations or having a degenerative disease that does not yet meet the medically frail definition).

Exhibit A.7: Gateway to Work Qualifying Activities and Exempt Populations

Gateway to Work Qualifying Activities	Exempt Populations

Employment
• Employment (subsidized or unsubsidized)
• Health plan employment programs
• Job search activities
• Education related to employment (on-the-job training)
• Caregiving
• Homeschooling
• Members of the Pokagon Band of Potawatomi participating in the Pathways program
Education
• General Education:
  ○ High School Equivalency
  ○ Adult education
  ○ Post-secondary education
• Job skills training (e.g., Next Level Jobs)
• Vocation education or training
• English as a second language education
Community Service
• Community service/public service
• Volunteer work
• Gateway to Work community work experience
Other
• Qualifying activities based on State or MCE review
• MCE Qualifying Activities (MCE-specific programs)
• Attending Alcoholic Anonymous or Narcotics Anonymous meetings
• Completing pre-suspension courses
	• Age 60 years or older
	• Temporary Assistance for Needy Families (TANF)/ Supplemental Nutrition Assistance Program (SNAP) recipients
	• Medically frail
	• Pregnant women
	• Homeless individuals
	• Recently Incarcerated (up to 6 months from release)
	• Certified illness or incapacity (temporary)
	• SUD treatment
	• Student (full or half time)
	• Primary caregiver:
	  ○ Dependent child below the compulsory age (seven and under prior to October 1, 2019; changed to under 13 years of age effective October 1, 2019)
	  ○ Disabled dependent
	  ○ Kinship caregiver of abused or neglected children
	• Good cause exemption (e.g., hospitalization, domestic violence, or the death of a family member)

The State began to phase-in the reporting requirements in 2019 with a member grace period of six months of voluntary reporting only to allow for operational readiness and promote member awareness. Members required to report qualifying activities had to start reporting a minimum of five hours per week beginning on July 1, 2019, increasing over time to 20 hours per week by July 1, 2020. **Exhibit A.8** outlines this phase-in period.

Exhibit A.8: Gateway to Work Phase In Hours

HIP Eligibility Period	Required Participation Hour Reporting
January 2019 – June 2019	0 hours per week
July 2019 – September 2019	5 hours per week
October 2019 – December 2019	10 hours per week
January 2020 – June 2020	15 hours per week
July 2020 – Ongoing	20 hours per week

The State assesses member compliance with the Gateway to Work reporting requirement in December of each year; at least eight months of compliance during a calendar year (CY) results in continued enrollment. Effective October 31, 2019, the State temporarily removed the enrollment suspension for members who do not meet their reporting requirements pending the result of the federal lawsuit.

3. Population Groups Impacted by the Demonstration

Indiana will evaluate whether the HIP demonstration has the intended effects on the target population. HIP includes low-income, non-disabled adults ages 19 to 64. The other adults eligible for Medicaid in Indiana include individuals who are 65 and older, blind, or disabled and who are not eligible for Medicare. The other eligible adults in the State are low-income adults who can receive home and community-based services or who are in nursing homes and other facilities.

B. Evaluation Questions and Hypotheses

The evaluation will focus on the demonstration policy goals described in **Section A**. This section provides the hypotheses and research questions (RQ) that correspond to each of the goals. Logic models are provided for Goals 2, 3, and 4, which are focused on evaluating the impact of a specific policy change. Logic models are not provided for Goals 1, 5, and 6, which are descriptive in nature.

1. Goal One - Improve health care access, appropriate utilization, and health outcomes among HIP members

The evaluation determines whether the HIP policies have the intended effects on members, including improving health care access, appropriate utilization, and health outcomes. **Exhibit B.1** below lists the hypotheses and research questions corresponding to this goal.

Exhibit B.1: Hypotheses and Research Questions for Goal 1

Hypotheses	Research Questions
Hypothesis 1 – Member use of preventive care, primary care, needed prescription drugs, chronic disease management care, and urgent care will be stable during the HIP demonstration period.	**Primary research question 1.1:** How has the following changed over time for HIP members? • Preventive, primary, urgent and specialty care • Prescription drug use • Chronic care management
Hypothesis 2 – Unnecessary emergency department services will not rise over time for HIP members.	**Primary research question 2.1 –** How have avoidable emergency department visits among HIP members changed over time?
Hypothesis 3 – HIP members will report positive health outcomes.	**Primary research question 3.1:** How has reported health status for HIP members changed over time?
Hypothesis 4 – HIP members will report satisfaction with health care access.	**Primary research question 4.1:** What percentage of HIP members report getting health care as soon as needed? **Primary research question 4.2** – To what extent do HIP members receive coverage through Fast Track and presumptive eligibility policies?
Hypothesis 5 – The Indiana Medicaid enrollment rate will be comparable to other Medicaid expansion states.	**Primary research question 5.1:** How does the Indiana Medicaid coverage rate compare to other Medicaid expansion states?

2. Goal Two - Increase community engagement leading to sustainable employment and improved health outcomes among HIP members

Indiana's community engagement requirements aim to result in sustainable employment, increased income, and improved health outcomes among HIP members. **Exhibit B.2** below lists the hypotheses and research questions corresponding to this goal.

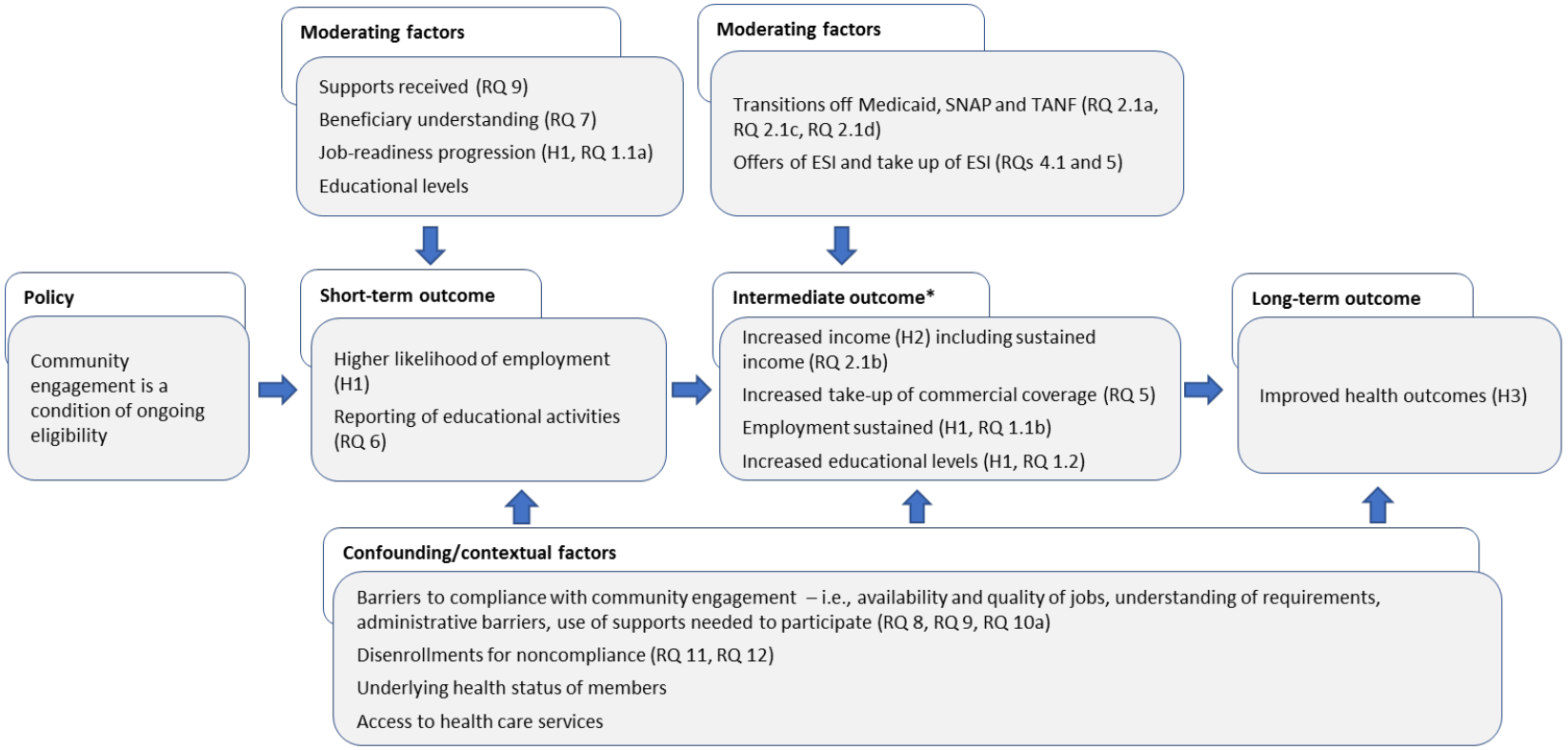
Exhibit B.2: Hypotheses and Research Questions for Goal 2

Hypotheses	Research Questions
Hypothesis 1 – Medicaid beneficiaries subject to community engagement requirements will have higher employment levels than Medicaid beneficiaries not subject to the requirements.	**Primary research question 1.1:** Are HIP members subject to community engagement requirements more likely than other similar Medicaid beneficiaries not subject to these requirements to be employed? **Subsidiary research question 1.1a:** Do HIP members who initially participate in qualifying activities other than employment gain employment within 6 months or one year (i.e., is there evidence of job-readiness progression)? **Subsidiary research question 1.1b:** Is employment among individuals subject to community engagement requirements sustained over time, including after separating from Medicaid? **Primary research question 1.2:** Is being subject to community engagement requirements associated with increases in educational level?
Hypothesis 2 – Community engagement requirements will increase the average income of Medicaid beneficiaries subject to the requirements compared to Medicaid beneficiaries not subject to the requirements.	**Primary research question 2.1:** Do community engagement requirements increase income? **Subsidiary research question 2.1a:** Do community engagement requirements change income from public assistance programs? **Subsidiary research question 2.1b:** Are changes in income sustained over time, including after separating from Medicaid? **Subsidiary research question 2.1c:** To what extent is community engagement associated with an increase in the number of HIP members transitioning off Medicaid because they are no longer income eligible for Medicaid? **Subsidiary research question 2.1d:** To what extent is community engagement associated with households transitioning off other public programs like SNAP or TANF?
Hypothesis 3 – Community engagement requirements will improve the health outcomes of current and former Medicaid beneficiaries subject to the requirements, compared to Medicaid beneficiaries not subject to the requirements.	**Primary research question 3.1:** Are community engagement requirements associated with improved health outcomes for beneficiaries subject to the requirements? **Subsidiary research question 3.1a:** What are the trajectories of HIP member health status over time, including after separation from Medicaid? **Subsidiary research question 3.1b:** Is disenrollment for noncompliance with community engagement requirements associated with differences in health outcomes?

Hypotheses	Research Questions
Hypothesis 4 – HIP policies including community engagement and required payment policies increase the likelihood that Medicaid beneficiaries transition to commercial health insurance after separating from Medicaid, compared to Medicaid beneficiaries not subject to the requirements.	**Primary research question 4.1:** What are the coverage outcomes of individuals who separate from HIP, by separation reason?
Implementation Questions	**Primary research question 5:** To what extent do individuals subject to community engagement requirements who become ineligible for Medicaid due to an increase in income obtain health insurance coverage? **Primary research question 6:** What is the distribution of activities HIP members engage in to meet community engagement requirements? **Subsidiary research question 6a:** How do activity patterns change over time? **Primary research question 7:** Do HIP members subject to community engagement requirements understand the requirements, including how to satisfy them and the consequences of noncompliance? **Primary research question 8:** What are common barriers to compliance with community engagement requirements? **Primary research question 9:** Do HIP members subject to community engagement requirements report that they received supports needed to participate, such as links to volunteer opportunities or job and education resources? **Primary research question 10:** What is the distribution of HIP members who are exempt, meeting the requirement through current work at 20 hours a week or more, or required to report qualified activities to maintain status? What is the distribution of exemption types and sources? **Subsidiary research question 10a:** What strategies has the State pursued to reduce HIP member reporting burden, such as matching to State or MCE database? **Primary research question 11:** What is the distribution of reasons for disenrollment among HIP members? **Primary research question 12:** Are HIP members who are disenrolled for noncompliance with community engagement requirements more or less likely to re-enroll than HIP members who disenroll for other reasons?

The logic model in **Exhibit B.3** depicts the expected short-term, intermediate, and long-term outcomes[16] for community engagement.

Exhibit B.3: Logic Model for Goal 2



*CMS' logic model also included "ESI sustained" and "Marketplace enrollment" which is not being evaluated here.

[16] Since we will be estimating the outcome measures based on data from the observation period (2015-2020), the evaluation will not provide conclusions about the long-term outcomes of the HIP program (e.g., related to health status, employment, and education level) beyond this period.

3. Goal Three - Discourage tobacco use among HIP members through a premium surcharge and the utilization of tobacco cessation benefits

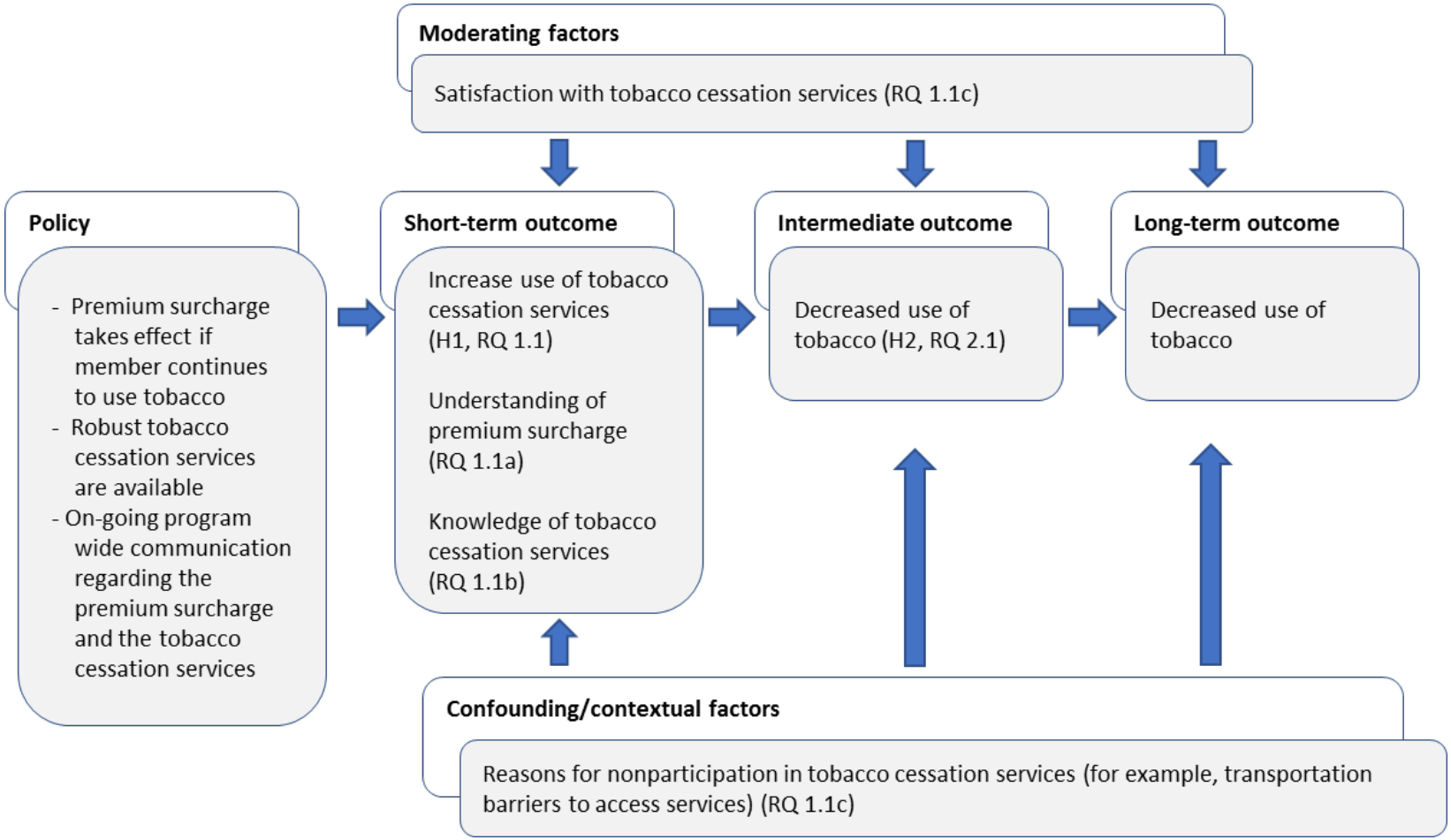
Indiana will test whether the POWER Account Contribution surcharge and utilization of tobacco cessation benefits will discourage tobacco use among HIP members. **Exhibit B.4** below lists the hypotheses and research questions corresponding to this goal.

Exhibit B.4: Hypotheses and Research Questions for Goal 3

Hypotheses	Research Questions
Hypothesis 1 – The tobacco premium surcharge will increase use of tobacco cessation services among HIP members.	**Primary research question 1.1:** What impact has the tobacco premium surcharge had on the use of tobacco cessation benefits for HIP members? **Subsidiary research question 1.1a:** Do HIP members understand the premium surcharge policy? **Subsidiary research question 1.1b:** Do HIP members know about the cessation services offered through HIP? **Subsidiary research question 1.1c:** Are HIP members satisfied with tobacco cessation services?
Hypothesis 2 – The tobacco premium surcharge and availability of tobacco cessation benefits will decrease tobacco use.	**Primary research question 2.1:** Has tobacco use decreased among the target population?

The logic model in **Exhibit B.5** depicts the expected short-term, intermediate, and long-term outcomes[17] for the premium surcharge and the utilization of tobacco cessation benefits.

Exhibit B.5: Logic Model for Goal 3



[17] Since we will be estimating the outcome measures based on data from the observation period (2015-2020), the evaluation will not provide conclusions about the long-term outcomes of the HIP program (e.g., related to health status, employment, and education level) beyond this period.

4. Goal Four - Promote member understanding and increase compliance with payment requirements by changing the monthly POWER Account payment requirement to a tiered structure.

Indiana will test whether the tiered POWER Account structure is easy to understand and increases compliance with payments[18] (**Subsection A.2** provides additional background on POWER Account policies). Research questions under Goal 1 cover efficient use of health care services as defined by utilization. **Exhibit B.6** below lists the hypotheses and research questions corresponding to this goal.

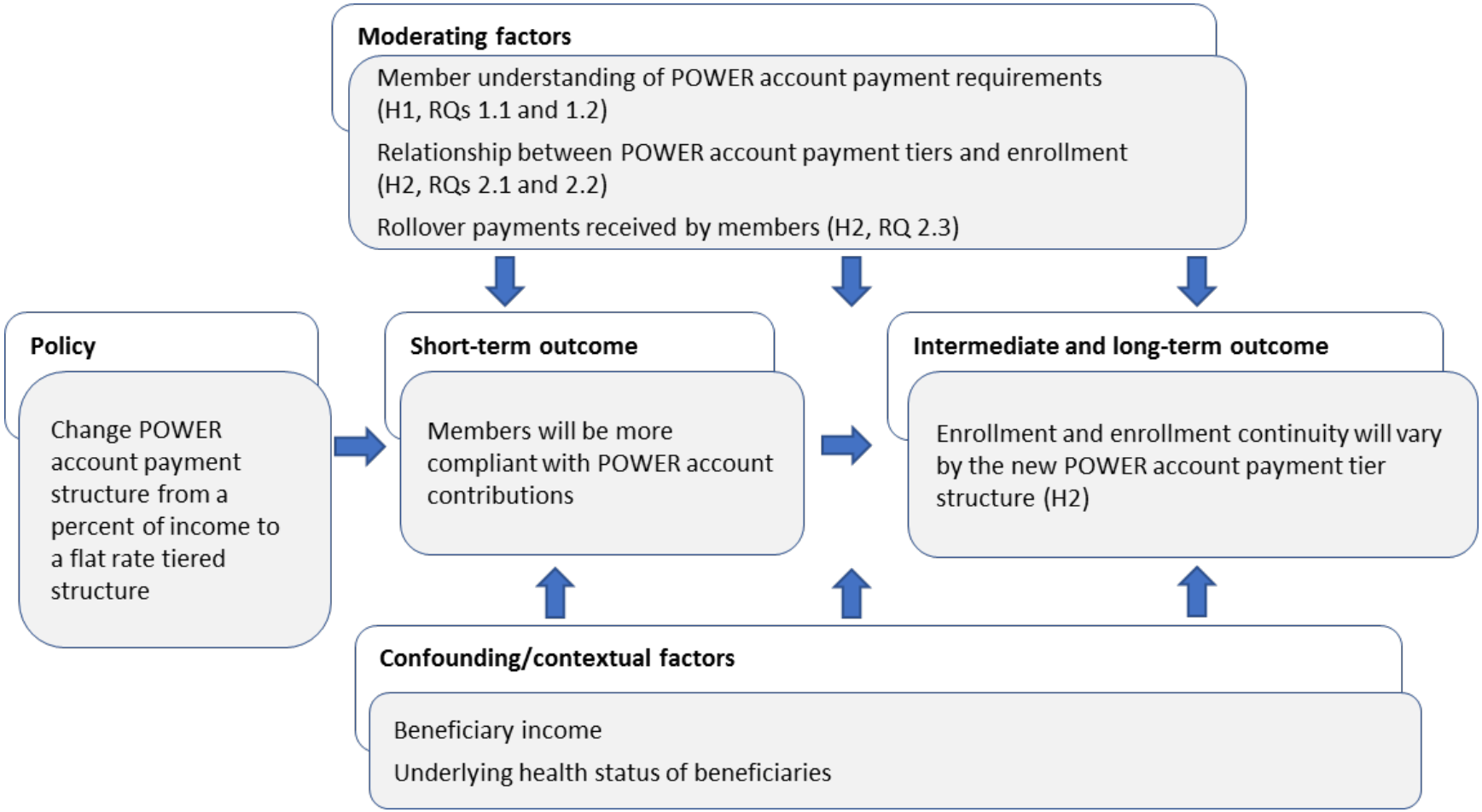
Exhibit B.6: Hypotheses and Research Questions for Goal 4

Hypotheses	Research Questions
Hypothesis 1 – HIP's new income tier structure for POWER Account Contributions will be clear to HIP members.	**Primary research question 1.1:** Do HIP members with POWER account payment requirements understand their payment obligations? **Primary research question 1.2:** Do HIP members with POWER Account payment requirements who initiate payments continue to make regular payments throughout their 12-month enrollment period?
Hypothesis 2 – Enrollment and enrollment continuity will vary for the POWER Account payment tiers.	**Primary research question 2.1:** Is there a relationship between POWER Account payment tiers and total and new enrollment in Medicaid? **Primary research question 2.2:** Is there a relationship between POWER Account payment tiers and continued enrollment in Medicaid? **Primary research question 2.3:** Do HIP members that receive rollover have greater coverage continuity than HIP members who do not receive rollover?

[18] Previous versions of this goal included a reference to "efficient use of services" consistent with the STCs. This wording is no longer included as efficient use of services is addressed under Goal 1.

The logic model in **Exhibit B.7** depicts the expected short-term, intermediate, and long-term outcomes[19] for the tiered structure of the monthly POWER Account payment.

Exhibit B.7: Logic Model for Goal 4



[19] Since we will be estimating the outcome measures based on data from the observation period (2015-2020), the evaluation will not provide conclusions about the long-term outcomes of the HIP program (e.g., related to health status, employment, and education level) beyond this period.

5. Goal Five - Ensure HIP program policies align with commercial policies, are understood by members, and promote positive member experience and minimize coverage gaps

Indiana will test whether the HIP policies align with commercial policies, use easy to understand language, and result in a positive member experience for all HIP members. **Exhibit B.8** below lists the hypotheses and research questions corresponding to this goal.

Exhibit B.8: Hypotheses and Research Questions for Goal 5

Hypotheses	Research Questions
Hypothesis 1 – Beneficiaries subject to HIP policies will understand program policies.	**Primary research question 1.1:** Are HIP members knowledgeable about policies on payment of POWER Account Contributions, preventive care and rollover? **Primary research question 1.2:** Do HIP members subject to non-eligibility periods understand program requirements and how to comply with them? **Primary research question 1.3:** Do HIP members subject to non-eligibility periods understand the non-eligibility period consequence for noncompliance with program requirements? **Primary research question 1.4:** What are common barriers to compliance with program requirements that have non-eligibility period consequences for noncompliance?
Hypothesis 2 – Beneficiaries will be satisfied with the HIP program.	**Primary research question 2.1:** What is the level of satisfaction with HIP among HIP members?
Hypothesis 3 – Individuals subject to the non-eligibility/"lockout" periods (payment and redetermination) and retroactive eligibility are no different from commercial market populations.[20]	**Primary research question 3.1:** Do HIP members that are subject to non-eligibility periods have similar demographic characteristics as the commercial market population? **Primary research question 3.2:** Do HIP members that are not retroactively eligible have similar demographic characteristics as the commercial market population?

[20] A core principal underlying HIP policy is that the program is designed for non-disabled working aged adults who may be moving between eligibility for HIP and eligibility for commercial coverage on a frequent basis and who are more closely aligned with commercial market populations than with traditional Medicaid populations. Thus, instead of mimicking traditional Medicaid, HIP pulls in elements of commercial market design including required cost sharing, lack of retroactive benefits, required monthly payments, enrollment periods, incentives, tobacco surcharges, and member accounts. This hypothesis looks to test the foundational theory of HIP that HIP enrollees are aligned with commercial market populations looking at enrollee's subject to non-eligibility periods and enrollees subject to the retroactive coverage waiver.

6. Goal Six – Assess the costs to implement and operate HIP and other non-cost outcomes of the demonstration

Indiana's goal is to assess the costs to implement and operate HIP and other non-cost outcomes of the demonstration. **Exhibit B.9** below lists the hypotheses and research questions corresponding to this goal. In order to reduce the duplication of efforts, and thus cost, this analysis will completed by Indiana's actuary, Milliman, Inc. and appended to the Summative Evaluation Report. The results will be incorporated into the overall evaluation analysis where relevant and as appropriate.

Exhibit B.9: Hypotheses and Research Questions for Goal 6

Hypotheses	Research Questions
Implementation Questions	**Primary research question 1.1:** What are the administrative costs incurred by the State to implement and operate the HIP demonstration? **Primary research question 1.2:** What are the short- and long-term effects of eligibility and coverage policies on Medicaid health care expenditures? **Primary research question 1.3:** What are the impacts of eligibility and coverage policies on provider uncompensated care costs?

C. Methodology

This section provides a summary of Indiana's evaluation design, including data sources, target and comparison populations, evaluation period, and analytic methods. Throughout the previous HIP 2.0 demonstration, the State tracked meaningful measures of health care access, utilization, health outcomes, and member satisfaction. This Evaluation Plan builds on this tracking and expands the quantitative and qualitative data collection and analysis to reflect new program goals and to incorporate CMS' Section 1115(a) Eligibility and Coverage Evaluation Guidance,[21] most notably:

- Impact of community engagement requirements – The evaluation includes interrupted time series (ITS) analyses of outcomes among non-elderly adult Medicaid beneficiaries in Indiana and difference-in-differences analyses to assess outcomes among non-elderly adult Medicaid beneficiaries in Indiana compared to similar Medicaid beneficiaries in other states.
- Impact of tobacco surcharge – The evaluation includes ITS analyses of tobacco cessation service use and tobacco use among HIP members.
- HIP members' compliance with the new tiered POWER Account structure – The evaluation includes analyses of enrollment outcomes pre/post-implementation of the new tiered account structure among HIP members.

Subsection C.2 describes how Indiana identified comparison groups and determined when an ITS or pre/post analysis was appropriate for a particular research question. Appropriate matching techniques (e.g., propensity score or Mahalanobis distance) will be used as necessary to identify and develop comparison groups.

The observation period for the evaluation will be CYs 2015 to 2020. This time period includes three years before the HIP renewal took effect in 2018 and three years following renewal. For some research questions and analyses, the time period is limited to fewer years. Since we will be estimating the outcome measures based on data from the observation period, the evaluation will not provide conclusions about the impact of the HIP program (e.g., related to health status, employment, and education level) beyond this period. The evaluation will include descriptive analysis of changes in the composition of the enrolled population and the evaluator will consider any findings from this analysis for interpreting the results of the analyses described in the Evaluation Plan.

Section F includes the analytic design tables for each goal, detailing the relevant hypotheses, research questions, data sources, outcome measures, analytic methods, and comparison group(s) (if applicable). These tables also specify the years of data to be used for individual research questions and the research questions to be addressed in the Interim and/or Summative Evaluation Reports.

1. Data Sources and Collection

The evaluator will compile data from federal surveys as well as state-specific surveys, claims, and enrollment data. The evaluator will also capture qualitative data via key informant interviews (i.e., members, FSSA officials, MCEs, and providers). **Exhibit C.1** summarizes the data sources anticipated to be used to evaluate each goal ("X" indicates relevant sources for each goal), followed by detailed descriptions of key data sources. **Section F** provides specific information regarding how these data sources will be used in the evaluation.

[21] CMS. 1115 Demonstration State Monitoring & Evaluation Resources. Released and Accessed March 13, 2019 at https://www.medicaid.gov/medicaid/section-1115-demo/evaluation-reports/evaluation-designs-and-reports/index.html

Exhibit C.1: Data Sources by Goal

Type	Data Sources	Goal 1 Access, Utilization, Health Outcomes	Goal 2 Community Engagement	Goal 3 Tobacco Cessation	Goal 4 POWER Account	Goal 5 Positive Member Experience	Goal 6 Cost and Non-Cost
External – Quantitative	1. American Community Survey (ACS)	X	X	-	X	X	-
	2. Uncompensated care data as reported on Medicare cost reports	-	-	-	-	-	X
	3. Behavioral Risk Factor Surveillance System (BRFSS)	X	X	-	-	-	-
Indiana – Quantitative	1. Indiana Medicaid Historical Data *Note: Historical data will be leveraged as necessary for the goals.*	X	X	X	X	X	X
	2. Member Eligibility, Application, and Enrollment Data *Note: Enrollment data will be used to draw member survey samples that are applicable across goals.*	X	X	-	X	-	-
	3. Claims Data	X	-	X	-	-	-
	4. State administrative data – for example, POWER Account data, Gateway to Work data, POWER Account rollover data, data for tobacco use/cessation[22]	-	X	X	-	X	X
	5. Data reported by health plan, including Healthcare Effectiveness Data and Information Set (HEDIS) and annual chronic disease management program utilization	X	-	-	-	-	-
	6. Member Longitudinal Survey (2020 and 2021)	X	X	X	X	X	-

[22] Other sources of State administrative data may be leveraged as available.

Type	Data Sources	Goal 1 Access, Utilization, Health Outcomes	Goal 2 Community Engagement	Goal 3 Tobacco Cessation	Goal 4 POWER Account	Goal 5 Positive Member Experience	Goal 6 Cost and Non-Cost
Indiana – Quantitative, continued	7. Leaver #1 – Income	-	X*	-	-	X	-
	8. Leaver #2 – Power Account Contribution non-payment (2021)	-	X*	-	-	X	-
	9. Leaver #3 – Community Engagement non-compliant (2021)	-	X*	-	-	X	-
Indiana – Qualitative	1. Key Informant Interviews with FSSA Officials		X	X	X	X	-
	2. Key Informant Interviews with MCEs		X	-	X	X	-
	3. Key Informant Interviews with MCEs on Tobacco-Related Topics	-	-	X	-	-	-
	4. Key Informant Interviews with Providers	-	X	X	X	X	-
	5. Key Informant Interviews with Members	-	X	X	X	X	-

*Note: Some of the implementation questions in Goal 2 address reasons why HIP members separate from HIP and what kinds of health care coverage they received after leaving (regardless of Community Engagement reporting status). Therefore, we include all Leaver Surveys under Goal 2 in this exhibit, even if a member left for reasons other than non-compliance with Community Engagement reporting requirements.

External Data Source Descriptions – Quantitative

American Community Survey (ACS): The 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. See **Section E.4** for a description of key ACS variables.

Medicare Cost Report Data: Medicare cost report data contains provider information such as facility characteristics, utilization data and cost and charges by cost center. This data are available through the Healthcare Provider Cost Reporting Information System (HCRIS), which CMS maintains. Medicare cost report data include information on uncompensated care, bad debt and charity care.

Behavioral Risk Factor Surveillance System (BRFSS): The BRFSS is a nationwide survey operated jointly by the Centers for Disease Control and Prevention (CDC) and state health departments. The survey collects data on health status and health risk behaviors including chronic diseases, access to health care, and use of preventive health services related to the leading causes of death and disability for non-institutionalized population.

Internal Data Source Descriptions – Quantitative

Other applicable data sources may be included as available and validated. Current sources include:

- *Indiana Medicaid Historical Data:* Indiana Medicaid historical data refers to data that the State has summarized in previous assessments and evaluations, either directly or through contracted services for the previous HIP demonstration population. As necessary, the evaluation will use data summaries from previous HIP evaluations on a variety of metrics including POWER Account, enrollment, and utilization.
- *Member Eligibility, Application, and Enrollment Data:* Member application and enrollment data provide information on the size, location, and socio-demographic makeup of HIP enrollees (e.g., members with household income under 138% of the FPL).
- *Claims Data:* The claims records (encounter data) that the MCEs submit to the State provide information about the health care utilization patterns of all HIP enrollees and identifies enrolled HIP providers that are actively providing services.
- *State Administrative Data:* Program administrative data will include items related to POWER Accounts (e.g., member usage of POWER Account fund and POWER Account payments), Gateway to Work activities (e.g., reporting of qualifying activities and exemptions by member) and tobacco use status. Data will permit identification of individuals that have been suspended from Medicaid due to lack of compliance with community engagement activities or that have had HIP eligibility closed due to non-payment of POWER Account Contributions.
- *HIP Surveys:* Surveys will capture the perspectives of members regarding HIP and contribute to addressing research questions across the evaluation. **Exhibit C.2** describes, by survey, the type of individuals to be surveyed, key topics, process for selecting the sample, mode of data collection, the targeted number of respondents, and statistical power assumptions. **Section F** provides additional information by research question.

As appropriate and feasible, selection of members for survey data collection will be based on probability sampling methods, such as simple random sampling or stratified random sampling, to ensure that the sample is representative of the larger population under study, reduce bias, and increase validity of study findings.

In implementing each survey, the State will ensure that all informed consent procedures are followed, so that respondents are aware of the reason for the survey and have the information they need to fully participate. To maximize the response rate, the evaluator will leverage the most up-to-date contact information for sampled members using program administrative data. The longitudinal survey will follow all respondents from the first year of the survey (2020) (all members who have remained enrolled or have disenrolled from Medicaid). The State will provide a refresh of the contact information for sampled members prior to administering the follow-up survey.

All surveys will be administered using computer-assisted telephone interviewing (CATI) software to ensure data completeness and consistency. Prior to analysis, data will be weighted to adjust for sample design, non-response, and differences in characteristics between the survey respondents and the population. Participant rewards will not be provided.

The average survey length will be six minutes; a longer average survey length will result in a lower survey completion rate and strain existing evaluation resources. The evaluator will prioritize research questions within the available survey time and make adjustments to data collection accordingly.

Exhibit C.2: Summary of Indiana-Specific Surveys

Area	Longitudinal Member Survey	Leaver Survey – Community Engagement non-compliant	Leaver Survey – POWER Account Contribution non-payment	Leaver Survey – Increased Income
Individuals Surveyed	HIP Basic and HIP Plus members The coverage status of these individuals will vary between the 2020 and 2021 surveys; some will continue to be HIP members while others may leave the program.	Individuals who had been fully enrolled in HIP but who left the program (i.e., coverage is closed) due to not meet community engagement reporting requirements	Individuals who had been fully enrolled in HIP but who left the program (i.e., coverage is closed) due to not paying the POWER Account Contribution	Individuals who had been fully enrolled in HIP but who left the program (i.e., coverage is closed) due to changes in income eligibility
Timeframe	2020, 2021	2021	2021	2021
Topics	• Access to care • Education • Health status • Tobacco use and related surcharge • Satisfaction with HIP and knowledge of HIP policies • POWER Accounts • Employment • Community engagement requirements	• Reasons for leaving HIP • Current insurance coverage/ employer offer of coverage • Knowledge of HIP policies • Access to care • Satisfaction with HIP	• Reasons for leaving HIP • Current insurance coverage/ employer offer of coverage • Knowledge of HIP policies • Access to care • Satisfaction with HIP	• Reasons for leaving HIP • Current insurance coverage/ employer offer of coverage • Knowledge of HIP policies • Access to care • Satisfaction with HIP
Mode of Administration	Telephone Up to three attempts in 2020 and up to five attempts in 2021	Telephone Up to three attempts	Telephone Up to three attempts	Telephone Up to three attempts
Sampling Strategy	Stratified Random	Random	Random	Random

Area	Longitudinal Member Survey	Leaver Survey – Community Engagement non-compliant	Leaver Survey – POWER Account Contribution non-payment	Leaver Survey – Increased Income
Anticipated Timeline (May change depending on data availability or other program nuances and changes)	• Sampling Universe: All members enrolled with HIP Basic or HIP Plus in March 2020 • Select sample: April 2020 • Survey instrument test: May (2020, 2021) • Conduct survey: June – July (2020, 2021)	• Sampling Universe: All members who were suspended in January 2021 • Select sample: March 2021 • Survey instrument test: April 2021 • Conduct survey: May – June 2021	• Sampling Universe: HIP members who disenrolled between January 1, 2020 and December 31, 2020 • Select sample: March 2021 • Survey instrument test: April 2021 • Conduct survey: May – June 2021	Same as Leaver Survey – POWER Account Contribution non-payment
Estimated number of completed surveys	2020: 4,500 2021: 650 to 900 (dependent on response rate among respondents in 2020)	250	250	400

Area	Longitudinal Member Survey	Leaver Survey – Community Engagement non-compliant	Leaver Survey – POWER Account Contribution non-payment	Leaver Survey – Increased Income
Statistical power assumptions	Assuming a population of 400,000, this sample size will allow for estimating population metrics (e.g., proportion has access to care) with 95% confidence level with a margin of error of +/- 1.38% for 2020 and 3.8% for 2021. The evaluator anticipates contacting all respondents in the 2020 for the 2021 longitudinal survey. The adequacy of the resulting 2021 sample for subgroup analysis will be assessed prior to analysis. The adequacy of the sample size for conducting subgroup analyses was assessed for one outcome of interest (high HIP satisfaction); the sample size supports comparisons (detectable difference of 10% or more with confidence level of 95% and power level of 80%) between HIP Basic and HIP Plus members and between members who are below and above 100% FPL.	Assuming a population of 5,000 this sample size will allow for estimating population metrics (e.g., proportion has access to care) with 95% confidence level with a margin of error of +/-6.05%. Subgroup analysis may be limited due to sample size. The adequacy of the sample for subgroup analysis will be assessed prior to analysis.	Assuming a population of 5,000, this sample size will allow for estimating population metrics (e.g., proportion has access to care) with 95% confidence level with a margin of error of +/-6.05%. Subgroup analysis may be limited due to sample size. The adequacy of the sample for subgroup analysis will be assessed prior to analysis.	Assuming a population of 28,000, this sample size will allow for estimating population metrics (e.g., proportion has access to care) with 95% confidence level with a margin of error of +/-4.86%. Subgroup analysis may be limited due to sample size. The adequacy of the sample for subgroup analysis will be assessed prior to analysis.

Internal Data Source Descriptions – Qualitative

In addition to quantitative data collection and analysis, Indiana will conduct key informant interviews to capture member and provider experience and evaluate other outcomes related to each goal. Participant responses to targeted questions will provide an opportunity to explore trends and outliers in the quantitative data, and allow participants to use their own words to describe their experiences. Indiana will identify potential participants based on existing contacts and other member and provider lists including enrollment data. Indiana is not planning to use any monetary incentives for recruitment and participation will not affect member enrollment status. **Exhibit C.3** describes the targeted number of interviewees, timeframe, and potential topics.

Exhibit C.3: Summary of Indiana-Specific Qualitative Data Collection – Key Informant Interviews

Type	Potential Topics	Targeted Number of Interviewees	Timeframe
FSSA Officials	• Implementation of HIP POWER Account changes, community engagement requirement, and tobacco surcharge • Identification of factors related to member enrollment and participation in/compliance with policy changes • Member satisfaction	8 semi-structured interviews (including group interviews) each year	2019, 2020, 2021
MCEs	• Implementation of HIP POWER Account changes, community engagement requirement, and tobacco surcharge • Identification of factors related to member enrollment and participation in/compliance with policy changes • Member satisfaction	4 semi-structured interviews with representatives from the four MCEs each year	2019, 2020, 2021
Providers	• Understanding of and experience with HIP policies—community engagement, POWER Accounts, tobacco surcharge, tobacco cessation services • Member satisfaction with HIP	50 to 70 *Note: To be determined based on provider availability. Interviews will include provider associations and certified navigators,*	50 in 2019 (36 completed in 2019) The number of interviews and timing in 2020 and 2021 will depend on area of interest for follow-up based on other data.
HIP Members	• Access to care • Tobacco use • Satisfaction with HIP • Knowledge of HIP policies—community engagement, POWER Accounts, tobacco surcharge, tobacco cessation services • Process for and barriers to reporting community engagement activities	80 to 100 *Note: To be determined based on member availability.*	25 interviews in 2019 (27 completed in 2019) The number of interviews and timing in 2020 and 2021 will depend on area of interest for follow-up based on other data.
Other Stakeholders	• Topics to be determined based on key areas of interest from the State	10 *Note: To be determined based on stakeholder availability.*	2020, 2021

2. Target and Comparison Populations

The target population for analysis is all beneficiaries covered by HIP or – where applicable and possible – the HIP member sub-population specific to the research question and related outcome measure(s). HIP includes low-income, non-disabled adults ages 19 to 64. The other adults eligible for Medicaid in Indiana include individuals who are 65 and older, blind, or disabled and who are also not eligible for Medicare, or low-income adults who can receive home and community-based services or who are in nursing homes and other facilities.

During the development of strategies for comparative analyses, both within-state and other-state comparison groups who are similar to HIP members but not subject to the policies being evaluated were considered. Ideally, a comparison group used to evaluate the impact of program implementation is a population with similar demographics but without comparable program or policy changes.

CMS' guidance outlined several possible within-state comparison groups,[23] which are not feasible or ideal for this evaluation due to specific aspects of Indiana HIP, specifically:

- The State includes all eligible non-elderly, non-disabled adults in HIP. The unique characteristics of other Medicaid-eligible adults in the state (e.g., individuals with disabilities and children less than 19 years of age) limits the availability of appropriate within-state comparison groups for the HIP evaluation.
- HIP does not involve random assignment and the State has not staged HIP policy implementation based on beneficiary characteristics.
    - All HIP members are enrolled in Gateway to Work regardless of exemption status and receive the same communications, access to resources, and ability to report hours.
    - Changes to POWER Account Contribution payment tiers apply to all HIP members interested in enrolling in HIP Plus.

For these reasons, depending on the research question, Indiana's Evaluation Plan uses two types of comparison groups: (1) HIP population prior to policy implementation, and (2) other state Medicaid populations, with a particular focus on states that did not implement any comparable demonstrations during the evaluation period and have populations with similar demographic characteristics.

In instances when adequate data are available before and after policy implementation, the evaluator will develop quasi-experimental analyses (e.g., ITS). For such analyses, the HIP population post-policy implementation is the target while the member population prior to policy implementation is the comparison group. As necessary, the evaluator will explain in the Interim and Summative Evaluation Reports why regression discontinuity designs using age, medical frailty, or parents with dependents were not used.

[23] Feedback received previously from CMS included considering use of regression discontinuity (RD) designs using age and medical frailty cutoffs, where feasible. For instance: RD around the age 60 cutoff for CE requirements and difference-in-differences comparing those just above and just below the age 60 cutoff; threshold for medical frailty; and parents with dependents.

Exhibit C.4 summarizes a preliminary set of states to be considered for comparison based on select characteristics. Prior to developing the relevant analyses for the Summative Evaluation Report,[24] the evaluator will refine this set to two to three states, taking into account recent state-specific policy changes or data challenges that might make comparisons challenging. The evaluator may choose to vary the final states selected by research question. The below parameters were used to select the preliminary set of states:

- Expanded Medicaid to childless adults, have similar eligibility for childless adults as Indiana, and expansion did not take place during the evaluation time period.
- Have not implemented the 1115(a) waiver policy under study (e.g., community engagement requirements) but are similar to Indiana in other Medicaid policies.
- Have similar population characteristics.
- Have sufficient sample size for analysis.

The main data source to be used for cross-state comparisons will be the ACS. In addition to age (19-64), income (138% FPL or less), and Medicaid coverage, the evaluator will leverage other available variables to approximate the HIP population (e.g., HIP members who are required to participate in the community engagement requirements). There are limitations to the ability to define these comparison groups, however, and Indiana's Summative Evaluation Report will include discussion of how these limitations affect the interpretation of the results.[25]

Indiana anticipates identifying the ACS sample size by including individuals that:

- Live in households with income less than 138% of the FPL (Integrated Public Use Microdata Series (IPUMS) ACS variable POVERTY)
- Are 19-64 years old (IPUMS ACS variable AGE)
- Are not covered by Medicare (IPUMS ACS variable HINSCARE)
- Are not receiving social security income (IPUMS ACS variable INCSUPP)

The definition of the study population may be based on either (1) likely eligible or (2) Medicaid-enrolled individuals. The sample representing the likely eligible population can be identified in ACS using the variables listed above, while the "Have Medicaid coverage (IPUMS ACS variable HINSCAID)" variable can be used in addition to the others listed to identify the sample representing the potential Medicaid enrolled population. The evaluator will explore and assess use of analysis results based on both approaches and will include a comprehensive rationale and relevant analyses in the Interim and Summative Evaluation Reports on the choice of a specific population definition (e.g., why the enrolled population was used instead of the eligible population or vice-versa).

[24] Comparison group analyses are only included in the Summative Evaluation Report due to the timeframe of data required for analysis.

[25] For example, it will not be possible to remove all individuals who are excluded from Indiana's community engagement requirements such as pregnant women (ACS does not contain a pregnancy variable) and individuals who have been recently incarcerated or are receiving substance use disorder treatment.

Exhibit C.5 provides the anticipated sample sizes for ACS for both definitions of the study population under consideration. Once the Indiana and other state samples are identified from the ACS, the evaluator will conduct descriptive analyses to assess the similarities and differences in the Indiana sample compared to the other state samples in terms of key characteristics (e.g., age, race, sex). The evaluator will consider the need for leveraging appropriate matching techniques (e.g., propensity score or Mahalanobis distance) to identity matching comparison group of beneficiaries who are similar to the Indiana sample members. The evaluator will apply this same approach as appropriate when using other data sources to perform cross-state comparisons; the Interim and Summative Evaluation Reports will include a description of the approach(es) and the rationale for selection.

The evaluator will use BRFSS data to analyze health status of the Medicaid-eligible population as indicated in **Section F** (Goal 1 and Goal 2). BRFSS data will only allow for the identification of the eligible Medicaid population; it is not possible to also identify the enrolled Medicaid population.

Section F provides additional detail regarding how these comparison groups will be used and also identifies unique within-state comparison groups pertinent to specific research questions.[26]

[26] Goal 5, Primary Research Question 2.3 (HIP members who do not receive rollover) and Subsidiary Research Question 3.1 (Low-income adults in Indiana enrolled in commercial coverage); Goal 2, Subsidiary Research Question 3.1b (beneficiaries initially subject to community engagement requirements who remain enrolled).

Exhibit C.4: Summary of Key State Characteristics

Characteristic	Indiana	Colorado	Minnesota	New Mexico	Pennsylvania	Washington
Non-Elderly Adult Expansion FPL Percent[27]	138%	138%	138%	138%	138%	138%
Percent Unemployed[28]	3.6%	3.5%	3.2%	5.1%	3.9%	4.6%
Minimum Wage[29]	$7.25	$11.10	$9.86/$8.04[30]	$7.25	$7.25	$12.00
Percent Rural Households[31]	31%	24%	35%	35%	17%	16%
Percent Uninsured[32]	8.2%	7.6%	4.5%	9.1%	5.5%	6.1%
Percent Employees with Employer Offer[33]	82%	83%	83%	80%	88%	85%
Race (selected)[34]	79% White 9% Black 7% Hispanic 2% Asian	68% White 4% Black 22% Hispanic 3% Asian	80% White 6% Black 5% Hispanic 5% Asian	37% White 2% Black 49% Hispanic 1% Asian	77% White 11% Black 7% Hispanic 3% Asian	69% White 3% Black 13% Hispanic 9% Asian
Type of Marketplace[35]	Federally-facilitated	State-based	State-based	State-based with Federal Platform[36]	Federally-facilitated	State-based

Note: All of the states listed expanded their Medicaid programs prior to 2015.

27 Henry J. Kaiser Family Foundation. Medicaid and CHIP Eligibility, Enrollment, and Cost Sharing Policies as of January 2019: Findings from a 50-State Survey. Retrieved May 3, 2019 from https://www.kff.org/medicaid/report/medicaid-and-chip-eligibility-enrollment-and-cost-sharing-policies-as-of-january-2019-findings-from-a-50-state-survey/

28 Bureau of Labor Statistics. Local Area Unemployment Statistics for March 2019. Retrieved May 3, 2019 from https://www.bls.gov/web/laus/laumstrk.htm

29 National Conference of State Legislatures State 2019. Minimum Wages by State. Retrieved May 3, 2019 from http://www.ncsl.org/research/labor-and-employment/state-minimum-wage-chart.aspx#Table

30 For large employers, with an annual sales volume of $500,000 or more, the minimum wage is currently $9.50; for small employers, those with an annual sales volume of less than $500,000, the minimum wage is $7.75.

31 University of Minnesota. 2017 American Community Survey accessed through IPUMS USA. Retrieved May 3, 2019 from https://usa.ipums.org/usa/

32 Ibid.

33 Medical Expenditure Panel Survey. Insurance Component 2017 Chartbook, Exhibit 1.3. Retrieved May 3, 2019 from https://meps.ahrq.gov/data_files/publications/cb22/cb22.pdf

34 Henry J. Kaiser Family Foundation. Population Distribution by Race/Ethnicity, 2017. Retrieved May 11, 2019 from https://www.kff.org/other/state-indicator/distribution-by-raceethnicity/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D

35 Henry J. Kaiser Family Foundation. State Insurance Marketplace Types 2018. Retrieved May 3, 2019 from https://www.kff.org/health-reform/state-indicator/state-health-insurance-marketplace-types/

36 While New Mexico has a state-based marketplace with a federal platform, the state component of the marketplace only applies to small employers/employees.

Exhibit C.5: ACS Sample Sizes for Key States

Note: The adequacy of the sample sizes for testing state comparisons was assessed for two outcomes of interest (employment and college education); the sample sizes support comparisons (detectable difference of 5% or more with confidence level of 95% and power level of 80%) between Indiana and other states.[37]

Definition	Year	Indiana	Colorado	Minnesota	New Mexico	Pennsylvania	Washington
Likely Eligible	**2015**	7,773	5,103	4,168	2,990	12,472	6,692
	2016	7,216	5,135	4,075	2,750	12,370	6,490
	2017	7,065	5,096	3,957	2,843	11,936	6,186
Medicaid Enrolled	**2015**	2,069	2,018	1,879	1,414	3,952	2,848
	2016	2,328	1,839	1,847	1,449	4,564	2,898
	2017	2,378	1,923	1,775	1,534	4,680	2,715

[37] University of Minnesota. 2017 American Community Survey accessed through IPUMS USA. Retrieved May 3, 2019 from https://usa.ipums.org/usa/

3. Analytic Methods

Indiana will use a mixed-methods approach employing both quantitative and qualitative analyses to answer the research questions in this evaluation. Qualitative analyses will support an understanding of stakeholders' perspectives related to context, implementation, and outcomes and will identify contextual factors that help to explain outcomes. Quantitative analyses will examine changes in outcomes and estimate the impact of policy changes, as demonstration design and data permit. Quantitative and qualitative analyses will reinforce each other and contribute to understanding context, implementation, impact, and variation.

The evaluation will employ a convergent approach incorporating mixed methods. With a convergent approach, qualitative data and analysis may inform the collection, analysis, and interpretation of quantitative data, and quantitative data and analysis can inform the collection, analysis, and interpretation of qualitative data. For example, interviews with HIP members will provide important contextual information that may help to explain the results of claims analysis, and the claims analyses may inform the development of survey and interview protocols. Both quantitative and qualitative data will be used throughout the course of the evaluation. Any quantitative analyses that leverages survey sample data will apply appropriate sample weights and weighting techniques.

Qualitative Analyses: Qualitative data collected through interviews will be analyzed using thematic analysis, a systematic data coding and analysis process during which information is categorized with codes developed iteratively to reflect themes or patterns within the data.

Quantitative Descriptive and Trend Analyses: Descriptive statistics (e.g., total, average, proportion) will be calculated to summarize the characteristics of HIP members (across time where necessary) as well as assess trends in outcomes of interest. Where applicable and feasible, we will leverage appropriate statistical tests (e.g., Chi-Square test for independence) to test for differences between HIP members and comparison groups or to test for differences between subgroups of interest.

Cross-Sectional Analyses: We will use cross-sectional models to assess associations and compare risk-adjusted outcomes for HIP members to comparison beneficiaries. Standard power calculations will be conducted to ensure adequacy of sample sizes in available data for model development. A variety of parametric models and techniques to estimate the models are available. The outcome variable characteristics, for example type (e.g., categorical or continuous) and distribution (e.g., normal, skewed), will be used to determine the model specifications (e.g., logistic, linear, log-linear). Models will include beneficiary and geographic-level covariates to control for differences between the groups of interest. The covariates will include demographic characteristics, income level, health status, regional characteristics, and other variables that are relevant and available within the data sources used.

Quantitative Impact Analyses: Because the implementation of Indiana's policy changes did not involve a randomized control design (as discussed in *Target and Comparison Population* section), the evaluation will use quasi-experimental approaches to estimate the impact of policy changes. Specifically, the evaluation will use a difference in differences (DiD) approach to address several research questions. DiD is a regression technique that measures the impact of the model by comparing changes in risk-adjusted outcomes for the target population to changes in outcomes in a comparison group, between the baseline and intervention periods. Standard power calculations will be conducted to assess adequacy of sample size in available data for model development. We will ensure model specifications are appropriate for the outcome variable (e.g., logit for dichotomous outcomes) of interest. Models will

include beneficiary and geographic-level covariates to control for differences between the groups of interest. The covariates will include demographic characteristics, income level, health status, regional characteristics, and other variables that are relevant and available in the data sources used. The validity of the DiD approach relies on the assumption that the intervention and comparison groups were on parallel trends in the baseline. Tests for parallel trends in the baseline period for key outcomes will be conducted using statistical testing and visual trend analysis.

When a comparison group is not available but multiple years of data (before and after the policy change) are available for HIP members, the evaluation will rely on an ITS design (or a pre/post design if only two points in time are available) to assess change in an outcome before and after the policy change. To strengthen this analysis, multivariate regression analysis will be used to control for possible confounders. Prior to implementing these analyses, pre-implementation trends will be evaluated and comparability in samples over time will be assessed, relying on appropriate methods (e.g., matching) to address sample differences.

Subgroup Analysis: The primary DiD analysis will produces estimates of the average impact of a policy change. However, the impact may vary by beneficiary subgroups (e.g., by older and younger HIP members, by length of enrollment, by income, by region within state). As data and sample size allow, estimates for impact of change in policy will be calculated by subgroups of interest. To inform the selection of characteristics that will define subgroups, information gathered through interviews as well as through the descriptive analysis will be considered. The evaluator will first test whether subgroups of HIP and comparison beneficiaries are adequately balanced across key characteristics. If necessary, matching methods will be used to develop subgroup-specific comparison groups, so that intervention and comparison groups are balanced in observed characteristics. The ability to look at subgroups and differentiated effects is ultimately limited by the number of beneficiaries in each group and the variability in the data. The evaluation will weigh the value of testing for differences among subgroups against having adequate sample size and power to do so precisely. Again, as the data and sample sizes allow, subgroup analyses will also be conducted as part of descriptive, cross-sectional, and interrupted time-series analyses.

D. Methodological Limitations

Exhibit D.1 describes the known limitations of the evaluation and anticipated approaches to minimizing those limitations and/or acknowledges where limitations might preclude casual inferences about the effects of demonstration policies. **Section C** contained information on limitations regarding identifying comparison groups. The Interim and Summative Evaluation Reports will describe limitations of the evaluation, which may include data and methodological challenges and other limitations identified during the evaluation process that are not described below. These reports will acknowledge approaches taken by the evaluator and necessary modifications made to the Evaluation Plan to address these challenges and limitations.

Exhibit D.1: Summary of Methodological Limitations and Approach to Minimizing Limitations

Area	Issue	Description	Anticipated Approaches to Minimizing Limitations
Overall issues	Limited ability to control for differences between states when using other State Medicaid populations as a comparison group	State Medicaid populations are different in observable and unobservable ways. For example, state-specific policies and economies vary from state to state. Available variables and sample sizes in proposed federal data sources (e.g., ACS) limit the ability to control for these differences.	• Select states for comparison that: ○ Did not implement comparable demonstrations during the evaluation period ○ Implemented Medicaid expansion prior to 2015 ○ Have similar Medicaid eligibility FPL requirements for adults ages 19-64 ○ Have similar geographic variation ○ Have sufficient sample sizes • Include a description in the Summative Evaluation Report of types of differences that cannot be taken into account given available evaluation resources and data limitations. • Use appropriate methods (e.g., matching) to account for observable differences.

Area	Issue	Description	Anticipated Approaches to Minimizing Limitations
Overall issues, continued	Quality of provider contact information for key informant interviews	Provider contact information reliability made completing provider key informant interviews challenging. For example, provider email addresses and phone numbers listed in the MCE provider list often provided only generic office email addresses.	• Obtain support from key provider associations to identify providers for key informant interview purposes. • Make modifications to the Summative Evaluation Report's approach to key informant provider interviews (including the number of providers) based on the experience with key informant provider interviews during the Interim Evaluation Report.
	Ability to identify HIP members within ACS survey data	HIP members include low-income (<138% FPL), non-disabled adults aged 19-64; HIP members also include the medically frail, TMA participants, and low-income parents and caretakers. Available fields within ACS will limit the ability to identify all of these groups.	• Use available survey fields related to Medicaid coverage, income, disability, and age. • Highlight in the evaluation narrative what HIP member characteristics could not be taken into account.
	Ability to use BRFSS data to identify individuals enrolled in HIP and potentially eligible for HIP	BRFSS data does not allow for identification of individuals in the sample enrolled in Medicaid. Additionally, limited availability of fields in BRFSS will limit the ability to identify individuals that are potentially eligible for HIP. HIP members include low-income (<138% FPL), non-disabled adults aged 19-64; HIP members also include the medically frail, TMA participants, and low-income parents and caretakers.	• Use available survey fields related to income, disability, and age (Medicaid enrollment is not an available field). • Include in the evaluation narrative that BRFSS survey data can only identify individuals that are potentially eligible for HIP; describe related limitations for analyses.
	Impact of changes in case-mix over time	Changes in HIP case mix over time may have an impact on a variety of areas of this evaluation, including service utilization, prevalence of medical frailty exemptions for the Gateway to Work program, and member preference for the HIP Plus versus HIP Basic benefit plan.	• Provided context for interpretation of results.

Area	Issue	Description	Anticipated Approaches to Minimizing Limitations
Overall issues, continued	Limited survey respondents for Longitudinal Member Survey – 2021 follow-up survey	The State anticipates sample attrition between the 2020 and 2021 surveys. The sample size for the 2021 Longitudinal Member Survey is estimated at 650 to 900, which is approximately 15 to 20% of the 2020 sample respondents. HIP Basic members and members non-compliant with community engagement requirements or POWER Account Contributions may be particularly less likely to respond to the 2021 follow-up survey.	• To maximize the response rate, leverage the most up-to date-contact information for sampled beneficiaries using program administrative data, reach out to sampled members via mail prior to the telephone survey, and call each sampled member for a total of three attempts. The State will provide a refresh of the contact information for sampled beneficiaries prior to administering the follow-up survey. • Report separate response rates for compliant and non-compliant members in the Summative Evaluation Report and consider methodological options for addressing differential response prior to analysis. It is not possible to oversample non-compliant members as Indiana anticipates contacting all respondents in the 2020 survey when performing the follow on survey in 2021.
	Analyses across time using Longitudinal Member Survey	It is not possible to know in advance how many respondents will be associated with the desired subgroups for analysis. The ability to perform analyses across time or for subgroup is dependent on response during the 2021 Longitudinal Member Survey.	• Assess sample size based on survey respondents to determine appropriateness of subgroup or comparison analyses.
	Survey length / respondent burden and corresponding response rate for member surveys	The average survey length will be six minutes; a longer average survey length will result in a lower survey completion rate and strain existing evaluation resources.	• Prioritize research questions within the available survey time and make adjustments to data collection accordingly.
	Quality of MCE encounter data	MCE encounter data is self-reported and the procedure codes and units recorded in the encounter data analyzed for the evaluation of the 2015 to 2017 demonstration period appeared incomplete and/or inaccurate.	• Perform data checks on key variables (e.g., expected versus populated values). • Adjust or eliminate analyses as necessary if data are not reliable.

Area	Issue	Description	Anticipated Approaches to Minimizing Limitations
Overall issues, continued	Identification of unique HIP members	Recipient identification numbers can change over time and the State performs on-going adjustments to data so that each member has only one active recipient identification number.	• Confirm whether data received from the State is fully adjusted for duplicate members. • Request a mapping of duplicate recipient identification numbers, if applicable. • Indicate in the Interim and Summative Evaluation Reports if there is possibility that data analyzed contains duplicated HIP members.
	Identification of FPL	Member income can change throughout the year and as often as monthly. We anticipate defining member FPL based on the first enrollment month in the CY under analysis (based on analyses of the income in enrollment data and feedback from the State). There may be FPL amounts in the data that appear inconsistent with HIP policies (e.g., a small number of HIP Plus members with income at or less than 100% had disenrollments with non-payment as a reason). Based on discussions with the State, there are several possible reasons for inconsistencies, for example: • The member changed income after the first HIP Plus enrollment month in the CY under analysis. • Interplay between the required member notification for coverage changes (e.g., HIP Plus to HIP Basic) and when the State/MCE received and updates data, in conjunction with member changes in FPL across months. • Inconsistencies in FPL data transfer between eligibility and the Medicaid Management Information System that resulted in null FPL values on disenrollment, which appear as zero in provided enrollment data and in some cases in the application of updated FPL numbers to prior months. The State has indicated that this data issue is resolved but on a minority of historical records included in this analyses these data artifacts remain.	• Do not place restrictions on FPL when identifying HIP Plus members for analysis. • Provided context for interpretation of results.

Area	Issue	Description	Anticipated Approaches to Minimizing Limitations
Overall issues, continued	Limitations of interrupted time series (ITS) and pre/post analyses	ITS involves estimating the impact of an intervention based on pre/post analyses of an outcome of interest based on a longitudinal measure of outcome. Use of this approach can be unsuitable to measure the impact of intervention in certain situations, including: • Intervention is introduced gradually or at multiple points in time, making it difficult to identify and quantify for pre/post measures. • Characteristics of the population with intervention changes across time. • Underlying trend is not linear; other factors are also impacting the population (e.g., simultaneous implementation of a different).	• Perform checks of population differences over time; consider matching or other appropriate methods to address observed differences. • Use regression analysis to control for potential confounders to the extent possible.
	Distinguishing the impacts of overlapping initiatives	Multiple policy changes have been implemented under the renewal. As such, distinguishing the impacts of the individual initiatives becomes challenging. In addition to the HIP waiver policies, non-waiver operational items have overlapping impacts, for example: • Implementation of a new Medicaid Management Information System in 2017. • Updates to verification policies over time. • New processes for reporting and tracking community engagement activities.	• Provide context for interpretation of results in the Interim and Summative Evaluation Reports, including the need for caution in interpreting and presenting results for take-up and continued enrollment in HIP.
Goal 1: Improve health care access, appropriate utilization, and health outcomes among HIP members	Variations in health care utilization based on time of enrollment	Members may experience higher utilization of service when first enrolled in Medicaid based on previously unmet health care needs. This higher utilization may make identification of trends in the use of preventative, primary, urgent and specialty care challenging.	• Use members continuously enrolled for at least one year to calculate the participation rate for each service type.

Area	Issue	Description	Anticipated Approaches to Minimizing Limitations
Goal 2: Increase community engagement leading to sustainable employment and improved health outcomes among HIP members	Ability to use ACS and BRFSS data to identify HIP program members who are required to report qualifying community engagement activities	ACS and BRFSS data do not allow for the exclusion of populations who are exempt from the community engagement requirement, with the exception of individuals who are 60 years old and older or are receiving TANF/SNAP. Approximately 20% of the HIP population are required to report qualifying community engagement activities. Any effect observed using ACS or BRFSS data will likely be for the overall Medicaid eligible population.	• Include a description in the Summative Evaluation Report of the limitations of the comparisons and how those limitations might affect interpretation of the results.
	Gradual phase-in of community engagement requirements	The State is phasing in the community engagement reporting requirements during 2019 and the first six months of 2020, with members required to report hours for the first time starting in July 2019. As such, member experiences and compliance with these requirements in 2019 and 2020 will not reflect full implementation.	• Include a description in the Interim and Summative Evaluation Reports of how this gradual phase-in might affect results.
	Compliance with community engagement reporting	Some members may gain employment but will not report it to FSSA. These members may officially close due to other reasons (e.g., POWER Account Contribution non-payment, failure to verify information, failure to complete redetermination). This may underestimate the number of members who close due to increased income, and may overestimate the number of members who close due to non-compliance or other reasons.	• Provide context for this issue in the Summative Evaluation Report.
Goal 3: Discourage tobacco use among HIP members, through a premium surcharge and the utilization of tobacco cessation benefits	Tobacco surcharge is only assessed on members who self-report tobacco use via defined channels	The tobacco surcharge determination relies on reporting of tobacco use by members during the MCE selection period, when changing MCEs, or if members otherwise voluntarily contact the MCE to report their tobacco use status. This underestimates the number of members who continue to use tobacco.	• Provide context for this issue in the Interim and Summative Evaluation Reports.
	Members may under-report tobacco use	Members may have an incentive to refrain from reporting tobacco use if they want to avoid the related premium surcharge increase.	• Provide context in the evaluation narrative for this issue.

Area	Issue	Description	Anticipated Approaches to Minimizing Limitations
Goal 3, continued	Medicaid encounter data may not fully reflect use of tobacco cessation services	Encounter data will not have codes for all tobacco cessation service since some programs will not be reimbursable by the provider.	• Ask questions about MCE tobacco cessation initiatives during key informant interviews with MCEs • Ask questions about cessation services received during member key informant interviews
Goal 4: Promote member understanding and increase compliance with payment requirements by changing the monthly POWER Account payment requirement to a tiered structure	Ability to use ACS data to identify Medicaid populations in other states that match Indiana's HIP program members subject to POWER Account payment policies	ACS data are limited in regards to excluding populations that are exempt from the HIP POWER Account non-payment penalty, specifically individuals who are: • Medically frail • Living in a domestic violence shelter • In a state-declared disaster area	• Include a description of limitations of the comparisons in the Summative Evaluation Report and potential impact on the interpretation of the results
	Variability in FPL amounts	Discussed as an overall methodological limitation above	• Refer to description above.
Goal 5: Ensure that HIP policies promote a positive member experience for all HIP members	None noted	n.a.	n.a.
Goal 6: Assess the costs to implement and operate HIP and other non-cost outcome of the demonstration	Expenditures and enrollment may be affected by factors other than eligibility and coverage policies	Neglecting to control for other factors such as changes in the economy, demographic shifts, individual market changes, or coverage changes in other Medicaid programs could result in mistakenly attributing their impact to that of the demonstration.	• Per Member Per Month (PMPM) expenditures will be normalized for changes in population mix • Additional variables will be considered in the difference-in-differences regression model to control for alternative factors • Model results and residuals will be iteratively examined to determine if other significant factors may have been omitted and can be added

Area	Issue	Description	Anticipated Approaches to Minimizing Limitations
Goal 6, continued	Difficulty in controlling for factors related to the reporting of hospital uncompensated care	There are many factors that affect the reporting of hospital uncompensated care, including if HCRIS Worksheet S-10 is relied upon for payment purposes in the State (if not, hospitals may not report data fully), hospital reporting practices, state-specific Medicaid shortfalls, and the proportion of uninsured or underinsured individuals in a state.	• Control for the proportion of uninsured and underinsured individuals in the state • Include a discussion in the Summative Evaluation Report of the potential impact of aspects of hospitals' uncompensated care reporting that are not easy to measure • Evaluate if Worksheet S-10 data are used for payment purposes in the comparison states (which would suggest that they are more fully completed by hospitals)

E. Attachments

Attachment E.1. Summary of Independent Evaluator Approach

In April 2018, the State of Indiana posted and distributed a request for proposals (RFP) to acquire an independent party to evaluate the HIP Program. A copy of the RFP and all related attachments are publically available at https://www.in.gov/idoa/proc/bids/rfp-18-091/. All bidders were required to provide information on evaluations they have initiated in other states that could be replicated in Indiana, processes that would be unique to Indiana, any license sanctions or formal complaints that they have been subject to, and any corrective actions, if applicable. Similarly, bidders had to describe their experience in evaluating other Section 1115 Medicaid waivers, statewide healthcare programs, programs authorized by the United States Department of Health and Human Services, and any other equivalent experience. In addition, they had to describe any experience, if any, in evaluating other programs where employment (and vocational training and engagement leading to employment) was a key objective. Once the State received and reviewed proposal responses, Indiana selected to work with The Lewin Group, Inc. (Lewin) for the evaluation. Lewin demonstrated that they had the technical expertise and resources available to conduct a rigorous evaluation.

In order to ensure an independent evaluation, the evaluation process will be independent of any process involving program policy making, management, or activity implementation of the waiver demonstration. The State's responsibility towards an independent evaluation is the assurance of quality data to the evaluator, support in understanding program context of any data anomalies, and identifying the program components that are important for the evaluation. Additionally, Lewin has provided a copy of their Organizational Conflict of Interest (OCI) Disclosure Statement to the State of Indiana. This ensured that there were no conflicts of interest to report as stated in Section XV, Paragraph 1 of CMS's STCs for HIP Waiver Evaluation. A copy of the OCI is available below.

The sustainability component of this evaluation is a new CMS requirement that was not originally included in the independent evaluator search. Incorporating this work into their contract substantially increased the cost of the evaluation. In an effort to avoid duplication of work, and reduce costs, the State of Indiana received permission to use the State's actuary, Milliman Inc., to facilitate this portion of the evaluation.

Exhibit E.1: Organizational Conflict of Interest

Exhibit A to Lewin Transmittal Letter

Organizational Conflict of Interest Disclosure Statement
RFP: 18-091: Healthy Indiana Plan (HIP) 1115 Waiver Evaluation

The Lewin Group, Inc. ("Lewin") is submitting a proposal in response to the Indiana Department of Administration on behalf of the Indiana Family and Social Services Administration ("FSSA") Request for Proposal 18-091 ("RFP"). FSSA is seeking a Vendor to assist in its comprehensive evaluation of the Healthy Indiana Plan 1115 Waiver demonstration (hereby referred to as the "HIP Evaluation").

In accordance with the RFP, Section 1.25-CONFLICT OF INTEREST, FSSA prohibits the submission of a proposal from an entity, including individuals that has worked with and/or advised the State in the preparation of the RFP, or has hired a state employee who has worked on the preparation of this RFP within one year prior to its publication. After reviewing these restrictions, Lewin can confirm to FSSA that no such Conflict of Interest ("COI") would exist should it be awarded a contract under this RFP.

Additionally, in accordance with the Centers for Medicare and Medicaid ("CMS") Special Terms and Conditions ("STC") 11-W-00296/5, Attachment A-Developing the Evaluation Design, Section F-Conflict of Interest, FSSA is required to assure CMS that it will obtain an Independent Evaluator which will "conduct a fair and impartial evaluation, prepare an objective Evaluation Report, and that there would be no conflict of interest." These types of COIs are normally referred to as Organizational Conflicts of Interest ("OCI"). Accordingly, what follows in this Disclosure Statement ("Disclosure") is an explanation of why an award to Lewin as the HIP Evaluation Contractor under this RFP will not create an actual or potential OCI. This Disclosure is organized to describe; 1) Lewin's relevant corporate affiliates and, 2) Lewin's OCI analysis.

I. Lewin's Affiliate Interests

Lewin is part UnitedHealth Group, Incorporated ("UHG"), a diversified health and well-being company dedicated to improving the health care system in the United States. UHG is organized into seven (7) businesses. Four of those businesses — UnitedHealthcare Employer & Individual, UnitedHealthcare Community & State ("C&S"), , UnitedHealthcare Medicare & Retirement and UnitedHealthcare Military & Veterans — provide network-based health care benefits and related services under the "UnitedHealthcare" brand. The other three (3) businesses operate under the "Optum" brand and include OptumHealth, OptumRx, and OptumInsight. The Optum businesses offer health technology and innovation support services. Although UHG provides certain shared services across the enterprise, Optum and United operate as separate businesses with separate operational structures and separately reported financial results. For more information, please see www.unitedhealthgroup.com and www.optum.com.

In conducting its OCI analysis, Lewin identified three (3) affiliated businesses relevant for discussion, and are as follows:

- *MedExpress:* MedExpress, which is part of OptumHealth, is an urgent care provider operating in over one two hundred (200) neighborhood care centers in eighteen (18) states, including Indiana. MedExpress offers medical services, such as wellness and preventative care, imaging and lab services, and worker's compensation and occupational medical services. MedExpress serves consumers, health systems, employers, health plans and other payers. MedExpress currently provides services to eligible Indiana Medicaid recipients in seven (7) locations throughout the State which include Anderson, Bloomington, Indianapolis, Kokomo, Lafayette, Marion, and Muncie.

- *OptumRx:* OptumRx specializes in the delivery, clinical management and affordability of prescription medications and consumer health products. It serves over 65 million members, processes more than one billion pharmacy claims annually and has a national network of approximately 67,000 community pharmacies. OptumRx serves customers in multiple markets and government programs, including commercial, managed care, Medicaid, Medicare, labor and trust, workers compensation and others. In 2015, OptumRx acquired Catamaran, which, similar to OptumRx, provides full-service pharmacy benefits

management services, including mail order and specialty pharmacy benefits, for both government and private sector employer groups, union trusts, managed care organizations, Medicare-contracted plans, Medicaid plans and third party administrators. Its services include claims processing, retail network contracting, rebate contracting and management, and clinical programs, such as step therapy, formulary management and disease/drug therapy management programs. OptumRx is presently under contract with FSSA to provide pharmacy benefit management services for the Indiana Health Coverage Program.

- *UnitedHealthcare Community and State ("UHC C&S"):* UHC C&S provides healthcare services through public sector health plans to beneficiaries in Medicaid and the Children Health Insurance Program ("CHIP") in twenty-eight (28) states and the District of Columbia. UHC C&S plans are Medicaid Managed Care Organizations ("MCOs") serving Medicaid (Title 19), CHIP (Title 21), Dually Eligible, Long Term Care and Children with Special Needs (Title V). Presently, C&S is not an MCO in the State of Indiana.

II. Lewin's OCI Analysis

For the purpose of this OCI Analysis, Lewin refers to the Federal Acquisition Regulation Part 9.5 which defines three types of conflicts, Upon review, Lewin is not aware of any facts or circumstances that would create an actual or potential OCI. To the extent that an OCI may be perceived to exist, Lewin will explain how the OCI is avoided, neutralized, or mitigated. These conclusions are based on the following:

A. Biased Ground Rules

A Biased Ground Rules OCI arises where a company, as part of its performance of a government contract, sets the ground rules for a later government procurement by, for example, writing the statement of work or the specifications. The primary concern is that the company could create an unfair competitive advantage by biasing the competition in favor of itself or its affiliate. Neither Lewin nor any of its affiliates has engaged in the development of this RFP, or in assisting FSSA in the procurement represented in the RFP. Accordingly, no Biased Ground Rules OCI exists.

B. Impaired Objectivity

An Impaired Objectivity OCI commonly occurs when a company's work under one government contractor could require the company to evaluate the work that company itself or its affiliates performed under a separate government contract. The primary concern is that the company's ability to render impartial advice to the government could be impaired, where that advice involves the use of subjective judgment, and where the advice could affect the economic interests of the company as broadly construed. Lewin has not identified any situation while performing work as the contracted Independent Evaluator under this RFP that would create an actual or potential Impaired Objectivity OCI. The purpose of this evaluation is to determine the impact of HIP with regard to eligible Indiana Medicaid recipients and their access to health care services, utilization of those services, and health outcomes. FSSA requires that the evaluation utilizes both data and outcomes from the previous HIP 2.0 demonstration, along with data and outcomes from the analysis of added policy enhancements approved by CMS for this demonstration renewal. As the awarded Contractor, Lewin will work under an FSSA/CMS-approved evaluation design in accordance with evaluation guidance set forth in CMS STC 11-W-00296/5. Data for the evaluation data is collected from FSSA-directed sources to include statewide Medicaid member surveys, focus groups, key informant interviews, and prescribed data sets from the Indiana Medicaid Management Information System ("MMIS"). Data sets required by Lewin for analysis from state MCOs are provided to Lewin directly from state staff members. Given these requirements and parameters, Lewin's work is objective and administrative, and significantly restricts Lewin from exercising subjective judgment. Furthermore, there is no nexus between the outcomes of Lewin's evaluation of this demonstration and the financial interests of Lewin or any of its affiliates providing healthcare services Indiana Medicaid recipients. As such, no Impaired Objectivity OCI exists.

C. Unequal Access to Information

An Unequal Access to Information OCI exists where a company has access to non-public information as part of its performance of a government contract and that information may provide the company with an unfair competitive advantage in a later competition for a government contract. Lewin has not had access to non-public information that has given it an unfair advantage in competing for contract under this RFP. Lewin recognizes, however, if it were awarded a contract under this RFP, Lewin may have access to non-public and confidential

information such as claims and benefit data from Indiana MCOs. If this information was inadvertently accessed by Lewin's UHC C&S affiliate it could conceivably generate an unfair competitive advantage in future MCO competitions in Indiana. However, any such OCI concerns would be unfounded because Lewin understands and complies with its obligation to handle non-public and confidential information in accordance with applicable laws, regulations, and contract requirements. As a result, in the regular course if its business, Lewin has implemented measures that would prospectively prevent any Unequal Access to Information OCI from occurring and that includes the following:

- *Information and Security Firewalls:* Lewin has established effective firewalls to prevent unauthorized use or disclosure of protected information and to guard against the risk of even inadvertent disclosure of such information. These firewalls provide an information disclosure barrier between Lewin and other business units and employees of UHG. All protected program information in electronic form will be maintained on a secure, password-protected server that is dedicated to Lewin. Electronic documents or data files containing protected information will be accessible only to Lewin employees on a need to know basis.

- *Physical Separation:* Lewin's work will be performed by employees at Lewin's office in Falls Church, Virginia and all servers and data will be similarly housed at this location. This office space is physically separate from the rest of Lewin's affiliates. The office has physical security systems in place designed to prevent unauthorized entry and access to both computer systems and hard copies of files. Staff from Lewin's affiliates is treated like any other visitor, meaning that they must sign in and must be escorted by Lewin staff within the secure portion of the office suite.

- *Separate Staffing:* The personnel that Lewin uses for the contract are separate and distinct from the staff used by Lewin's affiliates. There is no overlap of staffing in this regard between the very separate businesses.

- *Information Security Policies and Procedures:* Lewin has implemented numerous P&Ps regarding the manner in which employees are to handle and disclose confidential information. This includes, for example a "need-to-know" policy, which provides that individual employees have access to the minimal amount of confidential information necessary to perform his or her work on the specific project to which the employee is assigned. Furthermore, Lewin employees are annually trained on the firewall and its policies and have a continuing obligation to report suspected violations of the policy, including any suspected violations of the information firewall. This obligation is emphasized as part of their training on the enterprise Code of Conduct. The policy identifies the company hotline and other means through which they may make such a report (anonymously, if desired). Employees are advised that violations could result in consequences such as termination of employment.

- *Contract Requirements:* In accordance with Attachment B-Sample Contract of the RFP, Lewin as the awarded Contractor is required abide by HIPAA Rules as such Rules apply to Business Associates.

IV. Conclusion

For all the foregoing reasons, an award of a contract to Lewin under this RFP would not create an actual OCI nor adversely affect or impact FSSA. Lewin understands that, if it were to be awarded a contract under this RFP, there is a continuing obligation to provide assurance to FSSA that no OCIs arise in the course of performing the work. In the event there is a change in facts that would give rise to an actual or significant, potential OCI, Lewin will promptly disclose the circumstances to FSSA, along with a mitigation plan, and Lewin will not proceed with performing the conflicted work until a mutually acceptable mitigation plan is in place.

Attachment E.2. Evaluation Budget

The budget for the Independent Evaluation from the awarded evaluator contract is included below. Oversight and support of this contract and provision of data to the evaluator on behalf of the state are considered to be encompassed in general program administrative costs and are not reported in this document. The required analyses specifically related to the sustainability of the demonstration waiver will leverage its existing contract with Milliman Inc. for incorporation into the Summative Evaluation Report.

Exhibit E.2: Evaluation Budget-Total Costs

	State Fiscal Year	Dates	Deliverable Costs
Base 5-Year Contract	SFY 2019	(8/1/18 to 6/30/19)	$ 277,893.50
	SFY 2020	(7/1/19 to 6/30/20)	$ 1,396,573.56
	SFY 2021	(7/1/20 to 6/30/21)	$ 200,312.00
	SFY 2022	(7/1/21 to 6/30/22)	$ 1,152,194.51
	SFY 2023	(7/1/22 to 6/30/23)	$ 384,064.84
	4-Year 11-Month Contract Total		**$ 3,411,038.41**

Exhibit E.3: Evaluation Budget-Deliverables by State Fiscal Year

Deliverable	SFY 2019	SFY 2020	SFY 2021	SFY 2022	SFY 2023
3.1 Evaluation Design	$ 76,135.50				
3.2 Quarterly Monitoring Report - Q1	$ 1,446.00	$ 1,446.00			
3.2 Quarterly Monitoring Report - Q2	$ 1,446.00	$ 1,446.00	$ 1,446.00		
3.2 Quarterly Monitoring Report - Q3	$ 1,446.00	$ 1,446.00	$ 1,446.00		
3.2 Annual Monitoring Report	$ 2,288.00	$ 2,288.00	$ 2,288.00		
3.3 Interim Evaluation Report		$ 1,194,815.56			
3.4 Final Summative Evaluation Report				$ 1,152,194.51	$ 384,064.84
3.5 Ad Hoc Report - 1	$ 97,566.00	$ 97,566.00	$ 97,566.00		
3.5 Ad Hoc Report - 2	$ 97,566.00	$ 97,566.00	$ 97,566.00		
Total for All Deliverables	**$ 277,893.50**	**$ 1,396,573.56**	**$ 200,312.00**	**$ 1,152,194.51**	**$ 384,064.84**

Attachment E.3. Timeline and Major Milestones

Exhibit E.4: Timeline and Milestones

Task	2018	2019				2020				2021				2022			
	Oct-Dec	Jan-Mar	Apr-Jun	Jul-Sep	Oct-Dec	Jan-Mar	Apr-Jun	Jul-Sep	Oct-Dec	Jan-Mar	Apr-Jun	Jul-Sep	Oct-Dec	Jan-Mar	Apr-Jun	Jul-Sep	Oct-Dec
Prepare and Implement Evaluation Design																	
Conduct kick-off meeting	■																
Draft Evaluation Design	■																
Receive CMS Feedback and Evaluation Guidance Documents		■	■	■	■												
Revise Evaluation Design		■	■	■	■												
Receive CMS Approval					■												
Data Collection or Data Pull																	
External Data Sources-Quantitative																	
American Community Survey (ACS) Data									■				■				
Behavioral Risk Factor Surveillance System (BRFSS) Data																	
Indiana Data Sources-Quantitative																	
Indiana Medicaid Historical Data			■	■	■	■	■	■	■	■	■	■	■	■			
Enrollment/Claims Pull and Analysis			■	■								■	■	■			
Administrative Data--POWER Account, Gateway to Work Program						■				■				■			
Data, Tobacco Program Data						■				■				■			
Member Longitudinal Panel Survey (2020 and 2021)						■	■	■		■	■	■					
Leaver Survey(s) (2021)										■	■	■					
Indiana Data Sources-Qualitative																	
Key Informant Interviews with FSSA Staff, MCEs, Providers, HIP Members				■	■	■	■	■	■	■	■	■					
Conduct Analysis																	
Quantitative Analysis			■	■	■		■	■	■		■	■	■	■			
Qualitative Analysis																	
Reporting																	
Quarterly Report	■		■	■	■		■	■	■								
Annual Report		■				■				■							
Draft Interim Report				■	■												
Final Interim Report					■	■											
Draft Summative Report															■		
Final Summative Report																■	

Attachment E.4. Variable Descriptions for ACS Data to be Used in this Evaluation

Exhibit E.5: American Community Survey Variable Descriptions[38]

Domain	Name	Variable	Description
Age	AGE	Age	Person's age in years as of the last birthday.
Children	CHBORN	Children Ever Born	Number of children ever born to each woman. Women report all live births by all fathers, whether or not the children were still living; they exclude stillbirths, adopted children, and stepchildren.
Citizenship	CITIZEN	Citizenship Status (U.S. Citizenship Status)	Citizenship status of respondents, distinguishing between naturalized citizens and non-citizens. Respondents were asked to select one of five categories: (1) born in the United States, (2) born in Puerto Rico, Guam, the U.S. Virgin Islands, or Northern Marianas, (3) born abroad of U.S. citizen parent or parents, (4) U.S. citizen by naturalization, or (5) not a U.S citizen. Respondents indicating they are a U.S. citizen by naturalization also are asked to print their year of naturalization.
Disability Status	DISABWRK	Disability Status	Per the Institute of Medicine (IOM) and the International Classification of Functioning, Disability, and Health (ICF), disability is defined as the product of interactions among individuals' bodies; their physical, emotional, and mental health; and the physical and social environment in which they live, work, or play. Disability exists where this results in limitations of activities and restrictions to full participation at school, at work, at home, or in the community
Education	EDUC	Educational Attainment	Indicates respondents' educational attainment, as measured by the highest year of school or degree completed. Note that completion differs from the highest year of school attendance; for example, respondents who attended 10th grade but did not finish were classified in EDUC as having completed 9th grade.
Education	SCHLTYPE	Type of School	Indicates whether respondents attending school were enrolled in a public or a private school.
Education	SCHOOL	Attending School	Indicates whether the respondent attended school at the time of interview in the past three months.
Education	GRADEATT	Level attending	Reports the grade or level of recent schooling for people who attended "regular school or college" at the time of interview in the past three months. "Regular school or college" includes only nursery school or preschool, kindergarten, elementary school, and schooling that leads to a high school diploma or a college/graduate degree.

[38] University of Minnesota. IPUMS USA Variables. Retrieved April 19, 2019 from https://www.usa.ipums.org/usa-action/variables

Domain	Name	Variable	Description
Health Coverage	HCOVANY	Any Health Insurance Coverage	Indicates whether the respondent had any health insurance coverage at the time of interview, including employer-provided insurance, privately purchased insurance, Medicare, Medicaid or other governmental insurance, TRICARE or other military care, or Veterans Administration-provided insurance.
Health Coverage	HINSCAID	Health Insurance through Medicaid	Indicates whether, at the time of interview, the respondent was covered by Medicaid, Medical Assistance, or any other kind of government-assistance plan for those with low incomes or a disability.
Health Coverage	HINSCARE	Health insurance through Medicare	Indicates whether, at the time of interview, the respondent was covered by Medicare.
Income	INCWAGE	Wage and salary income	Respondent's total pre-tax wage and salary income (e.g., money received as an employee) for the previous year. For the ACS and the Puerto Rican Community Survey (PRCS), the reference period was the past 12 months. Sources of income include wages, salaries, commissions, cash bonuses, tips, and other money income received from an employer. Payments-in-kind or reimbursements for business expenses are not included.
Income	INCSUPP	Supplementary Security income	Reports how much pre-tax income (if any) the respondent received from Supplemental Security Income (SSI) during the previous year. Amounts are expressed in contemporary dollars, and users studying change over time must adjust for inflation.
Income	INCSS	Social Security income	Reports how much pre-tax income (if any) the respondent received from Social Security pensions, survivors benefits, or permanent disability insurance, as well as U.S. government Railroad Retirement insurance payments, during the previous year. Amounts are expressed in contemporary dollars, and users studying change over time must adjust for inflation.
Income	HHINCOME	Income of Households	The total money income of all household members age 15 years old and over during the previous year. The amount should equal the sum of all household members' individual incomes, as recorded in the person-record variable INCTOT. The persons included were those present in the household at the time of the census or survey. People who lived in the household during the previous year but who were no longer present at census time are not included, and members who did not live in the household during the previous year but who had joined the household by the time of the census or survey, are included. Note that household income differs from family income. The family income variable only reports the incomes of household members related to the head, while HHINCOME includes the incomes of all household members.

Domain	Name	Variable	Description
Income	FTOTINC	Income of Families	The incomes of all members 15 years old and over related to the household head are summed and treated as a single amount. Although the family income statistics cover the past 12 months, the characteristics of individuals and the composition of families refer to the time of interview.
Income	INCTOT	Income of Individuals	Reports each respondent's total pre-tax personal income or losses from all sources for the previous year. The censuses collected information on income received from these sources during the previous CY; for the ACS and the PRCS, the reference period was the past 12 months. Amounts are expressed in contemporary dollars, and users studying change over time must adjust for inflation.
Income	INCWELFR	Pre-tax income from public assistance programs	Reports how much pre-tax income (if any) the respondent received during the previous year from various public assistance programs commonly referred to as "welfare." Assistance from private charities was not included. The censuses collected information on income received from these sources during the previous CY; for the ACS and the PRCS, the reference period was the past 12 months. The following are included within INCWELFR: • Federal/State SSI payments to elderly (age 65+), blind, or disabled persons with low incomes. (In the 2000 census, the ACS, and the PRCS, SSI payments are specified in INCSUPP only, not in INCWELFR); • Aid to Families with Dependent Children (AFDC); and • General Assistance (This does not include separate payments for hospital or other medical care).
Income	POVERTY	Poverty Status in the Past 12 Months	Each family's total income for the previous year as a percentage of the poverty thresholds established by the Social Security Administration in 1964 and subsequently revised in 1980, adjusted for inflation. Assigns all members of each family (not each household) the same code. Whether an individual falls below the official "poverty line" depends not only on total family income, but also on the size of the family, the number of people in the family who are children, and the age of the household head (under/over age 65).
Marital Status	MARST	Marital Status	Each individual's marital status, including married, spouse present; married, spouse absent; separated; divorced; widowed; never married/single.
Race	RACE	Race	The racial categories included in the census questionnaire generally reflect a social definition of race recognized in this country and not an attempt to define race biologically, anthropologically, or genetically. Includes white, black/African American, American Indian or Alaskan Native, Chinese, Japanese, other Asian or Pacific Islander, other race, two major races, three or more major races.

Domain	Name	Variable	Description
Residence	MIGCITY1	Residence 1 Year Ago	For respondents who lived in a different residence one year before the survey date, identifies the city of residence at that time, if the prior residence was in an identifiable city. Cities are not directly identified in the source Integrated Public Use Microdata Series (IPUMS) files, so IPUMS bases MIGCITY1 coding on relationships between cities and the Migration Public Use Microdata Areas.
Sex	SEX	Sex	Either “male” or “female.”
Work Status	EMPSTAT	Work Status in the Past 12 Months	Whether the respondent was a part of the labor force (e.g., working or seeking work) and, if so, whether the person was currently unemployed.
Work Status	WKSWORK1	Weeks Worked in the Past 12 Months	The number of weeks that the respondent worked for profit, pay, or as an unpaid family worker during the previous year. Weeks of active service in the Armed Forces are also included.
Work Status	UHRSWORK	Usual Hours Worked Per Week Worked in the Past 12 Months	The usual hours worked per week worked in the past 12 months. This question was asked of people 16 years old and over who indicated that they worked during the past 12 months. The respondent was to report the number of hours worked per week in the majority of the weeks he or she worked in the past 12 months. If the hours worked per week varied considerably during the past 12 months, the respondent was to report an approximate average of the hours worked per week.
Work Status	CLASSWKR	Class of Worker	The type of ownership of the employing organization. These categories are: 1. An employee of a private for-profit company or business, or of an individual, for wages, salary, or commissions. 2. An employee of a private not-for-profit, tax-exempt, or charitable organization. 3. A local government employee (e.g., city, county). 4. A state government employee. 5. A Federal government employee. 6. Self-employed in own not incorporated business, professional practice, or farm. 7. Self-employed in own incorporated business, professional practice, or farm. 8. Working without pay in a family business or farm.
Work Status	IND	Industry	A 4-digit un-recoded variable reporting the work setting and economic sector, as opposed to the worker's specific technical function, or "occupation." Respondents unsure about this were to report the industry in which they spent the most time. For persons listing more than one industry, the samples use the first one listed. Persons not currently employed were to give their most recent industry.

Domain	Name	Variable	Description
Work Status	OCC	Occupation	The person's primary occupation, coded into a contemporary census classification scheme. Generally, the primary occupation is the one from which the person earns the most money; if respondents were not sure about this, they were to report the one at which they spent the most time. Unemployed persons were to give their most recent occupation. For persons listing more than one occupation, the samples use the first one listed.
Work Status	LABFORCE	Labor Force Status	Participation in the civilian labor force (e.g., working or seeking work) and, if so, whether the person was currently unemployed, or participation in the U.S. Armed Forces (i.e., people on active duty with the United States Army, Air Force, Navy, Marine Corps, or Coast Guard).

F. Analytic Tables

Goal 1: Improve health care access, appropriate utilization, and health outcomes among HIP members

Exhibit F.1: Goal 1[39]

Hypothesis	Research Question	Outcome Measure(s)	Data Sources	Analytic Approach	Comparison Strategy	Reporting Schedule
H.1 – Member use of preventive care, primary care, needed prescription drugs, chronic disease management care, and urgent care will be stable during the HIP demonstration period.	**Primary RQ 1.1—** How has the following changed over time for HIP members?[40] • Preventive, primary, urgent and specialty care • Prescription drug use • Chronic care management	Outcome measures will reflect utilization of the types of service during defined time frame as described in the research question and are anticipated to include for instance based on yearly utilization: • Proportion of members receiving qualifying preventive care services[41] • Proportion of members using primary care[42] • Proportion of members using specialty care[43] • Enrollment in disease management programs by MCE • Adherence to prescription drugs • Proportion of members with urgent care visits[44] • Proportion of members with ED visit	• Claims data (2015-2020) • Annual MCE reporting on enrollment in chronic disease management programs (2015-2020)	Descriptive quantitative analysis with subgroup analysis for preventive, primary, urgent and specialty care	n.a.	Interim Evaluation 2019 Summative Evaluation 2022

[39] For the evaluation, outcome measures will include the time frame component, for example, the proportion of members using primary care within a 6-month period or enrollment in disease management within 12 month. The exact definition of the measures will be included in the Interim and Summative report.

[40] CMS' premium-related research question 2.2a (Are beneficiaries with accounts equally likely to receive preventive care, which does not draw down beneficiary accounts, compared to beneficiaries who do not have accounts?) is not included here because all HIP members (HIP Plus and HIP Basic) have accounts. As noted in the Evaluation Plan narrative, non-HIP members vary substantively from HIP members and comparing preventive care use between these two populations is problematic.

Hypothesis	Research Question	Outcome Measure(s)	Data Sources	Analytic Approach	Comparison Strategy	Reporting Schedule
H.1, continued	**Primary RQ 1.1, continued**	Proportion of members: • Receiving breast cancer screening (BCS) • Receiving cervical cancer screening (CCS) • Receiving adult body mass index assessment (ABA) • Controlling high blood pressure (CBP) • Receiving comprehensive diabetes care hemoglobin A1c (HbA1c) testing (CDC) • On persistent medications that receive annual monitoring (MPM) • With an appropriate type of asthma medication (MMA)	HEDIS data as summarized by health plan in existing Indiana HEDIS reports (2015-2020)[45]	n.a.	n.a. *Note:* Indiana's HEDIS reports compare HIP to other Medicaid health plans nationally	Interim Evaluation 2019 Summative Evaluation 2022

41 The evaluator anticipates using the Center for Disease Control (CDC) list of preventive care procedures, identified by Current Procedural Terminology (CPT) codes and accompanying diagnosis.

42 The evaluator anticipates identifying primary care office and ambulatory care visits using (1) primary care provider specialties and (2) evaluation and management (E&M) procedures, International Classification of Diseases (ICD)-9 and ICD-10 codes, and institutional revenue codes.

43 The evaluator anticipates identifying these services using provider specialty.

44 The evaluator anticipates identifying these services using the urgent care "Place of Service" code on the professional medical claim in addition to an accompanying ambulatory or outpatient procedure code, diagnosis code or revenue code from the HEDIS® value set directory for "Ambulatory Visits Value Set."

45 Indiana's 2018 HEDIS measures, for example, can be found online at: https://www.in.gov/fssa/ompp/5534.htm (accessed May 9, 2019).

Hypothesis	Research Question	Outcome Measure(s)	Data Sources	Analytic Approach	Comparison Strategy	Reporting Schedule
H.2 – Unnecessary emergency department services will not rise over time for HIP members.	**Primary RQ 2.1 –** How have avoidable emergency department visits among HIP members changed over time?	Proportion of members with preventable/avoidable emergency department visits in a year[46]	Claims data (2015-2020)	Descriptive quantitative analysis; identification of visits based on the New York University (NYU) Emergency Department algorithm	n.a.	Interim Evaluation 2019 Summative Evaluation 2022
H.3 – HIP members will report positive health outcomes.	**Primary RQ 3.1 –** How has reported health status for HIP members changed over time?	Proportion of members reporting excellent/very good, good, or fair/ poor health	Longitudinal Member Survey (2020, 2021)	Descriptive quantitative analysis across time	n.a.	Summative Evaluation 2022
		Reported health status *Note: Goal 2's research question 3.1 also includes this outcome measure*	BRFSS (2015 – 2018)	Descriptive quantitative analysis	n.a.	Summative Evaluation 2022
H.4 – HIP members will report satisfaction with health care access.	**Primary RQ 4.1 –** What percentage of HIP members report getting health care as soon as needed?	Proportion of members reporting that they access care as soon as needed *Note: Survey length constraints will determine how many questions might be asked to determine access by type of service*	Longitudinal Member Survey (2020, 2021)	Descriptive quantitative analysis across time by type of care	n.a.	Summative Evaluation 2022

[46] The evaluator anticipates using place of service and revenue code to identify emergency department visits.

Hypothesis	Research Question	Outcome Measure(s)	Data Sources	Analytic Approach	Comparison Strategy	Reporting Schedule
H.4, continued	**Primary RQ 4.2** – To what extent do HIP members receive coverage through Fast Track and presumptive eligibility policies?	Proportion of members receiving coverage under Fast Track and presumptive eligibility policies, by ranges of months	Enrollment data (2017-2020)	Descriptive quantitative analysis by number of months	n.a.	Interim Evaluation 2019 Summative Evaluation 2022

Hypothesis	Research Question	Outcome Measure(s)	Data Sources	Analytic Approach	Comparison Strategy	Reporting Schedule
H.5 – The Indiana Medicaid enrollment rate will be comparable to other Medicaid expansion states.	**Primary RQ 5.1 –** How does the Indiana Medicaid coverage rate compare to other Medicaid expansion states?	Proportion of eligible population enrolled in Medicaid	IPUMS ACS data, variables HINSCAID, HCOVANY and HINSCARE (2011-2020)	Difference in differences regression model of eligible population enrolling in Medicaid	Low-income Indiana adults (19-64) enrolled in/eligible for Medicaid from 2016/2017 and 2019/2020 compared to similar adults enrolled in/eligible for Medicaid during the same time period in Medicaid expansion states (27) and states with a Medicaid expansion (17). The evaluator will assess use of the Medicaid-enrolled versus the Medicaid-eligible population prior to deciding which population to use.	Summative Evaluation 2022

Goal 2: Increase community engagement leading to sustainable employment and improved health outcomes among HIP members

Exhibit F.2: Goal 2, Hypothesis 1[47,48,49]

Hypothesis	Research Question	Outcome Measure(s)	Data Sources	Analytic Approach	Comparison Strategy	Reporting Schedule
H.1 – Medicaid beneficiaries subject to community engagement requirements will have higher employment levels than Medicaid beneficiaries not subject to the requirements.	**Primary RQ 1.1 –** Are HIP members subject to community engagement requirements more likely than other similar Medicaid beneficiaries not subject to these requirements to be employed?[50]	• Probability of being employed	IPUMS ACS data, variable EMPSTAT (2015-2020)	• ITS analysis of employment among likely eligible population in Indiana	n.a.	Summative Evaluation 2022

[47] This hypothesis in the CMS guidance included "[…] including work in subsidized, unsubsidized […] settings." This phase is not included because while the data sources to be used may include this type of employment, the available variables do not provide this level of specificity.

[48] This table excludes CMS guidance question 1.1c (characteristics of jobs gained) because of limitations in the length of the forthcoming Member Survey.

[49] For the evaluation, outcome measures will include time frame component, for example, the proportion of members using primary care within a 6-month period or enrollment in disease management within 12 month. The exact definition of the measures will be included in the Interim and Summative report.

[50] This research question in the CMS guidance included "[…] including new and sustained employment." This phrase is not included because available ACS data will not allow this level of specificity.

Hypothesis	Research Question	Outcome Measure(s)	Data Sources	Analytic Approach	Comparison Strategy	Reporting Schedule
H.1, continued	**Primary RQ 1.1, continued**	• Probability of being employed	IPUMS ACS data, variable EMPSTAT (2015-2020)	• Difference-in-differences regression model of employment among the likely eligible population	Low-income Indiana adults (19-64) enrolled in Medicaid from 2017/2018 and 2019/2020 compared to similar adults enrolled in Medicaid during same times in select other states without a community engagement requirement	Summative Evaluation 2022

Hypothesis	Research Question	Outcome Measure(s)	Data Sources	Analytic Approach	Comparison Strategy	Reporting Schedule
H.1, continued	**Subsidiary RQ 1.1a –** Do HIP members who initially participate in qualifying activities other than employment gain employment within 6 months or one year (i.e., is there evidence of job-readiness progression)?[51]	• Proportion of members employed at 6 months and 1 year • Proportion employed at least 20 hours per week at 1 year[52] *Note: Outcome measures used may require adjustment depending on program administrative data received.*	Program administrative data (2019-2020)	Descriptive analysis of employment status at 6 months and 1 year among those who initially met requirements through non-employment activities	n.a.	Summative Evaluation 2022[53]
		• Proportion of members meeting community engagement requirement by activity (e.g., employment, education, volunteer work) by year	• Monthly program administrative data (2019-2020) • Community engagement monitoring metrics (2019-2020)	Descriptive analysis of changes in qualifying community engagement activities[54]	n.a.	Summative Evaluation 2022

[51] Indiana does not require beneficiary reporting until July 2019. As such, the timeframe for evaluation of this research question will be less than two years.

[52] Indiana is phasing in the number of hours required, with 20 hours of activity not required until July 2020. This phase-in limits the evaluation of the 20 hours/week requirement.

[53] Data for these time intervals will not be available for the Interim Report because Indiana will not require beneficiary reporting until July 2019. However, it is expected that information on initial reporting will be available for Interim Report (see Implementation Research Questions).

[54] While CMS' guidance indicates a quarterly timeframe for this analysis, this analysis is only possible with an annual look-back. Indiana will assess beneficiary compliance with community engagement requirements on an annual basis, specifically in December of each year.

Hypothesis	Research Question	Outcome Measure(s)	Data Sources	Analytic Approach	Comparison Strategy	Reporting Schedule
H.1, continued	**Subsidiary RQ 1.1b –** Is employment among individuals subject to community engagement requirements sustained over time, including after separating from Medicaid?[55]	Proportion of members employed continuously since application of requirements (i.e., has gained employment and kept it as reported at survey time 1 and/or 2)[56]	• Longitudinal Member Survey (2020, 2021) • Community Engagement Leaver Survey (2021)	Descriptive analysis of sustained employment for those who are employed following application of requirements *Note: The definition of sustained employment will include keeping the same job or sustaining employment with a number of jobs.*	n.a.	Summative Evaluation 2022

[55] This question in the CMS guidance included "[…] over time, for example a year or more […]." This phrase is not included here because the timeframe will depend on (1) the timing at which a member gained employment and (2) the data source to be used to assess duration of employment.

[56] The CMS guidance also includes probability of employment spell lasting a certain amount of time and average length of continuous employment as outcome measures. These measures are included below using program administrative data but have been excluded here because the brief nature of the member survey may not permit detailed questioning beyond point-in-time employment.

Hypothesis	Research Question	Outcome Measure(s)	Data Sources	Analytic Approach	Comparison Strategy	Reporting Schedule
H.1, continued	**Subsidiary RQ 1.1b, continued**	Proportion of members employed continuously since application of requirements (i.e., has gained employment and kept it at the time of compliance determination at end of year) Probability of an employment spell lasting 3 months (6 months, 1 year) since application of requirements Average length of continuous employment since application of requirements *Note: Community engagement is self-reported and members can report at end of year or any other time. Data might not be available to analyze continuous enrollment by time. Outcome measures might be revised based on data constraints.*	Program administrative data (2019, 2020)	Descriptive analysis of sustained employment for those who are employed following application of requirements and remain enrolled in Medicaid Comparison of regression-adjusted means in employment 1-year post-enrollment among: 1) those who were already employed 2) those who gained employment in the first 6 months 3) those who did not gain employment in first 6 months[57]	n.a.	Summative Evaluation 2022

Hypothesis	Research Question	Outcome Measure(s)	Data Sources	Analytic Approach	Comparison Strategy	Reporting Schedule
H.1, continued	**Primary RQ 1.2 –** Is being subject to community engagement requirements associated with increases in educational level?[58]	Highest grade attained (e.g., high school education or some college)	IPUMS ACS data, variable EDUC (2015-2020)	ITS analysis of education outcomes among the likely eligible population in Indiana	n.a.[59]	Summative Evaluation 2022
				Difference-in-differences regression model of education outcomes among the likely eligible population	Low-income Indiana adults (19-64) enrolled in Medicaid from 2016/2017 and 2019/2020[60] compared to similar adults enrolled in Medicaid during same times in select other states without a community engagement requirement	Summative Evaluation 2022

[57] CMS guidance also includes two years post-enrollment. This timeframe is not included because reporting requirements do not take effect until July 2019, which limits the ability to assess employment over the full two CYs of 2019 and 2020.

[58] The original question in CMS Guidance has been modified to be specific to educational level versus a specific educational achievement, reflecting the definition of IPUMS ACS' "EDUC" variable. The original question was "Is being subject to community engagement requirements associated with changes in education outcomes (either positive or negative), such as achievement of diplomas and certifications?" Outcome measures have been revised accordingly.

[59] This research question in the CMS guidance included "[…] including new and sustained employment." This phrase is not included because available ACS data will not allow this level of specificity.

[60] The community engagement requirement took effect in 2019. The pre-period excludes 2018 because Indiana initiated other program changes in 2018 under its waiver.

Exhibit F.3: Goal 2, Hypothesis 2[61]

Hypothesis	Research Question	Outcome Measure(s)	Data Sources	Analytic Approach	Comparison Strategy	Reporting Schedule
H.2 – Community engagement requirements will increase the average income of Medicaid beneficiaries subject to the requirements compared to Medicaid beneficiaries not subject to the requirements.	**Primary RQ 2.1 –** Do community engagement requirements increase income?[62]	Income	IPUMS ACS variables INCTOT and INCWAGE (2015-2020)	ITS analysis of income among the likely eligible population in Indiana	n.a.[63]	Summative Evaluation 2022
				Difference-in-differences regression model of income among the likely eligible population	Low-income Indiana adults (19-64) enrolled in Medicaid from 2016/2017 and 2019/2020[64] compared to similar adults enrolled in Medicaid during same times in select other states without a community engagement requirement	Summative Evaluation 2022
		Income, continued	Enrollment data (2015-2020)	Descriptive analysis of change in income among members who remain enrolled in Medicaid, with breakdowns by members exempt from community engagement requirements and members that are not exempt	n.a.	Summative Evaluation 2022

[61] For the evaluation, outcome measures will include time frame component, for example, the proportion of members using primary care within a 6-month period or enrollment in disease management within 12 month. The exact definition of the measures will be included in the Interim and Summative report.

[62] There are limitations in the ability to attribute impact to the community engagement requirements due to other policy changes that have occurred at a similar time. See Section D, Methodological Limitations, of the Evaluation Plan.

[63] This research question in the CMS guidance included "[…] including new and sustained employment." This phrase is not included because available ACS data will not allow this level of specificity.

[64] The community engagement requirement took effect in 2019. The pre-period excludes 2018 because Indiana initiated other program changes in 2018 under the waiver renewal.

Hypothesis	Research Question	Outcome Measure(s)	Data Sources	Analytic Approach	Comparison Strategy	Reporting Schedule
H.2, continued	**Subsidiary RQ 2.1a** – Do community engagement requirements change income from public assistance programs?[65]	Income from public assistance programs	IPUMS ACS variables INCWELFR (2015-2020)	ITS analysis of income receipt from public assistance among the likely eligible population	n.a.[66]	Summative Evaluation 2022
				Difference-in-differences regression model of income receipt from public assistance among the likely eligible population	Low-income Indiana adults (19-64) enrolled in Medicaid from 2016/2017 and 2019/2020[67] compared to similar adults enrolled in Medicaid during same times in select other states without a community engagement requirement	Summative Evaluation 2022
	Subsidiary RQ 2.1b – Are changes in income sustained over time, including after separating from Medicaid?[68]	Proportion of members who report higher or lower income	• Enrollment data • All Leaver Surveys (Community Engagement, non-payment of POWER Account Contribution, increase in income) (2021)	Descriptive analysis of sustained income changes over time, by data source	n.a.	Summative Evaluation 2022

[65] The original CMS question is slightly modified since the available ACS variable measure (INCWELFR) is specific to public assistance income. There are also limitations in the ability to attribute impact to the community engagement requirements due to other policy changes that have occurred at a similar time. See Section D, Methodological Limitations, of the Evaluation Plan.

[66] This research question in the CMS guidance included "[…] including new and sustained employment." This phrase is not included because available ACS data will not allow this level of specificity.

[67] The community engagement requirement took effect in 2019. The pre-period excludes 2018 because Indiana initiated other program changes in 2018 under the waiver renewal.

[68] This question in the CMS guidance included "[…] over time, for example a year or more […]." This phrase is not included here because the timeframe will depend on (1) the timing at which a member's income changes and (2) the data source to be used to assess duration of changed income.

Hypothesis	Research Question	Outcome Measure(s)	Data Sources	Analytic Approach	Comparison Strategy	Reporting Schedule
H.2, continued	**Subsidiary RQ 2.1b, continued**	Proportion of members with sustained higher income	Enrollment data (2015-2020)	Descriptive analysis of income over time among members subject to requirements and who remain enrolled in Medicaid	n.a.	Summative Evaluation 2022
	Subsidiary RQ 2.1c – To what extent is community engagement associated with an increase in the number of HIP members transitioning off Medicaid because they are no longer income eligible for Medicaid?[69]	Probability of disenrollment due to income	Monthly disenrollment data (2019 and 2020) – note this data does not indicate whose income changed in the household	Comparison of regression-adjusted disenrollment rates among: • Members meeting community engagement requirement through employment • Members meeting community engagement requirement through other activities • Exempt members	n.a.	Summative Evaluation 2022

[69] This question in the CMS guidance was phrased "[…] income increases resulting from […]." This question has been revised because multiple program changes have occurred along with the implementation of community engagement requirements, creating limitations in the ability to attribute impact to the community engagement requirements.

Hypothesis	Research Question	Outcome Measure(s)	Data Sources	Analytic Approach	Comparison Strategy	Reporting Schedule
H.2., continued	**Subsidiary RQ 2.1d –** To what extent is community engagement associated with households transitioning off other public programs like SNAP or TANF?[70]	Probability of receiving income from public assistance programs	IPUMS ACS variable INCWELFR (2015-2020)	Regression model of income receipt from public assistance among the likely eligible population	n.a.[71]	Summative Evaluation 2022
				Difference-in-differences regression model of income receipt from public assistance among the likely eligible population	Low-income Indiana adults (19-64) enrolled in Medicaid from 2016/2017 and 2019/2020[72] compared to similar adults enrolled in Medicaid during same times in select other states without a community engagement requirement	Summative Evaluation 2022

[70] This question in the CMS guidance was phrased "[…] income increases resulting from […]." This question has been revised because multiple program changes have occurred along with the implementation of community engagement requirements. As such, there are limitations in the ability to attribute impact to the community engagement requirements.

[71] This research question in the CMS guidance included "[…] including new and sustained employment." This phrase is not included because available ACS data will not allow this level of specificity.

[72] The community engagement requirement took effect in 2019. The pre-period excludes 2018 because Indiana initiated other program changes in 2018 under the waiver renewal.

Exhibit F.4: Goal 2, Hypothesis 3[73,74]

Hypothesis	Research Question	Outcome Measure(s)	Data Sources	Analytic Approach	Comparison Strategy	Reporting Schedule
H.3 – Community engagement requirements will improve the health outcomes of current and former Medicaid beneficiaries subject to the requirements, compared to Medicaid beneficiaries not subject to the requirements.	**Primary RQ 3.1 –** Are community engagement requirements associated with improved health outcomes for beneficiaries subject to the requirements? [75]	Reported health status	BRFSS (2015-2018)	ITS analysis of self-reported health status among likely eligible population	n.a.[76]	Summative Evaluation 2022
				Difference-in-differences regression model of self-reported health status among likely eligible population *Note: To be determined based on sample sizes and policy changes in other states.*	Low-income Indiana adults (19-64) likely eligible for Medicaid from 2016/2017 and 2019/2020[77] compared to similar adults during same times in select other states without a community engagement requirement	Summative Evaluation 2022

[73] This is Hypothesis 4 in CMS Guidance. Hypothesis 3 is not included in this Evaluation Plan but Goal 2, RQ 4 assesses whether or not disenrolled individuals have an employer offer and if they have enrolled in employer-based coverage.

[74] For the evaluation, outcome measures will include time frame component, for example, the proportion of members using primary care within a 6-month period or enrollment in disease management within 12 month. The exact definition of the measures will be included in the Interim and Summative report.

[75] This question in the CMS guidance was phrased "[…] lead to […]?" This question has been revised because multiple program changes have occurred along with the implementation of community engagement requirements. As such, there are limitations in the ability to attribute impact to the community engagement requirements.

[76] This research question in the CMS guidance included "[…] including new and sustained employment." This phrase is not included because available ACS data will not allow this level of specificity.

[77] The community engagement requirement took effect in 2019. The pre-period excludes 2018 because Indiana initiated other program changes in 2018 under the waiver renewal.

Hypothesis	Research Question	Outcome Measure(s)	Data Sources	Analytic Approach	Comparison Strategy	Reporting Schedule
H.3, continued	**Subsidiary RQ 3.1a –** What are the trajectories of HIP member health status over time, including after separation from Medicaid?	Reported health status	Longitudinal Member Survey (2020, 2021), which will follow members over time and will include individuals who are no longer eligible for Medicaid	Descriptive analysis of health status over time among members who are required to report activities. *Note: Availability of data for members who have separated from Medicaid is dependent on the response in the 2021 Longitudinal Member Survey.*	n.a.	Summative Evaluation 2022
	Subsidiary RQ 3.1b – Is disenrollment for noncompliance with community engagement requirements associated with differences in health outcomes?	Reported health status	Longitudinal Member Survey (2020, 2021), which will follow members over time and will include individuals who are no longer eligible for Medicaid	Descriptive analyses of self-reported health status (and regression-adjusted means as viable) among members initially subject to requirement who were disenrolled for noncompliance[78]	Members initially subject to requirement who remain enrolled Members initially subject to requirement who are disenrolled for other reasons	Summative Evaluation 2022

[78] The evaluator will perform the regression analysis as sample size permits.

Hypothesis	Research Question	Outcome Measure(s)	Data Sources	Analytic Approach	Comparison Strategy	Reporting Schedule
H.4 – HIP policies including community engagement and required payment policies increase the likelihood that Medicaid beneficiaries transition to commercial health insurance after separating from Medicaid, compared to Medicaid beneficiaries not subject to the requirements.	**Primary RQ 4.1 –** What are the coverage outcomes of individuals who separate from HIP, by separation reason?	Proportion of previous HIP members with employer-sponsored insurance (ESI), Marketplace coverage, and no coverage.	• All Leaver Surveys (Community Engagement, non-payment of POWER Account Contribution, increase in income) (2021) • Longitudinal Member Survey (2021)	Descriptive analysis of sources of coverage for previous members, by disenrollment reason and survey source (cannot combine results from longitudinal survey and the Leaver Surveys)	n.a.	Summative Evaluation 2022

Exhibit F.5: Goal 2, Implementation Research Questions[79]

Hypothesis	Research Question	Outcome Measure(s)	Data Sources	Analytic Approach	Comparison Strategy	Reporting Schedule
n.a.	**Primary RQ 5 –** To what extent do individuals subject to community engagement requirements who become ineligible for Medicaid due to an increase in income obtain health insurance coverage?[80]	• Proportion of members disenrolled who received offer of ESI • Proportion of members disenrolled who have enrolled in commercial coverage, including ESI and individual market/Marketplace plans	• All Leaver Surveys (Community Engagement, non-payment of POWER Account Contribution, income) (2021) • Longitudinal Member Survey (2020, 2021), which will follow members over time and will include individuals who are no longer eligible for Medicaid	Descriptive quantitative analysis of health insurance coverage changes among disenrolled members	n.a.	Summative Evaluation 2022
	Primary RQ 6 – What is the distribution of activities HIP members engage in to meet community engagement requirements?	Number/proportion of members reporting each qualifying activity, by year	Monthly program administrative data (2019-2020)	Descriptive quantitative analysis of qualifying activities	n.a.	Interim Evaluation 2019 Summative Evaluation 2022

[79] For the evaluation, outcome measures will include time frame component, for example, the proportion of members using primary care within a 6-month period or enrollment in disease management within 12 month. The exact definition of the measures will be included in the Interim and Summative report.

[80] This question was not included in Table 2 of CMS guidance ("Suggested measures, data sources, and analytic approaches for implementation research questions") but has been added to provide context around employer-sponsored insurance (ESI).

Hypothesis	Research Question	Outcome Measure(s)	Data Sources	Analytic Approach	Comparison Strategy	Reporting Schedule
n.a.	**Subsidiary RQ 6a –** How do activity patterns change over time?	Number/proportion of members reporting each qualifying activity, by year	Monthly program administrative data (2019-2020)	Descriptive quantitative analysis of monthly or quarterly trends of qualifying activities (Interim and Summative Report, respectively)	n.a.	Interim Evaluation 2019 Summative Evaluation 2022
	Primary RQ 7 – Do HIP members subject to community engagement requirements understand the requirements, including how to satisfy them and the consequences of noncompliance?	Themes related to understanding of requirements	• Key informant interviews with State staff, providers, MCE and members (2019, 2020, 2021)	Descriptive qualitative analysis of member knowledge of community engagement requirements and consequences of non-compliance	n.a.	Interim Evaluation 2019 Summative Evaluation 2022

Hypothesis	Research Question	Outcome Measure(s)	Data Sources	Analytic Approach	Comparison Strategy	Reporting Schedule
n.a.	**Primary RQ 7, continued**	Proportion of members aware of current community engagement reporting requirements	• Longitudinal Member Survey (2020, 2021)	Descriptive quantitative analysis of member knowledge of community engagement requirements and consequences of non-compliance among members required to report activities – across time	n.a.	Summative Evaluation 2022
	Primary RQ 8 – What are common barriers to compliance with community engagement requirements?	Themes related to barriers to compliance	Key informant interviews with State staff, providers, MCE staff, and members (2019, 2020, 2021)	Descriptive qualitative analysis of barriers to compliance with community engagement	n.a.	Interim Evaluation 2019
	Primary RQ 8, continued	Proportion of members reporting barriers to compliance	• Community Engagement Leaver Survey (2021) • Longitudinal Member Survey (2020, 2021)	Descriptive quantitative analysis of barriers to compliance with community engagement among those required to report activities	n.a.	Summative Evaluation 2022

Hypothesis	Research Question	Outcome Measure(s)	Data Sources	Analytic Approach	Comparison Strategy	Reporting Schedule
n.a.	**Primary RQ 9 –** Do HIP members subject to community engagement requirements report that they received supports needed to participate, such as links to volunteer opportunities or job and education resources?[81]	Themes regarding supports that are provided or arranged by MCEs	• Key informant interviews with members (2020, 2021)	Descriptive quantitative analysis of supports received to support compliance with community engagement among members required to report activities	n.a.	Summative Evaluation 2022

[81] The examples of supports have been revised from the CMS guidance to reflect supports to be provided in Indiana.

Hypothesis	Research Question	Outcome Measure(s)	Data Sources	Analytic Approach	Comparison Strategy	Reporting Schedule
n.a.	**Primary RQ 10 –** What is the distribution of HIP members who are exempt, meeting the requirement through current work at 20 hours a week or more, or required to report qualified activities to maintain status? What is the distribution of exemption types and sources?[82]	• Number/proportion of members with exemption during year by exemption type • Number/proportion of members meeting requirement through current work (20 hours/week) during year • Number/proportion of members required to report activities during year	Monthly program administrative data (2019, 2020)	Descriptive quantitative analysis	n.a.	Interim Evaluation 2019 Summative Evaluation 2022
	Subsidiary RQ 10a – What strategies has the State pursued to reduce HIP member reporting burden, such as matching to State or MCE databases?	State strategies for reducing reporting burden	Interviews with State Medicaid and MCE staff (2019, 2020, 2021)	Descriptive qualitative analysis	n.a.	Interim Evaluation 2019 Summative Evaluation 2022

[82] This question in the CMS guidance was phrased "How many beneficiaries are required to actively report their status, including exemptions, good cause circumstances, and qualifying activities?" This question is revised to reflect the program administrative data to be available; data are available to identify members that have received good cause exemptions.

Hypothesis	Research Question	Outcome Measure(s)	Data Sources	Analytic Approach	Comparison Strategy	Reporting Schedule
n.a.	**Primary RQ 11 –** What is the distribution of reasons for disenrollment among HIP members?	Number/proportion of members disenrolled for noncompliance, for being over-income, or other reasons, by year	Monthly program administrative data (2019, 2020)	Descriptive quantitative analysis of disenrollment among members required to report activities	n.a.	Interim Report 2019 (disenrollment for reasons other than non-compliance with community engagement activities) [83] Summative Evaluation 2022
	Primary RQ 12 – Are HIP members who are disenrolled for noncompliance with community engagement requirements more or less likely to re-enroll than members who disenroll for other reasons?	Probability of re-enrolling in Medicaid after a gap in coverage of at least 1 month (3 months)	Monthly program administrative data (2019, 2020)	Comparison of regression-adjusted probability of re-enrollment among members initially subject to the community engagement requirement who were: 1) disenrolled for noncompliance 2) disenrolled for reasons other than noncompliance	n.a.	Summative Evaluation 2022

[83] Because Indiana will not be assessing compliance with community engagement requirements until December 2019, data on this reason for disenrollment will not be available for the Interim Report.

Goal 3: Reduce tobacco use among HIP members, through a premium surcharge and the utilization of tobacco cessation benefits

Exhibit F.6: Goal 3[84]

Hypothesis	Research Question	Outcome Measure(s)	Data Sources	Analytic Approach	Comparison Strategy	Reporting Schedule
H.1 – The tobacco premium surcharge will increase use of tobacco cessation services among HIP members.	**Primary RQ 1.1 –** What impact has the tobacco premium surcharge had on the use of tobacco cessation benefits for HIP members?	Proportion of members using tobacco cessation services by year	Longitudinal Member Survey (2020, 2021)	Descriptive quantitative analysis	n.a.	Summative Evaluation 2022
			Claims data (2015-2020)	ITS analysis of tobacco cessation services among likely eligible population in Indiana	n.a.[85]	Summative Evaluation 2022

[84] For the evaluation, outcome measures will include time frame component, for example, the proportion of members using primary care within a 6-month period or enrollment in disease management within 12 month. The exact definition of the measures will be included in the Interim and Summative report.

[85] CMS's guidance outlined several possible within-state comparison groups, which are not possible for this evaluation due to specific aspects of Indiana HIP. HIP does not involve random assignment to the tobacco surcharge, and Indiana has not staged implementation based on beneficiary characteristics. For these reasons, this Evaluation Plan focuses on an interrupted time series analysis of outcomes within Indiana.

Hypothesis	Research Question	Outcome Measure(s)	Data Sources	Analytic Approach	Comparison Strategy	Reporting Schedule
H.1, continued	**Subsidiary RQ 1.1a –** Do HIP members understand the premium surcharge policy?	Themes related to member knowledge of surcharge	Key informant interviews with members (2019, 2020)	Descriptive qualitative analysis	n.a.	Interim Evaluation 2019
		Proportion of members who are tobacco users and report knowledge of the premium surcharge	Longitudinal Member Survey (2020, 2021)	Descriptive quantitative analysis on proportion of tobacco users reporting knowledge of premium surcharge.	n.a.	Summative Evaluation 2022
	Subsidiary RQ 1.1b – Do HIP members know about the cessation services offered through HIP?	Themes related to member knowledge of cessation services offered through HIP	Key informant interviews with members (2019, 2020)	Descriptive qualitative analysis	n.a.	Interim Evaluation 2019 Summative Evaluation 2022
		Proportion of members who are tobacco users and report knowledge of cessation services offered through HIP	Longitudinal Member Survey (2020, 2021)	Descriptive quantitative analysis	n.a.	Summative Evaluation 2022

Hypothesis	Research Question	Outcome Measure(s)	Data Sources	Analytic Approach	Comparison Strategy	Reporting Schedule
H.1, continued	**Subsidiary RQ 1.1c –** Are HIP members satisfied with tobacco cessation services?	Themes related to satisfaction with tobacco cessation services	Key informant interviews with members, providers, MCEs and State officials (2019, 2020 and 2021)	Descriptive qualitative analysis	n.a.	Interim Evaluation 2019 Summative Evaluation 2022
		Themes related to reasons for nonparticipation in cessation services	Key informant interviews with members, providers, MCEs, and State officials (2019, 2020, 2021)	Descriptive qualitative analysis	n.a.	Interim Evaluation 2019 Summative Evaluation 2022
H.2 – The tobacco premium surcharge and availability of tobacco cessation benefits will decrease tobacco use.	**Primary RQ 2.1 –** Has tobacco use decreased among the target population?	Proportion of members using tobacco by year	• Longitudinal Member Survey (2020, 2021) • State administrative data (2018-2020)	Quantitative descriptive analyses of proportion of respondents identifying as using tobacco across time. *Note: The ability to perform analyses across time based on the member survey is dependent on response during the 2021 Longitudinal Member Survey*	n.a.	Summative Evaluation 2022

Goal 4: Promote member understanding and increase compliance with payment requirements by changing the monthly POWER Account payment requirement to a tiered structure

Exhibit F.7: Goal 4[86,87,88]

Hypothesis	Research Question	Outcome Measure(s)	Data Sources	Analytic Approach	Comparison Strategy	Reporting Schedule
H.1 – HIP's new income tier structure for POWER Account Contributions will be clear to HIP members.[89]	**Primary RQ 1.1 –** Do HIP members with POWER account payment requirements understand their payment obligations?[90] *Note: Goal 5, H.1, RQ 1.2 also addresses this question.*	Themes regarding member understanding of payment obligations	Key informant interviews with members, providers, MCEs, and State officials (2019, 2020, 2021)	Descriptive qualitative analysis	n.a.	Interim Evaluation 2019 Summative Evaluation 2022

[86] To evaluate HIP's new tiered POWER account payment structure, CMS's evaluation guidance for premium and account payments has been consulted. Some of CMS's hypotheses and research questions within this guidance have been excluded or reworded because they pertain to impact of premium accounts in general and not to Indiana's new tiered structure, which involves multiple payment amounts. CMS items that have been excluded for this reason are research questions 3.1 and 3.2. Items that have been retained but reworded are noted in this document.

[87] For the purposes of this goal, Indiana has operationalized efficient use of health care services as continuity in coverage. For this reason, Hypothesis 2 and affiliated research questions from CMS's guidance is not included. However, Indiana's Goal 1 includes an analysis of health care utilization under the HIP program.

[88] For the evaluation, outcome measures will include time frame component, for example, the proportion of members using primary care within a 6-month period or enrollment in disease management within 12 month. The exact definition of the measures will be included in the Interim and Summative report.

[89] This hypothesis differs from Hypothesis 1 in CMS's evaluation guidance for premiums and account payments, which states "Beneficiaries who are required to make premium payments, including beneficiary account contributions, will gain familiarity with a common feature of commercial health insurance." This change more closely aligns the hypothesis with Indiana's stated goal and with the research questions included to address this hypothesis.

[90] CMS's research question 1.1 ("Do beneficiaries with premium or beneficiary account payment requirements understand their payment obligations?") has been reworded slightly to reflect the Indiana policy.

Hypothesis	Research Question	Outcome Measure(s)	Data Sources	Analytic Approach	Comparison Strategy	Reporting Schedule
H.1, continued	**Primary RQ 1.1, continued**	Proportion of members who are knowledgeable of payment obligations	Longitudinal Member Survey (2020, 2021)	Descriptive quantitative analysis (across time) *Note: The ability to perform analyses across time is dependent on response during the 2021 Longitudinal Member Survey*	n.a.	Summative Evaluation 2022
	Primary RQ 1.2 – Do HIP members with POWER account payment requirements who initiate payments continue to make regular payments throughout their 12-month enrollment period?[91]	• Proportion of members with payment obligations who make a contribution before end of grace period by year • Proportion of members with payment obligations who are disenrolled due to non-payment by year[92] • Proportion of members that moved from HIP Plus to HIP Basic due to nonpayment by year	Enrollment data (2015-2020)	Descriptive quantitative analysis	n.a.	Interim Evaluation 2019 Summative Evaluation 2022

[91] CMS's research question 1.2 ("Do beneficiaries with premium or beneficiary account obligations who initiate payments continue to make regular payments throughout their 12-month enrollment periods?") has been reworded slightly to reflect the Indiana policy.

[92] Disenrollment reason 001 is "Nonpayment of Initial POWER Account Contribution (PAC) (i.e., never fully enrolled in HIP Plus)." Disenrollment reason 002 is "Nonpayment of PAC (i.e., disenrolled from HIP Plus WITH 6 month lockout)." Disenrollment reason 003 is "Increased Income + Nonpayment of PAC (i.e., disenrolled from HIP Basic WITHOUT 6 month lockout).

Exhibit F.8: Goal 4, Hypothesis 2[93]

Hypothesis	Research Question	Outcome Measure(s)	Data Sources	Analytic Approach	Comparison Strategy	Reporting Schedule
H.2 – Enrollment and enrollment continuity will vary for the POWER Account payment tiers.[94]	**Primary RQ 2.1 –** Is there a relationship between POWER Account payment tiers and total and new enrollment in Medicaid?[95]	Reported enrollment in Medicaid among the likely eligible population (take-up)	IPUMS ACS, variable HINSCAID (2015-2020)	Descriptive analysis by income level[96]	n.a.	Summative Evaluation 2022
			IPUMS ACS, variable HINSCAID (2017-2020)[97]	Regression model of-Medicaid enrollment with pre/post indicator[98]	n.a.[99]	Summative Evaluation 2022
		• Number of individuals enrolled in Medicaid annually • Number of new enrollees in Medicaid annually	Enrollment data (2015-2020)	Descriptive analysis of enrollment	n.a.	Interim Evaluation 2019 Summative Evaluation 2022

[93] For the evaluation, outcome measures will include time frame component, for example, the proportion of members using primary care within a 6-month period or enrollment in disease management within 12 month. The exact definition of the measures will be included in the Interim and Summative report.

[94] This hypothesis in the CMS guidance was phrased "Premium requirements, including beneficiary account contributions, will reduce the likelihood of enrollment and enrollment continuity." This hypothesis has been revised to focus on the new POWER account tiered structure. In addition, multiple program changes have occurred along with the implementation of the tiered structure and there are limitations in the ability to attribute impact to the change in beneficiary account payment amount.

[95] This question is research question 3.3 in the CMS guidance for premiums and account payments. It has been reworded slightly to reflect the Indiana policy.

[96] Initial analyses of the data indicate sufficient sample size by income level within Indiana.

[97] This analysis will leverage data from 2015 to 2020 for Medicaid uptake. Enrollment in 2019 and onwards can be impacted by other policy changes that have taken/will take effect in 2019 and 2020.

[98] Evaluator will explore the appropriateness of the model based on the ability to control for differences in beneficiary characteristics between the two years. If resources permit, the evaluator will also explore the combined use of ACS and enrollment data to examine take-up rate on a monthly basis using a regression discontinuity design to examine results at different tier cutoffs in income.

[99] CMS's guidance outlined several possible within-state comparison groups, which are not possible for this evaluation due to specific aspects of Indiana HIP. Indiana has not staged implementation of the tiered payment structure based on beneficiary characteristics. For this reason, this Evaluation Plan focuses on alternative analyses of outcomes within Indiana.

Hypothesis	Research Question	Outcome Measure(s)	Data Sources	Analytic Approach	Comparison Strategy	Reporting Schedule
H.2, continued	**Primary RQ 2.2 –** Is there a relationship between POWER Account payment tiers and continued enrollment in Medicaid?[100]	Probability of disenrollment due to non-payment[101]	Enrollment data (2015-2020)	Descriptive quantitative analysis of disenrollment	n.a.	Interim Evaluation 2019 Summative Evaluation 2022
			Enrollment data (2015-2020)[102]	Regression model of-outcome with pre/post indicator[103]	n.a.[104]	Interim Evaluation 2019 Summative Evaluation 2022
		Probability of moving from HIP Plus to Basic	Enrollment data (2015-2020)	Descriptive analysis of movement to Basic	n.a.	Interim Evaluation 2019 Summative Evaluation 2022
			Enrollment data (2015-2020)[105]	Regression model of-outcome with pre/post indicator[106]	n.a.[107]	Interim Evaluation 2019 Summative Evaluation 2022

[100] This question is research question 3.4 in the CMS guidance for premiums and account payments: "Is there a relationship between payment amounts and continued enrollment in Medicaid, as reflected by mid-year disenrollments and renewal decisions?" It has been reworded to reflect the Indiana policy and the outcomes identified.

[101] Disenrollment reason 001 is "Nonpayment of Initial PAC (i.e., never fully enrolled in HIP Plus)." Disenrollment reason 002 is "Nonpayment of PAC (i.e., disenrolled from HIP Plus WITH 6 month lockout)." Disenrollment reason 003 is "Increased Income + Nonpayment of PAC (i.e., disenrolled from HIP Basic WITHOUT 6 month lockout).

[102] This analysis will leverage available data (2015 – 2020) to account for trend in disenrollment across time, even prior to 2018 implementation of POWER Account tiered payment, due to other policy or program changes.

[103] Prior to implementing these analyses, comparability in samples between the two periods will be assessed. Evaluator will explore the appropriateness of the model based on the ability to control for differences in beneficiary characteristics between the two years.

[104] CMS's guidance outlined several possible within-state comparison groups, which are not possible for this evaluation due to specific aspects of Indiana HIP. Indiana has not staged implementation of the tiered payment structure based on beneficiary characteristics. For this reason, this Evaluation Plan focuses on alternative analyses of outcomes within Indiana.

[105] This analysis will leverage available data (2015 – 2020) to account for trend in disenrollment across time, even prior to 2018 implementation of POWER Account tiered payment, due to other policy or program changes.

[106] Prior to implementing these analyses, the evaluator will assess comparability in samples between the two periods. Evaluator will explore the appropriateness of the model based on the ability to control for differences in beneficiary characteristics between the two years.

[107] CMS's guidance outlined several possible within-state comparison groups, which are not possible for this evaluation due to specific aspects of Indiana HIP. Indiana has not staged implementation of the tiered payment structure based on beneficiary characteristics. For this reason, this Evaluation Plan focuses on alternative analyses of outcomes within Indiana.

Hypothesis	Research Question	Outcome Measure(s)	Data Sources	Analytic Approach	Comparison Strategy	Reporting Schedule
H.2, continued	**Primary RQ 2.2, continued**	Probability of moving from HIP Basic to Plus	Enrollment data (2015-2020)	Descriptive analysis of movement to Plus	n.a.	Interim Evaluation 2019 Summative Evaluation 2022
			Enrollment data (2015-2020)[108]	Regression model of-outcome with pre/post indicator[109]	n.a.[110]	Interim Evaluation 2019 Summative Evaluation 2022
		Number of months with Medicaid coverage during year	Enrollment data (2015-2020)	Descriptive analysis of coverage months	n.a.	Interim Evaluation 2019 Summative Evaluation 2022
			Enrollment data (2015-2018)[111]	Regression model of-outcome with pre/post indicator[112]	n.a.[113]	Summative Evaluation 2022

[108] This analysis will leverage available data (2015 – 2020) to account for trend in disenrollment across time, even prior to 2018 implementation of POWER Account tiered payment, due to other policy or program changes.

[109] Prior to implementing these analyses, the evaluator will assess comparability in samples between the two periods. Evaluator will explore the appropriateness of the model based on the ability to control for differences in beneficiary characteristics between the two years.

[110] CMS's guidance outlined several possible within-state comparison groups, which are not possible for this evaluation due to specific aspects of Indiana HIP. Indiana has not staged implementation of the tiered payment structure based on beneficiary characteristics. For this reason, this Evaluation Plan focuses on alternative analyses of outcomes within Indiana.

[111] This analysis will leverage available data (2015 – 2020) to account for trend in disenrollment across time, even prior to 2018 implementation of POWER Account tiered payment, due to other policy or program changes.

[112] Prior to implementing these analyses, the evaluator will assess comparability in samples between the two periods. The evaluator will explore the appropriateness of the model based on the ability to control for differences in beneficiary characteristics between the two years.

[113] CMS's guidance outlined several possible within-state comparison groups, which are not possible for this evaluation due to specific aspects of Indiana HIP. Indiana has not staged implementation of the tiered payment structure based on beneficiary characteristics. For this reason, this Evaluation Plan focuses on alternative analyses of outcomes within Indiana.

Hypothesis	Research Question	Outcome Measure(s)	Data Sources	Analytic Approach	Comparison Strategy	Reporting Schedule
H.2, continued	**Primary RQ 2.3 –** Do HIP members who receive rollover have greater coverage continuity than HIP members who do not receive rollover?[114]	• Number of months with Medicaid coverage • Probability of disenrollment	Enrollment data (2018-2020)	Regression model of outcomes	Members who do not receive rollover	Summative Evaluation 2022

[114] This is a state-specific question that is not included in CMS guidance.

Goal 5: Ensure HIP program policies align with commercial policies, are understood by members, and promote positive member experience and minimize coverage gaps

Exhibit F.9: Goal 5[115,116]

Hypothesis	Research Question	Outcome Measure(s)	Data Sources	Analytic Approach	Comparison Strategy	Reporting Schedule
H.1 – Beneficiaries subject to HIP policies will understand program policies.[117]	**Primary RQ 1.1 –** Are HIP members knowledgeable about policies on payment of POWER Account Contributions, preventive care and rollover?[118]	Proportion of members who are knowledgeable about HIP policies related to payment of POWER Account Contributions Themes related to knowledge of POWER Account Contributions, preventive care and rollover	• Longitudinal Member Survey (2020, 2021) • Program administrative data (2017-2020) • Key informant interview with members (2019, 2020, 2021)	Descriptive quantitative analysis across time	n.a.	Summative Evaluation 2022

[115] Indiana does not have specific goals regarding non-eligibility periods. Furthermore, due to budget constraints and concerns about beneficiary burden, the member survey planned for the evaluation is limited in size, and Indiana has prioritized other topics for this survey. However, for Indiana's Goal 5, CMS' evaluation guidance for non-eligibility periods was reviewed and this Evaluation Plan includes research questions that are applicable to the State's goal that fall within the evaluation scope. Specifically, CMS questions related to beneficiary understanding of and experiences with these policies have been included. The hypotheses and research questions from CMS guidance that have been omitted are Hypothesis 1 (1.1, 1.1c), Hypothesis 2 (2.1, 2.1a-2.1d), and Hypothesis 3 (3.1, 3.1a, 3.1b).

[116] For the evaluation, outcome measures will include time frame component, for example, the proportion of members using primary care within a 6-month period or enrollment in disease management within 12 month. The exact definition of the measures will be included in the Interim and Summative report.

[117] This is a state-specific hypothesis. The research questions included here focus on non-eligibility periods. Goals 2, 3 and 4 address member understanding of and experiences with policies related to the community engagement requirements, the tobacco surcharge, and POWER accounts.

[118] This question takes the place of CMS' premium-related subsidiary research question 2.2b (Do beneficiaries with monthly account payments understand what services result in debits from their accounts and how their service use impacts account balances?).

Hypothesis	Research Question	Outcome Measure(s)	Data Sources	Analytic Approach	Comparison Strategy	Reporting Schedule
H.1, continued	**Primary RQ 1.2 –** Do HIP members subject to non-eligibility periods understand program requirements and how to comply with them? *Note: Goal 4, H.1, RQ 1.1 also addresses this question.*	Reported knowledge of program requirements and how to comply with them	• Member interviews (2019, 2020, 2021) • Longitudinal Member Survey (2020, 2021)	Descriptive quantitative and qualitative analysis (depending on data source)	n.a.	Interim Evaluation 2019 Summative Evaluation 2022
	Primary RQ 1.3 – Do HIP members subject to non-eligibility periods understand the consequence for noncompliance with program requirements?	Reported knowledge of non-eligibility period consequence for noncompliance with program requirements	• Member interviews (2019, 2020, 2021) • Longitudinal Member Survey (2020, 2021)	Descriptive quantitative and qualitative analysis (depending on data source)	n.a.	Interim Evaluation 2019 Summative Evaluation 2022

Hypothesis	Research Question	Outcome Measure(s)	Data Sources	Analytic Approach	Comparison Strategy	Reporting Schedule
H.1, continued	**Primary RQ 1.4 –** What are common barriers to compliance with program requirements that have non-eligibility period consequences for noncompliance?	Reported barriers to complying with program requirements	• Member, MCE and FSSA officials interviews (2019, 2020, 2021)	Descriptive qualitative analysis	n.a.	Interim Evaluation 2019 Summative Evaluation 2022
H.2 – Beneficiaries will be satisfied with the HIP program.[119]	**Primary RQ 2.1 –** What is the level of satisfaction with HIP among HIP members?[120]	Themes related to member satisfaction	• Member, provider, MCE and FSSA officials interviews (2019, 2020 and 2021)	Qualitative descriptive analysis	n.a.	Interim Evaluation 2019 Summative Evaluation 2022
		• Proportion of members having high satisfaction with the program • Proportion of members considering HIP a good value relative to its costs	• Longitudinal Member Survey (2020, 2021) • All Leaver Surveys (Community Engagement, non-payment of POWER Account Contribution, income) (2021)	Descriptive quantitative analysis	n.a.	Summative Evaluation 2022

[119] This is a State-specific hypothesis.
[120] This is a State-specific question.

Hypothesis	Research Question	Outcome Measure(s)	Data Sources	Analytic Approach	Comparison Strategy	Reporting Schedule
H.3 – Individuals subject to the non-eligibility/lockout periods (payment and redetermination) and retroactive eligibility are no different from commercial market populations.[121]	**Primary RQ 3.1** – Do HIP members that are subject to non-eligibility periods have similar demographic characteristics as the commercial market population?	Distribution of demographic characteristics by year such as the following: • Gender • Age • Educational level • Income • Race and ethnicity	IPUMS ACS data, variables SEX, AGE, EDUC, INCTOT, RACE, and HISPAN (2015-2020) Program administrative data (2015-2020)	Descriptive quantitative analysis	Adults ≤138% FPL enrolled in commercial coverage (2015-2020)	Summative Evaluation 2022
	Primary RQ 3.2 – Do HIP members that are not retroactively eligible have similar demographic characteristics as the commercial market population?	Distribution of demographic characteristics by year such as the following: • Gender • Age • Educational level • Income • Race and ethnicity	IPUMS ACS data, variables SEX, AGE, EDUC, INCTOT, RACE, HISPAN (2015-2020) Program administrative data (2015-2020)	Descriptive quantitative analysis	Adults ≤138% FPL enrolled in commercial coverage (2015-2020)	Summative Evaluation 2022

[121] This hypothesis pertains to three distinct HIP populations: 1) members subject to non-payment eligibility periods, 2) members subject to redetermination non-eligibility periods, and 3) individuals who do not receive retroactive eligibility.

Goal 6: Assess the costs to implement and operate HIP and other non-cost outcomes of the demonstration

Exhibit F.10: Goal 6[122]

Note: In order to reduce the duplication of efforts, and thus cost, Goal 6 analyses will be completed by Indiana's actuary, Milliman, Inc., and appended to the Summative evaluation. The results where relevant will be incorporated into overall evaluation analysis, as appropriate.

Hypothesis	Research Question	Outcome Measure(s)	Data Sources	Analytic Approach	Comparison Strategy	Reporting Schedule
n.a.	**Primary RQ 1 –** What are the administrative costs incurred by the State to implement and operate the HIP demonstration?	• Annual administrative costs to implement and operate the demonstration • Contracts or contract amendments to implement, monitor, and evaluate demonstration policies • Annual staff time equivalents needed to implement, administer, and communicate with members about demonstration policies • Annual Medicaid agency staff time for those hired to support the demonstration, and time redirected from other Medicaid operations • Identified costs or cost savings accruing to other state agencies that partner with Medicaid (i.e., increased state spending for job readiness programs	State administrative records for 2018-2020	Descriptive analysis of administrative costs	n.a.	Summative Evaluation 2022

[122] For the evaluation, outcome measures will include time frame component, for example, the proportion of members using primary care within a 6-month period or enrollment in disease management within 12 month. The exact definition of the measures will be included in the interim and Summative report.

Hypothesis	Research Question	Outcome Measure(s)	Data Sources	Analytic Approach	Comparison Strategy	Reporting Schedule
n.a.	**Primary RQ 2 –** What are the short- and long-term effects of eligibility and coverage policies on Medicaid health care expenditures?	• Total annual health service expenditures for demonstration population • Change in annual PMPM health service expenditures	CY 2016-2020 Medicaid funded-health care expenditures (in total and PMPM): • All HIP members • Expansion members only • Basic members • Plus members • Members subject to community engagement requirements (excluding any exempt members) New adult group enrollment from the Medicaid Budget and Expenditure System (MBES) and expenditures from Transformed Medicaid Statistical Information System (T-MSIS) Medicaid Analytic Extracts (MAX)—pending CMS approval for research • Indiana, Ohio, and Kentucky (two comparable states)	• Difference-in-differences regression model of total service expenditures • Difference-in-differences regression model of PMPM service expenditures	Compare health service expenditures for the demonstration population to health service expenditures for a similar population in two comparison states (total and PMPM)	Summative Evaluation 2022

Hypothesis	Research Question	Outcome Measure(s)	Data Sources	Analytic Approach	Comparison Strategy	Reporting Schedule
n.a.	**Primary RQ 3 –** What are the impacts of eligibility and coverage policies on provider uncompensated care costs?	Change in total uncompensated care costs annually	HCRIS data: • Worksheet S-10, line 31 • 2013-2014 (before HIP 2.0) vs 2018-2020 • Indiana, Ohio, and Kentucky (two comparable states) and South Carolina (non-expansion "control" state)	Difference-in-differences regression model of uncompensated care costs	Two comparable states that have similar Medicaid eligibility criteria but do not operate a similar demonstration	Summative Evaluation 2022

Attachment II: HIP Sociodemographic Statistics

This attachment provides a summary of the Healthy Indiana Plan (HIP) population by benefit plan (HIP Basic or HIP Plus), income, race, age, gender, health status, and type of geographic location for each year between 2015 and 2018. Lewin developed these summaries using the following data sources:

- Monthly HIP enrollment data from February 2015 through December 2018
- Geographic data from the United States Department of Agriculture to classify members' area of residence by Rural-Urban Continuum Code (RUCC).[1]

We provide results overall and by benefit plan. We included members in this analysis with the following HIP enrollment statuses: Regular Plus (RP), Regular Basic (RB), State Plan Plus (SP), State Plan Basic (SB), HIP Plus Copay (PC), and pregnant (MA). We did not include members with an Emergency Room services flag of "Y" or with a presumptive eligibility or conditional enrollment status. The MA category was effective in 2018; pregnant members were moved from HIP to another Medicaid category upon redetermination prior to this time. We note that there is no upper income limit for Transitional Medical Assistance (TMA) recipients and no upper age limit for low-income parents and caretakers. **Section B: HIP Program Description** provides additional information on the different HIP enrollment statuses.

When developing analyses by benefit plan type, we have included State Plan Basic and State Plan Plus members. While the State provides these members with a specific set of State Plan services due to their qualifying health condition or eligibility category,[2] the HIP Plus and HIP Basic member cost-sharing requirements still apply. As such, they do not experience the same choices between the HIP Plus and HIP Basic benefit plans, but do experience similar tradeoffs in cost-sharing in terms of paying copayments under HIP Basic versus the monthly Personal Wellness and Responsibility (POWER) Account Contribution amount under HIP Plus.

We defined the benefit plan of a HIP member for a calendar year such that an individual who is only enrolled in HIP Basic or HIP Plus for all months enrolled in the calendar year is classified as HIP Basic Only or HIP Plus Only accordingly. Members who are enrolled in HIP Basic during some months of the year and HIP Plus in others during the calendar year are classified as "HIP Switchers." HIP Switchers also include members with enrollment statuses of HIP Plus Copay and MA.

HIP Members by Benefit Plan Type

Exhibits II.1 through II.4 provides detail on the number of HIP members by benefit plan from February 2015 through December 2018. Overall HIP enrollment, presented in **Exhibit II.1**, increased 33% from 389,984 to 520,212 from 2015 to 2016 and continued to increase annually to 569,971 members in 2018. **Exhibits II.2 through II.4** presents the HIP population by benefit plan type. The number of members in each benefit plan all increased annually from 2015 to 2018 with the exception of HIP Basic Only members whose enrollment decreased from 2017 to 2018. The proportion of the HIP population in each benefit plan remained relatively consistent in each year from 2015 to 2018. There were 814,571 unique members enrolled in HIP over the time period analyzed.

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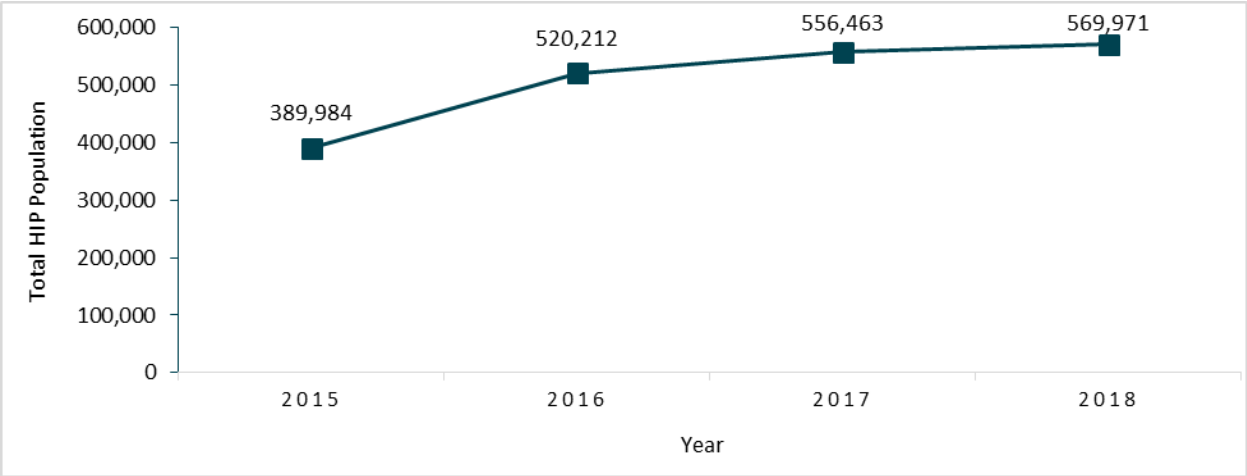
1 United States Department of Agriculture (2019, August 20). Rural-Urban Continuum Codes. Retrieved from https://www.ers.usda.gov/data-products/rural-urban-continuum-codes/

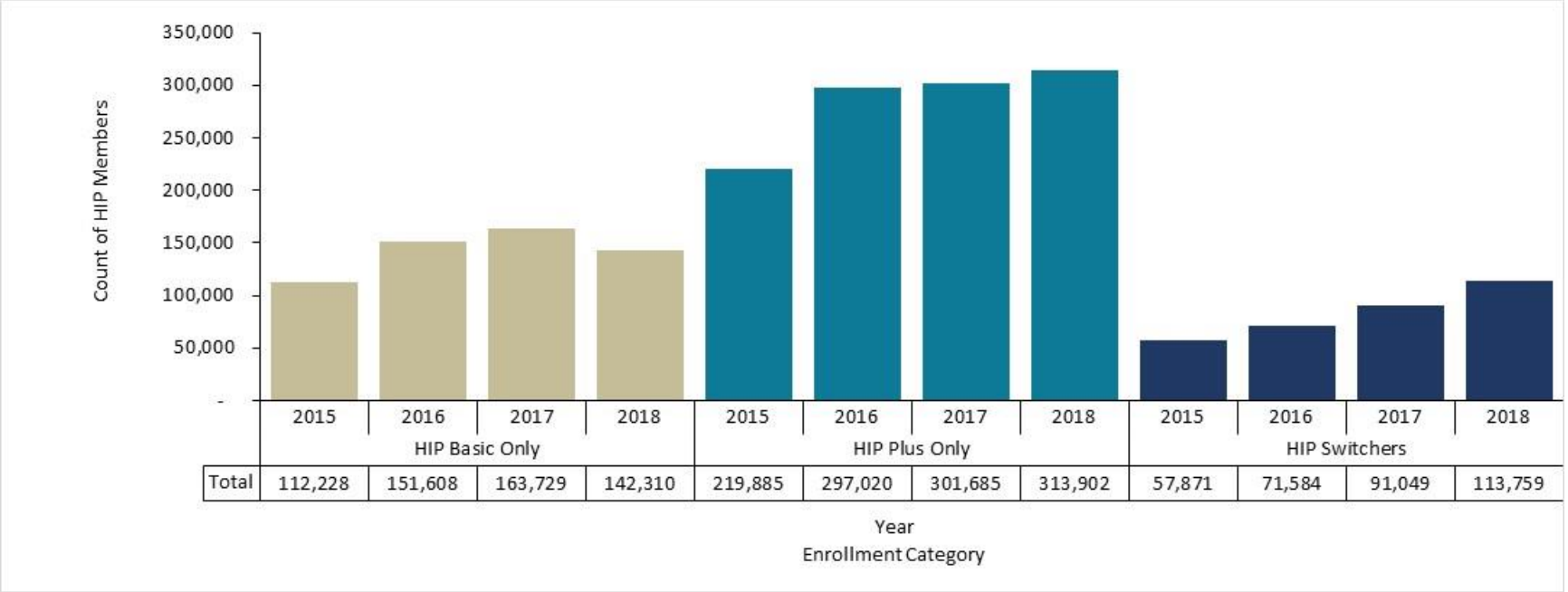
2 Medically frail, TMA participants, Section 1931 low-income (< 19% of the FPL) parents and caretakers, and low-income (< 19% of the FPL) 19 – 20 year olds.

Exhibit II.1: Total HIP Population by Year (February 2015 – December 2018)



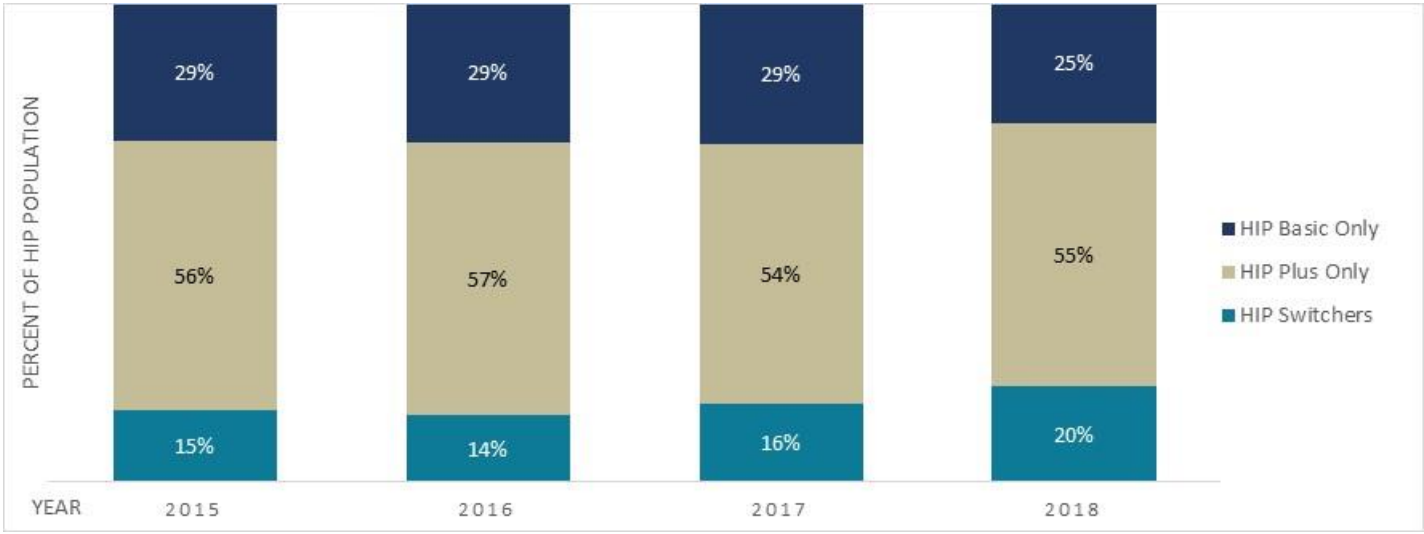
Source: HIP monthly enrollment files, February 2015 – December 2018.

Exhibit II.2: HIP Population by Benefit Plan Type (February 2015 – December 2018)



Source: HIP monthly enrollment files, February 2015 – December 2018.

Exhibit II.3: Composition of HIP Population by Benefit Plan Type (February 2015 – December 2018)



Source: HIP monthly enrollment files, February 2015 – December 2018.

Exhibit II.4. Number and Percent of HIP Members by Year and Benefit Plan Type (February 2015 – December 2018)

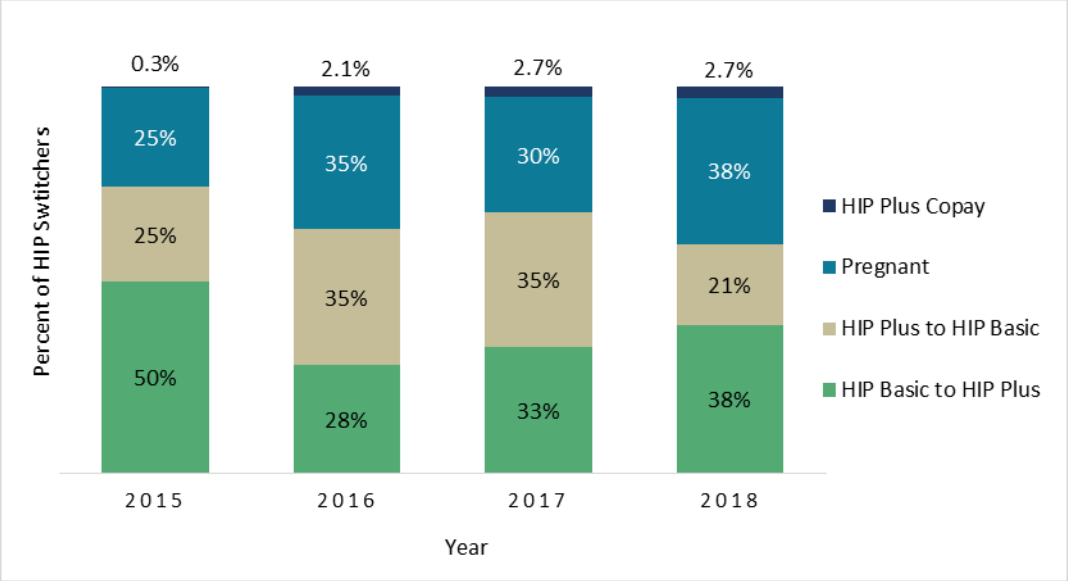
Benefit Plan	2015		2016		2017		2018	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent
HIP Basic Only	112,228	29%	151,608	29%	163,729	29%	142,310	25%
HIP Plus Only	219,885	56%	297,020	57%	301,685	54%	313,902	55%
HIP Switchers	57,871	15%	71,584	14%	91,049	16%	113,759	20%
Total	**389,984**	**100%**	**520,212**	**100%**	**556,463**	**100%**	**569,971**	**100%**

Source: HIP monthly enrollment files, February 2015 – December 2018.

Exhibit II.5 provides a breakdown of the HIP Switchers benefit plan category by type of switcher. As illustrated below, the largest category of switchers are members moving from HIP Basic to HIP Plus (43,579 in 2018). The number of individuals moving to HIP Plus increased from 2017 to 2018; State officials have indicated that full implementation of the POWER Account rollover policy during this same time period may have contributed to this increase. We also note that the reconciliation process in which rollover is determined was reconfigured during this time period, such that all accounts are now reconciled for the calendar year in December.

The number of members with an enrollment status related to pregnancy (MA) increased 59% between 2017 and 2018, with a high of 43,215 members in 2018 as the State brought all HIP-eligible pregnant members into the HIP program at that time.[3] The number of HIP Plus Copay members increased over time from 150 in 2015 to 3,124 in 2018. **Exhibits II.5 to II.8** provide additional detail specific to each switcher category.

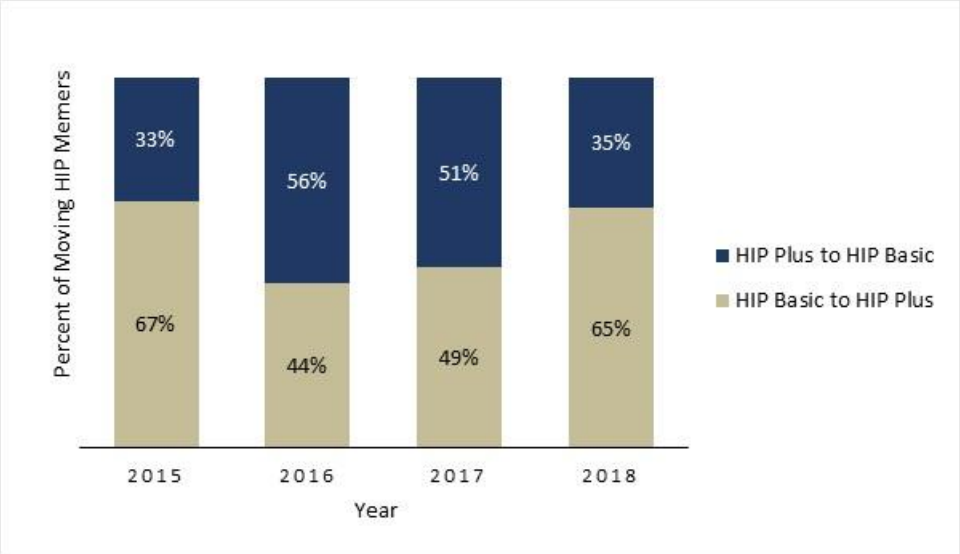
Exhibit II.5. Composition of HIP Switchers Population by Benefit Plan and Enrollment Status (February 2015 – December 2018)



Source: HIP monthly enrollment files, February 2015 – December 2018.

[3] There also is a special pregnancy category for pregnant women with income over the regular HIP limit of 138% FPL.

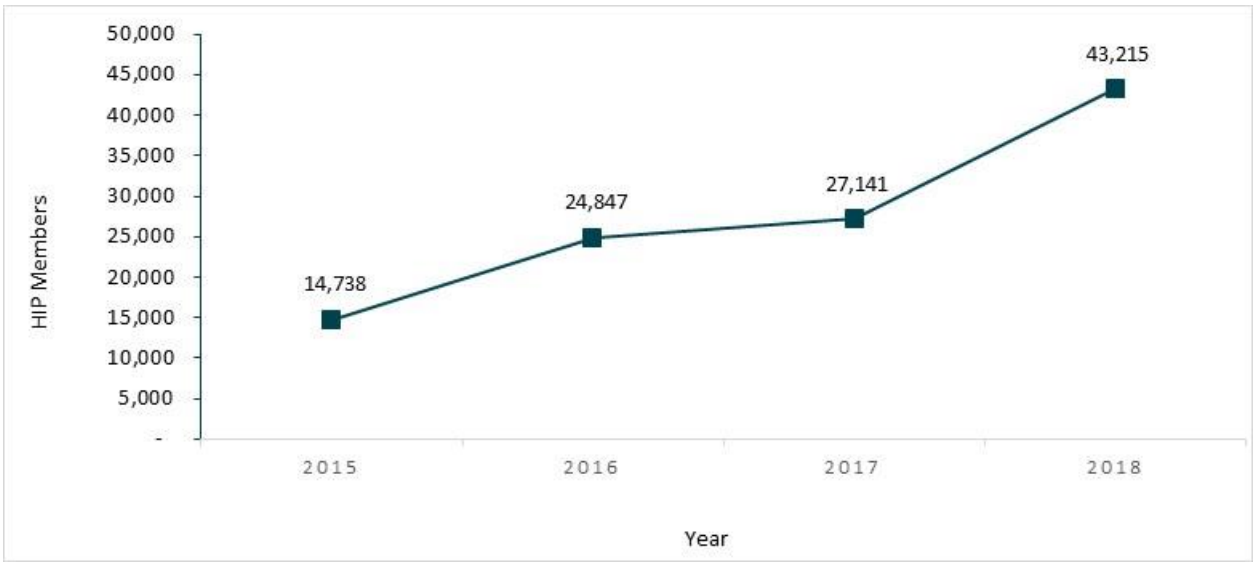
Exhibit II.6. Distribution and Direction of Movement Between Benefit Plans Among Members Moving Between HIP Plus and HIP Basic (February 2015 – December 2018)



Source: HIP monthly enrollment files, February 2015 – December 2018.

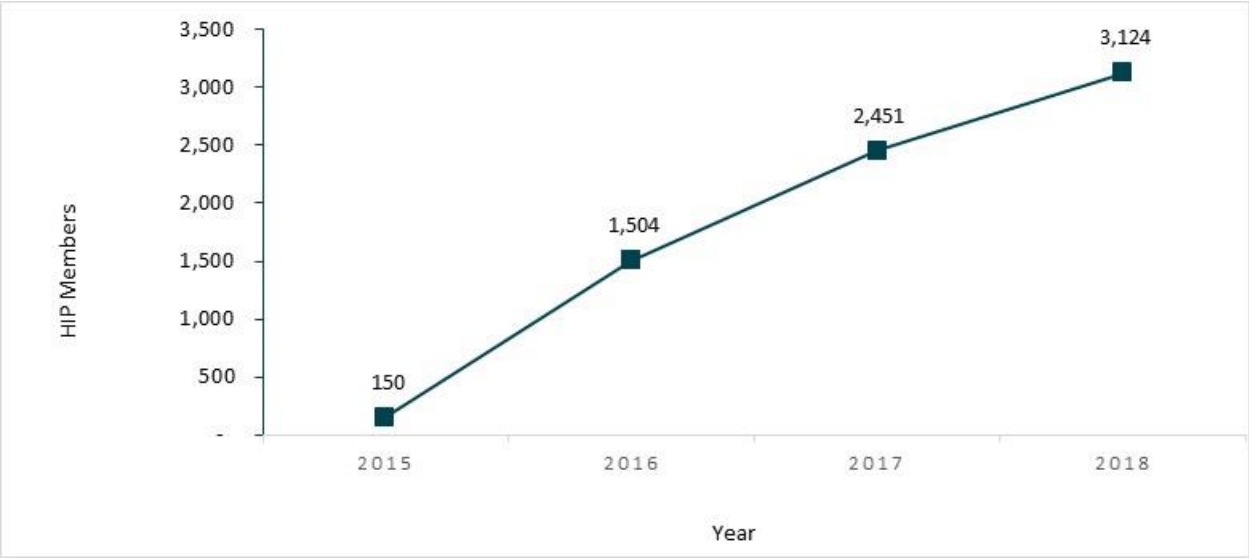
Exhibits II.7 and **II.8** indicate the distribution of Pregnant (MA) and HIP Plus Copay (PC) members who we have classified as HIP Switchers.

Exhibit II.7. Number of Members with Enrollment Status Related to Pregnancy (MA) (February 2015 – December 2018)



Source: HIP monthly enrollment files, February 2015 – December 2018.

Exhibit II.8. Number of HIP Members Enrolled HIP Plus Copay (PC) Annually (February 2015 – December 2018)



Source: HIP monthly enrollment files, February 2015 – December 2018.

Type of Geographic Area of Residence

Lewin determined the type of geographic region of residence for HIP members based on the county of residence as observed in the last month of enrollment on record in the calendar year. We then used the corresponding 2013 RUCC designation[4] to classify members as follows:

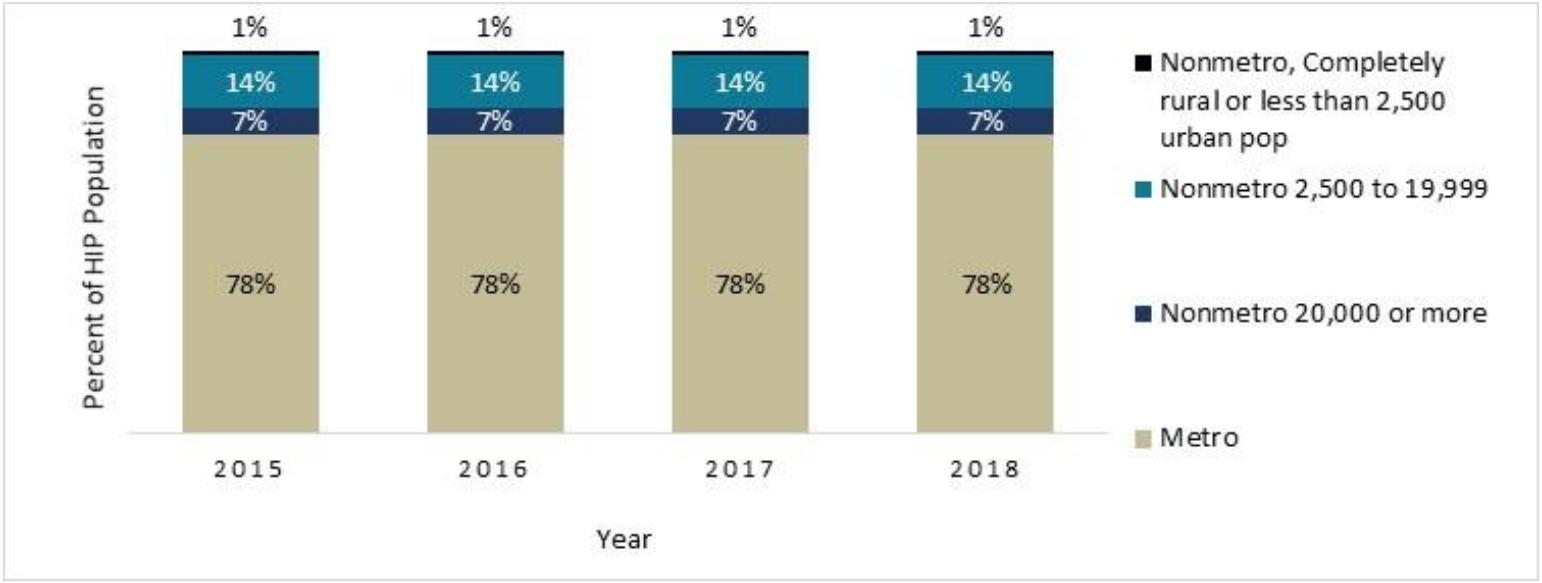
- Metro area – RUCC designation 1, 2, or 3
- Non-metro area of 20,000 or more – RUCC designation 4 or 5
- Non-metro area of 2,500 to 19,999 – RUCC designation 6 or 7
- Completely rural area or non-metro area of less than 2,500 – RUCC designation 8 or 9

Exhibits II.9 through II.13 presents the geographic distribution of the HIP population from 2015 to 2018. This distribution – both overall and by benefit plan – has remained relatively constant over time, with the large majority of members living in metro areas followed by non-metro areas with populations of 2,500 to 19,999. **Exhibits II.14 and 15** present the geographic distribution of the overall Indiana population. The geographic distribution of HIP members is similar to the overall Indiana population.

HIP Basic Only members were more likely to live in a metro area than HIP Plus Only members by approximately four percentage points each year, with HIP Plus Only members approximately three percentage points more likely to live in non-metro areas of 2,500 to 19,999. The composition of HIP Switchers in terms of type of geographic area was similar to that of HIP Plus Only members in each year.

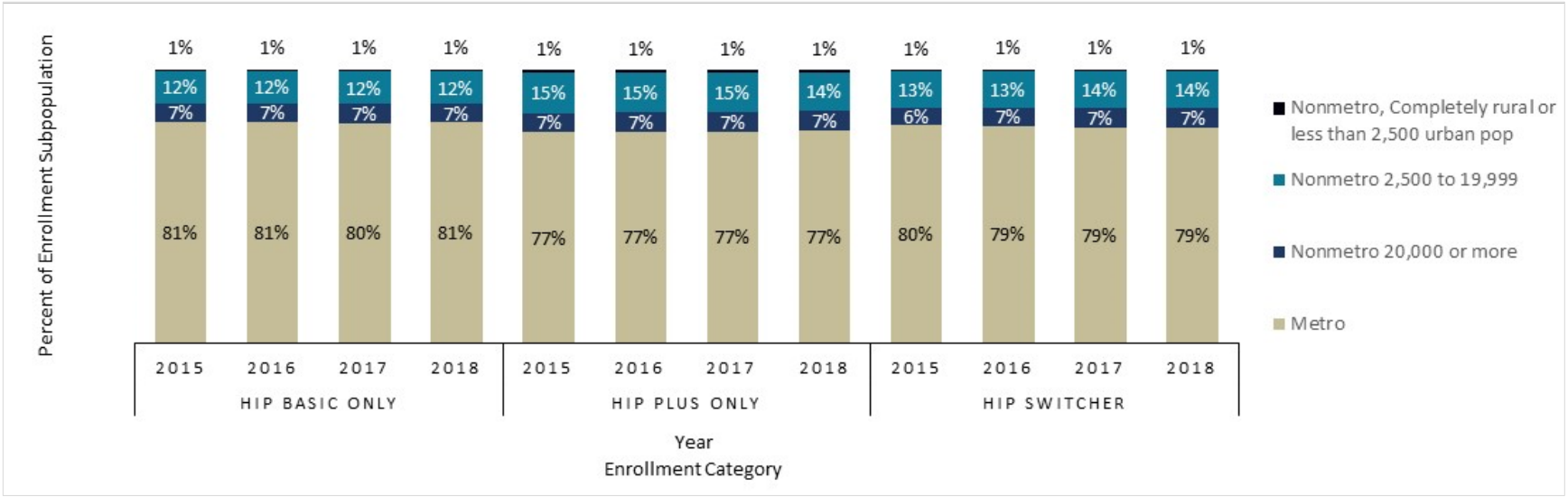
[4] United States Department of Agriculture (2019, August 20). Rural-Urban Continuum Codes. Retrieved from https://www.ers.usda.gov/data-products/rural-urban-continuum-codes/

Exhibit II.9: Composition of HIP Population by Type of Geographic Area of Residence for All Members (February 2015 – December 2018)



Source: HIP monthly enrollment files, February 2015 – December 2018. United States Department of Agriculture (2019). Rural-Urban Continuum Codes. Retrieved from https://www.ers.usda.gov/data-products/rural-urban-continuum-codes/

Exhibit II.10: Composition of HIP Population by Benefit Plan and Type of Geographic Area of Residence (February 2015 – December 2018)



Source: HIP monthly enrollment files, February 2015 – December 2018. United States Department of Agriculture (2019). Rural-Urban Continuum Codes. Retrieved from https://www.ers.usda.gov/data-products/rural-urban-continuum-codes/

Exhibit II.11: Number and Percent of HIP Members by Type of Geographic Area of Residence for All Members (February 2015 – December 2018)

Geographic Area	2015		2016		2017		2018	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent
Metro	305,319	78%	407,520	78%	436,136	78%	447,080	78%
Non-metro 2,500 to 19,999	53,872	14%	71,056	14%	75,979	14%	77,568	14%
Non-metro 20,000 or more	26,959	7%	36,667	7%	39,134	7%	40,013	7%
Non-metro, Completely rural or less than 2,500 urban pop	3,330	1%	4,468	1%	4,752	1%	4,908	1%
Total	**389,480**	**100%**	**519,711**	**100%**	**556,001**	**100%**	**569,569**	**100%**

Source: HIP monthly enrollment files, February 2015 – December 2018. United States Department of Agriculture (2019). Rural-Urban Continuum Codes. Retrieved from https://www.ers.usda.gov/data-products/rural-urban-continuum-codes/

Exhibit II.12: Number and Percent of HIP Members by Type of Geographic Area of Residence for HIP Basic Only (February 2015 – December 2018)

Geographic Area	2015		2016		2017		2018	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent
Metro	90,448	81%	122,309	81%	131,512	80%	114,565	81%
Non-metro 2,500 to 19,999	13,264	12%	17,640	12%	19,633	12%	16,858	12%
Non-metro 20,000 or more	7,592	7%	10,478	7%	11,259	7%	9,677	7%
Non-metro, Completely rural or less than 2,500 urban pop	781	1%	1,043	1%	1,173	1%	1,100	1%
Total	**112,085**	**100%**	**151,470**	**100%**	**163,577**	**100%**	**142,200**	**100%**

Source: HIP monthly enrollment files, February 2015 – December 2018. United States Department of Agriculture (2019). Rural-Urban Continuum Codes. Retrieved from https://www.ers.usda.gov/data-products/rural-urban-continuum-codes/

Exhibit II.13: Number and Percent of HIP Members by Type of Geographic Area of Residence for HIP Plus Only (February 2015 – December 2018)

Geographic Area	2015		2016		2017		2018	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent
Metro	168,903	77%	228,488	77%	233,003	77%	243,002	77%
Non-metro 2,500 to 19,999	32,926	15%	43,896	15%	44,046	15%	45,291	14%
Non-metro 20,000 or more	15,669	7%	21,450	7%	21,514	7%	22,442	7%
Non-metro, Completely rural or less than 2,500 urban pop	2,086	1%	2,889	1%	2,875	1%	2,938	1%
Total	**219,584**	**100%**	**296,723**	**100%**	**301,438**	**100%**	**313,673**	**100%**

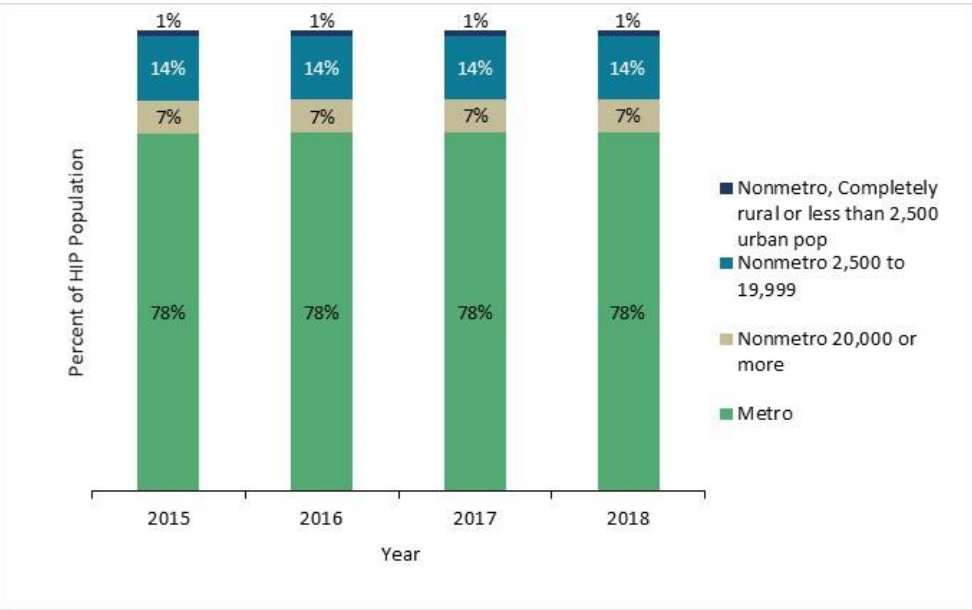
Source: HIP monthly enrollment files, February 2015 – December 2018. United States Department of Agriculture (2019). Rural-Urban Continuum Codes. Retrieved from https://www.ers.usda.gov/data-products/rural-urban-continuum-codes/

Exhibit II.14: Number and Percent of HIP Members by Type of Geographic Area of Residence for HIP Switchers (February 2015 – December 2018)

Geographic Area	2015		2016		2017		2018	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent
Metro	45,968	80%	56,723	79%	71,621	79%	89,513	79%
Non-metro 2,500 to 19,999	7,682	13%	9,520	13%	12,300	14%	15,419	14%
Non-metro 20,000 or more	3,698	6%	4,739	7%	6,361	7%	7,894	7%
Non-metro, Completely rural or less than 2,500 urban pop	463	1%	536	1%	704	1%	870	1%
Total	**57,811**	**100%**	**71,518**	**100%**	**90,986**	**100%**	**113,696**	**100%**

Source: HIP monthly enrollment files, February 2015 – December 2018. United States Department of Agriculture (2019). Rural-Urban Continuum Codes. Retrieved from https://www.ers.usda.gov/data-products/rural-urban-continuum-codes/

Exhibit II.15: Composition of General Indiana Population by Type of Geographic Area of Residence (2015 – 2018)



Source: STATS Indiana (2019). Information for Indiana. Retrieved from http://www.stats.indiana.edu/topic/population.asp

Exhibit II.16 Number and Percent of Indiana Residents by Type of Geographic Area of Residence (2015 – 2018)

Geographic Area	2015		2016		2017		2018	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent
Metro	1,864,710	78%	1,864,762	78%	1,857,228	78%	1,851,288	78%
Non-metro 20,000 or more	172,148	7%	170,490	7%	168,413	7%	167,160	7%
Non-metro 2,500 to 19,999	336,557	14%	334,217	14%	330,961	14%	328,210	14%
Non-metro, Completely rural or less than 2,500 urban pop	22,967	1%	22,697	1%	22,591	1%	22,429	1%
Total	**2,396,382**	**100%**	**2,392,166**	**100%**	**2,379,193**	**100%**	**2,369,087**	**100%**

Source: STATS Indiana (2019). Information for Indiana. Retrieved from http://www.stats.indiana.edu/topic/population.asp

Race/Hispanic Origin

Lewin reviewed descriptive characteristics for race by analyzing the reported race by HIP members upon enrollment. Over 99% of HIP members reported the following categories:

- Caucasian
- Black
- Hispanic
- Asian or Pacific Islander

We grouped observations outside the above four as "Other." For clarity and consistency across analyses we classified 'Caucasian' HIP members as "non-Hispanic White".

The composition of the overall HIP population in terms of race and ethnicity remained consistent across time, with non-Hispanic White members comprising approximately 71% of the overall HIP population, Black members approximately 20%, Hispanic members approximately 5%, and Asian or Pacific Islander members approximately 2%. The composition of race and ethnicity by HIP benefit plan category was also consistent across time.

HIP Basic Only members were more likely to be Black and less likely to be non-Hispanic White than HIP Plus Only members (by approximately 12 and 9 percentage points in 2018, respectively). HIP Switcher members included a slightly smaller proportion of Black HIP members as compared to the HIP Basic Only members. Hispanic members and Asian and Pacific Islander members comprised similar proportions of the HIP Basic Only, HIP Plus Only, and HIP Switchers subpopulations at 1% to 3% of members each.

In order to compare the HIP member population to the overall Indiana population and the potentially eligible HIP population, we used 2015-2017 American Community Survey (ACS) data.[5] ACS defines race and ethnicity by the race and Hispanic origin variables (RACE and HISPAN). The race variable has the following values:

- White
- Black/African American
- American Indian or Alaska Native
- Chinese
- Japanese
- Other Asian or Pacific Islander
- Other race
- Two major races
- Three or more major races

[5] IPUMS Online Data Analysis System (2019). IPUMS USA. Retrieved from https://usa.ipums.org/usa/sda/

The Hispanic origin variable has the following values:

- Not Hispanic
- Mexican
- Puerto Rican
- Cuban
- Other
- Not reported

In order to maintain a consistent comparison with the HIP enrollment data, we categorized:

- Individuals reporting as "Mexican," "Puerto Rican," or "Cuban" in the Hispanic origin variable as "Hispanic" regardless of the value of the race variable
- Individuals reporting as "Not Hispanic," "Other," and "Not reported" in the Hispanic origin variable according to the race variable, such that individuals reporting as "Chinese," "Japanese," or "Other Asian or Pacific Islander" are categorized as "Asian or Pacific Islander". We categorized individuals reporting as "American Indian or Alaska Native," "Other race," "Two major races," or "Three or more major races" as "Other or not available."

A 2015 to 2017 comparison of race and ethnicity of HIP members to the overall Indiana population and the potentially eligible HIP population[6] indicates that HIP members are more likely to be Black. Additionally, HIP members are less likely to be Hispanic as compared to the potentially eligible HIP population. This comparison used HIP monthly enrollment data and the most recently available ACS data.[7] In comparison to the overall Indiana population:

- HIP members are less likely to be non-Hispanic White (71% of HIP members as compared to approximately 80% of Indiana residents each year).
- HIP members are approximately twice as likely to be Black (20% of HIP members as compared to 9% of Indiana residents each year).
- The percentages of Asian and Hispanic members in the HIP population are similar (2% and 5-6%, respectively each year).

In comparison to potentially eligible HIP members:

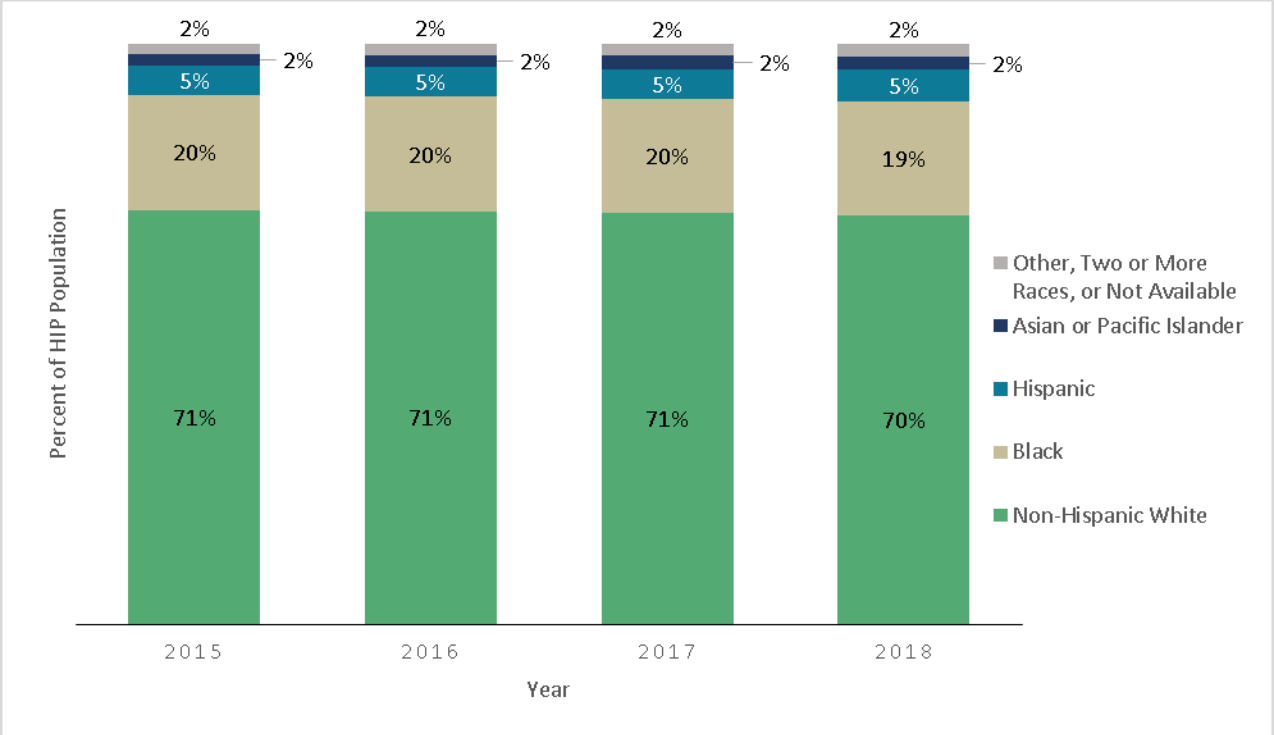
- HIP members are approximately as likely to be non-Hispanic White (71% of HIP members as compared to approximately 69% of potentially eligible HIP members).
- HIP members are more likely to be Black (20% of HIP members compared to approximately 15% of potentially eligible HIP members).
- HIP members are less likely to be Hispanic (5% of HIP members compared to approximately 9% of potentially eligible HIP members).

[6] Defined as those within come below 150% FPL, between the ages of 19 and 64, without Medicare coverage and without Supplemental Security Income

[7] IPUMS Online Data Analysis System (2019). IPUMS USA. Retrieved from https://usa.ipums.org/usa/sda/

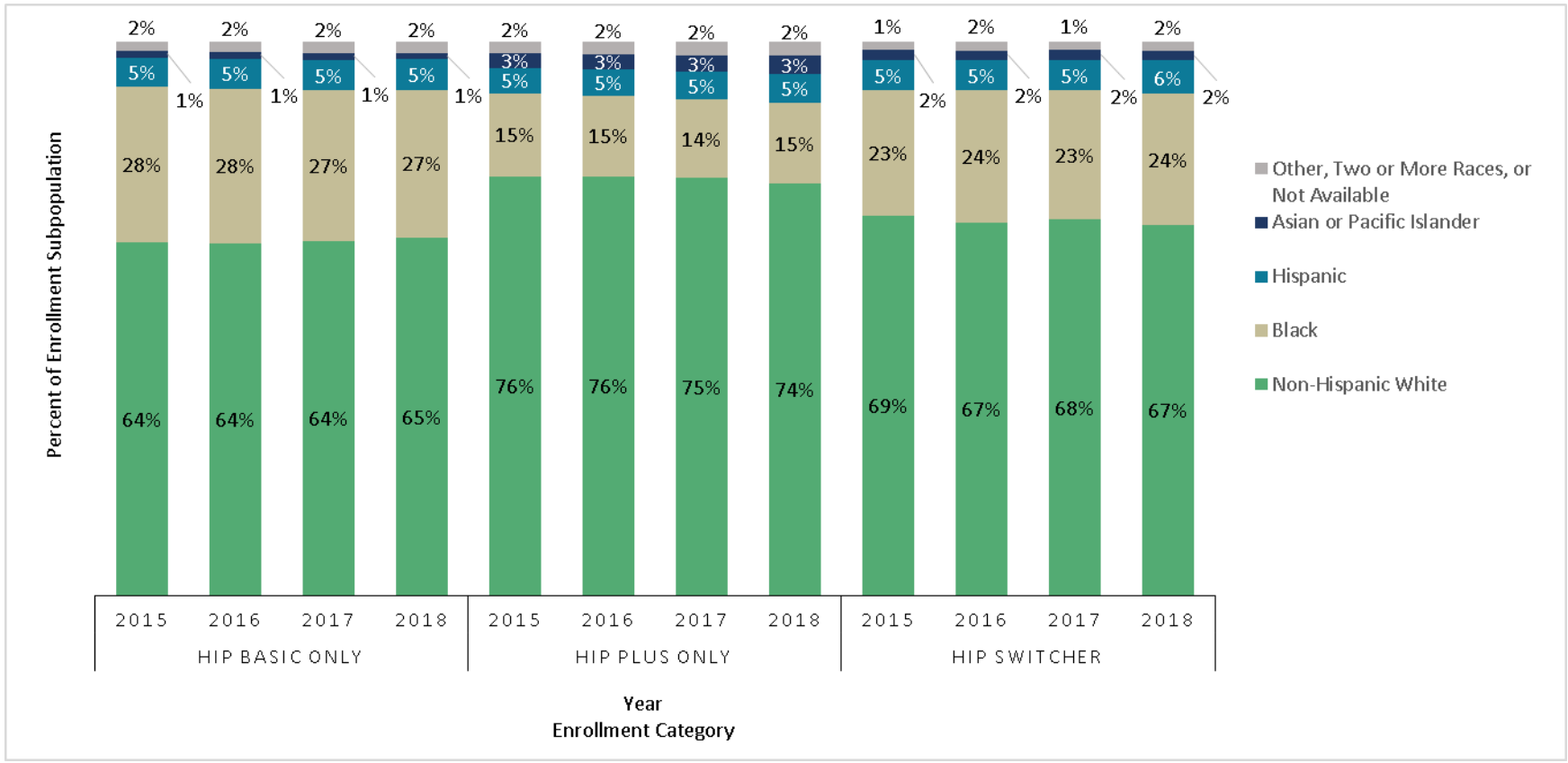
We present the composition of the HIP population in terms of race in **Exhibits II.17 through II.22** and the composition of the overall Indiana population in terms of race in **Exhibits II.23 through II.25.**

Exhibit II.17: HIP Population by Race/Hispanic Origin (February 2015 – December 2018)



Source: HIP monthly enrollment files, February 2015 – December 2018.

Exhibit II.18: Composition of HIP Population by Benefit Plan and Race/Hispanic Origin (February 2015 – December 2018)



Source: HIP monthly enrollment files, February 2015 – December 2018.

Exhibit II.19: Number and Percent of HIP Members by Race for All Members (February 2015 – December 2018)

Race	2015		2016		2017		2018	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent
Non-Hispanic White	277,789	71%	369,662	71%	394,323	71%	401,517	70%
Black	77,757	20%	102,827	20%	108,864	20%	111,119	19%
Hispanic	19,247	5%	26,272	5%	28,782	5%	31,105	5%
Asian or Pacific Islander	8,087	2%	11,218	2%	12,692	2%	13,662	2%
Other, Two or More Races, or Not Available	7,104	2%	10,233	2%	11,802	2%	12,568	2%
Total	**389,984**	**100%**	**520,212**	**100%**	**556,463**	**100%**	**569,971**	**100%**

Source: HIP monthly enrollment files, February 2015 – December 2018.

Exhibit II.20: Number and Percent of HIP Members by Race for HIP Basic Only (February 2015 – December 2018)

Race	2015		2016		2017		2018	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent
Non-Hispanic White	71,585	64%	96,447	64%	104,928	64%	91,979	65%
Black	31,549	28%	42,381	28%	44,600	27%	38,068	27%
Hispanic	5,992	5%	8,207	5%	8,939	5%	7,793	5%
Asian or Pacific Islander	1,315	1%	1,875	1%	1,998	1%	1,489	1%
Other, Two or More Races, or Not Available	1,787	2%	2,698	2%	3,264	2%	2,981	2%
Total	**112,228**	**100%**	**151,608**	**100%**	**163,729**	**100%**	**142,310**	**100%**

Source: HIP monthly enrollment files, February 2015 – December 2018.

Exhibit II.21: Number and Percent of HIP Members by Race for HIP Plus Only (February 2015 – December 2018)

Race	2015		2016		2017		2018	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent
Non-Hispanic White	166,532	76%	225,053	76%	227,527	75%	233,365	74%
Black	32,988	15%	43,197	15%	43,042	14%	46,144	15%
Hispanic	10,191	5%	14,255	5%	14,841	5%	16,431	5%
Asian or Pacific Islander	5,659	3%	8,065	3%	9,079	3%	10,123	3%
Other, Two or More Races, or Not Available	4,515	2%	6,450	2%	7,196	2%	7,839	2%
Total	**219,885**	**100%**	**297,020**	**100%**	**301,685**	**100%**	**313,902**	**100%**

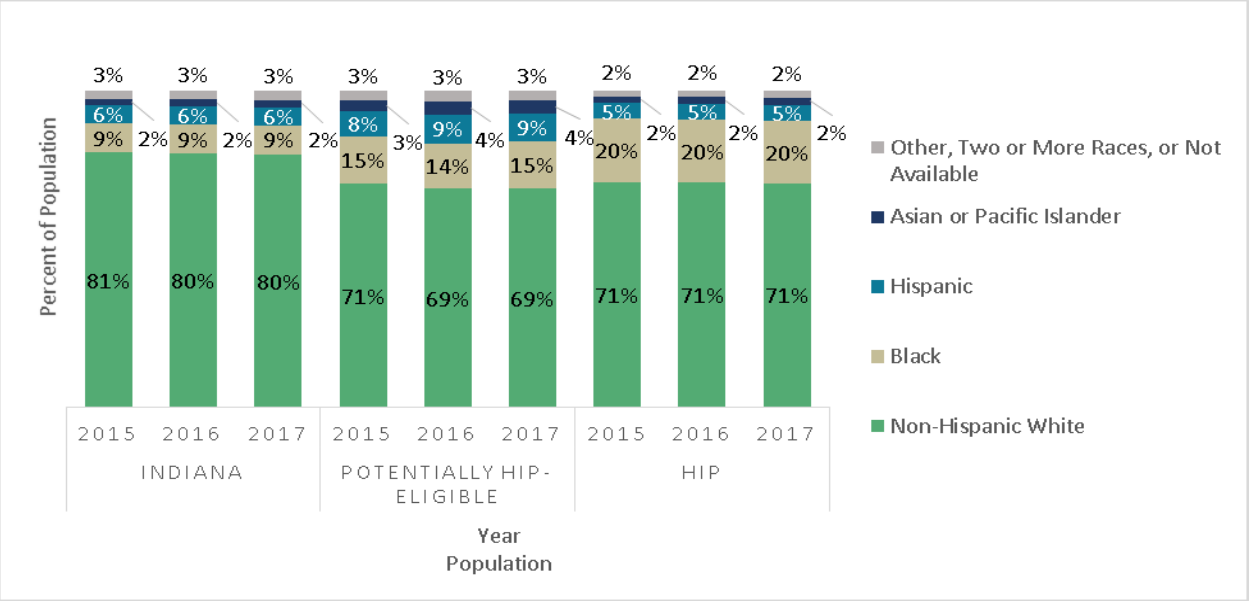
Source: HIP monthly enrollment files, February 2015 – December 2018.

Exhibit II.22: Number and Percent of HIP Members by Race for HIP Switchers (February 2015 – December 2018)

Race	2015		2016		2017		2018	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent
Non-Hispanic White	39,672	69%	48,162	67%	61,868	68%	76,173	67%
Black	13,220	23%	17,249	24%	21,222	23%	26,907	24%
Hispanic	3,064	5%	3,810	5%	5,002	5%	6,881	6%
Asian or Pacific Islander	1,113	2%	1,278	2%	1,615	2%	2,050	2%
Other, Two or More Races, or Not Available	802	1%	1,085	2%	1,342	1%	1,748	2%
Total	**57,871**	**100%**	**71,584**	**100%**	**91,049**	**100%**	**113,759**	**100%**

Source: HIP monthly enrollment files, February 2015 – December 2018.

Exhibit II.23: Indiana Population, Potentially Eligible HIP Population and HIP Population by Race (2015-2017)



Sources: HIP monthly enrollment files, February 2015 – December 2018; Integrated Public Use Microdata Series (IPUMS) Online Data Analysis System (2019). IPUMS USA. Retrieved from https://usa.ipums.org/usa/sda/

Exhibit II.24: Number and Percent of Indiana Population by Race (2015-2017)

Race	2015		2016		2017	
	Number	Percent	Number	Percent	Number	Percent
Non-Hispanic White	5,335,580	81%	5,318,291	80%	5,329,064	80%
Black	606,803	9%	611,187	9%	613,320	9%
Hispanic	368,065	6%	373,972	6%	384,393	6%
Asian or Pacific Islander	141,365	2%	145,813	2%	146,800	2%
Other, Two or More Races, or Not Available	167,867	3%	183,790	3%	193,241	3%
Total	**6,619,680**	**100%**	**6,633,053**	**100%**	**6,666,818**	**100%**

Source: IPUMS Online Data Analysis System (2019). IPUMS USA. Retrieved from https://usa.ipums.org/usa/sda/

Exhibit II.25: Number and Percent of Potentially Eligible HIP Population by Race (2015-2017)

Race	2015		2016		2017	
	Number	Percent	Number	Percent	Number	Percent
Non-Hispanic White	591,701	71%	551,577	69%	535,140	69%
Black	126,476	15%	114,326	14%	114,707	15%
Hispanic	67,297	8%	72,818	9%	68,682	9%
Asian or Pacific Islander	28,451	3%	32,662	4%	31,542	4%
Other, Two or More Races, or Not Available	24,122	3%	26,775	3%	23,919	3%
Total	**838,047**	**100%**	**798,158**	**100%**	**773,990**	**100%**

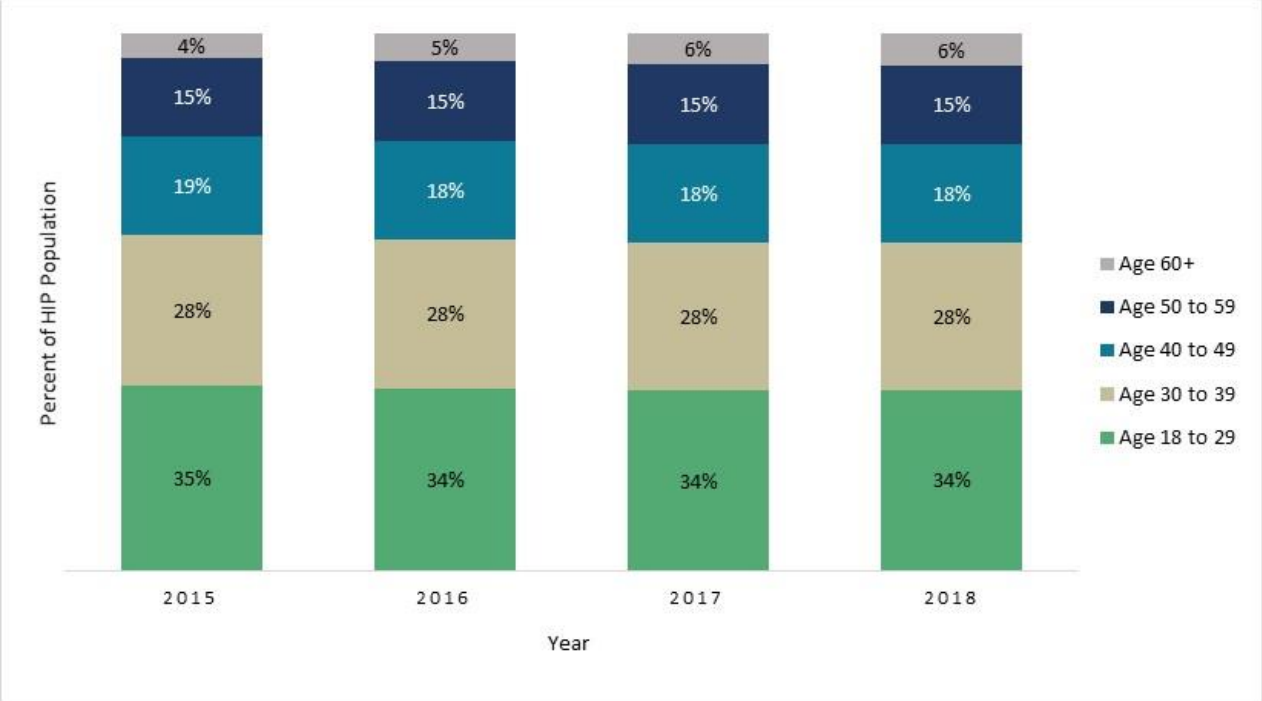
Source: IPUMS Online Data Analysis System (2019). IPUMS USA. Retrieved from https://usa.ipums.org/usa/sda/

Age Group

Lewin developed descriptive analyses for HIP members by age group according to members' age at the end of the calendar year. The population of HIP Basic Only members and Switchers was younger in general than the HIP Plus Only population. Approximately 73% to 77% of HIP Basic Only members and 74% to 78% of HIP Switchers were less than 40 years old between 2015 and 2018, compared to approximately 51% of HIP Plus Only each year. The HIP Basic Only population aged somewhat over time, as the proportion of members less than 30 years old decreased from 46% to 42% and the proportion of members 40 years old and above increased from 22% to 26%. The composition of the overall HIP population in terms of age remained fairly constant from 2015 to 2018.

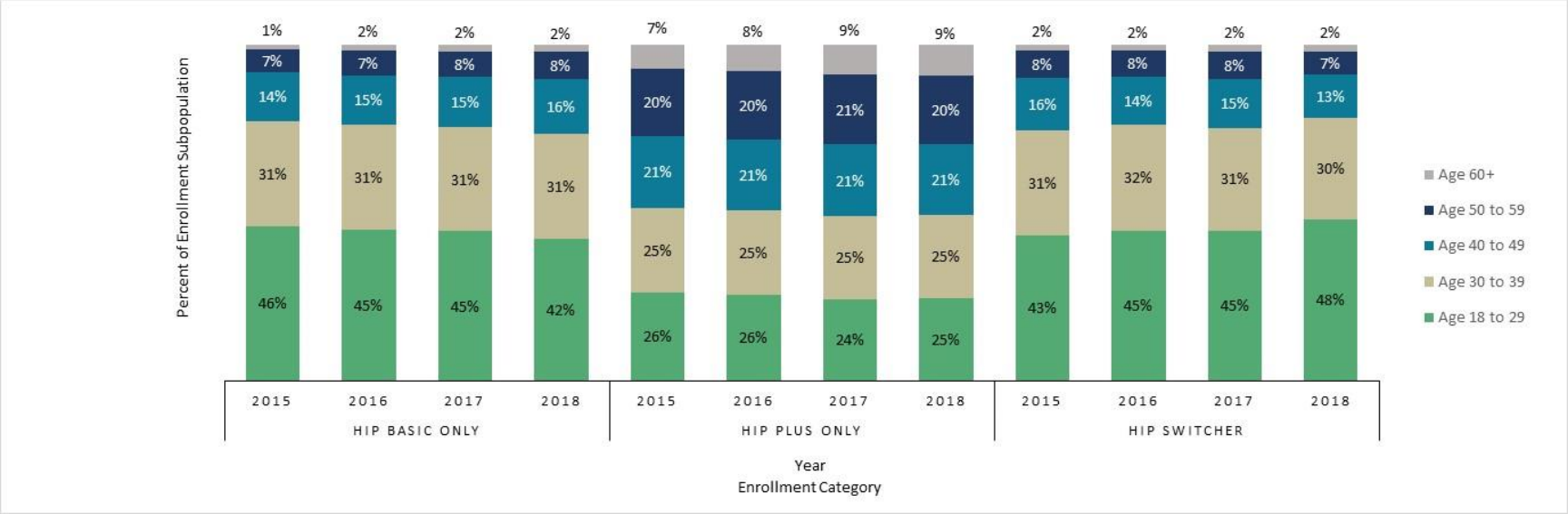
We present the composition of the HIP population by age group in **Exhibits II.26 through II.31**.

Exhibit II.26: HIP Population by Age Group (February 2015 – December 2018)



Source: HIP monthly enrollment files, February 2015 – December 2018.

Exhibit II.27: HIP Population by Benefit Plan and Age Group (February 2015 – December 2018)



Source: HIP monthly enrollment files, February 2015 – December 2018.

Exhibit II.28: Number and Percent of HIP Members by Age Group for All Members (February 2015 – December 2018)

Age Group	2015				2016			
	Number	Percent	Number	Percent	Number	Percent	Number	Percent
Age 0 to 17	16	0%	20	0%	13	0%	13	0%
Age 18 to 29	134,674	35%	176,791	34%	186,910	34%	191,805	34%
Age 30 to 39	108,805	28%	143,978	28%	153,329	28%	157,262	28%
Age 40 to 49	72,285	19%	96,005	18%	102,478	18%	104,301	18%
Age 50 to 59	56,704	15%	76,600	15%	82,349	15%	82,942	15%
Age 60 to 65	17,500	4%	26,818	5%	31,384	6%	33,648	6%
Total	**389,984**	**100%**	**520,212**	**100%**	**556,463**	**100%**	**569,971**	**100%**

Source: HIP monthly enrollment files, February 2015 – December 2018.

Exhibit II.29: Number and Percent of HIP Members by Age Group for HIP Basic Only (February 2015 – December 2018)

Age Group	2015		2016		2017		2018	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent
Age 0 to 17	10	0%	11	0%	6	0%	5	0%
Age 18 to 29	51,680	46%	68,407	45%	72,895	45%	59,992	42%
Age 30 to 39	35,240	31%	47,072	31%	50,745	31%	44,665	31%
Age 40 to 49	16,188	14%	22,547	15%	24,903	15%	23,108	16%
Age 50 to 59	7,757	7%	11,264	7%	12,314	8%	11,645	8%
Age 60 to 65	1,353	1%	2,307	2%	2,866	2%	2,895	2%
Total	**112,228**	**100%**	**151,608**	**100%**	**163,729**	**100%**	**142,310**	**100%**

Source: HIP monthly enrollment files, February 2015 – December 2018.

Exhibit II.30: Number and Percent of HIP Members by Age Group for HIP Plus Only (February 2015 – December 2018)

Age Group	2015		2016		2017		2018	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent
Age 0 to 17	4	0%	7	0%	4	0%	5	0%
Age 18 to 29	57,947	26%	76,380	26%	73,207	24%	76,961	25%
Age 30 to 39	55,450	25%	74,258	25%	74,725	25%	78,340	25%
Age 40 to 49	47,064	21%	63,202	21%	64,345	21%	66,388	21%
Age 50 to 59	44,171	20%	59,868	20%	62,658	21%	63,436	20%
Age 60 to 65	15,249	7%	23,305	8%	26,746	9%	28,772	9%
Total	**219,885**	**100%**	**297,020**	**100%**	**301,685**	**100%**	**313,902**	**100%**

Source: HIP monthly enrollment files, February 2015 – December 2018.

Exhibit II.31: Number and Percent of HIP Members by Age Group for HIP Switchers (February 2015 – December 2018)

Age Group	2015		2016		2017		2018	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent
Age 0 to 17	2	0%	2	0%	3	0%	3	0%
Age 18 to 29	25,047	43%	32,004	45%	40,808	45%	54,852	48%
Age 30 to 39	18,115	31%	22,648	32%	27,859	31%	34,257	30%
Age 40 to 49	9,033	16%	10,256	14%	13,230	15%	14,805	13%
Age 50 to 59	4,776	8%	5,468	8%	7,377	8%	7,861	7%
Age 60 to 65	898	2%	1,206	2%	1,772	2%	1,981	2%
Total	**57,871**	**100%**	**71,584**	**100%**	**91,049**	**100%**	**113,759**	**100%**

Source: HIP monthly enrollment files, February 2015 – December 2018.

Income

Lewin identified the income of HIP members as a percent of the federal poverty level (FPL) as reported in the first month of enrollment on record in the calendar year. Member income can change throughout the year and as often as monthly. We defined member FPL based on the first enrollment month in the calendar year under analysis (based on analyses of the income in enrollment data and feedback from the State).

In some instances we observed FPL amounts that appeared inconsistent with HIP policies (for example, a small number of HIP Plus members with income at or less than 100% had disenrollments with non-payment as a reason). Based on discussions with the State, there are several possible reasons for these inconsistencies, for example:

- The member changed income after the first HIP Plus enrollment month in the calendar year under analysis
- Interplay between the required member notification for coverage changes (e.g., HIP Plus to HIP Basic) and when the State/Managed Care Entity (MCE) received and updates data, in conjunction with member changes in FPL across months
- Inconsistencies in FPL data transfer between eligibility and the Medicaid Management Information System that resulted in null FPL values on disenrollment which appear as zero in the provided enrollment data and in some cases in the application of updated FPL numbers to prior months. The State has indicated that this data issue is resolved but on a minority of historical records included in this analyses these data artifacts remain. While the vast majority of HIP Basic Only members must be 100% of the FPL or below, there are some enrollment categories (e.g., TMA) where a member may be enrolled in HIP Basic Only and over 100% of the FPL. Additionally, starting in 2018, individuals transferring from other Medicaid categories or enrolling using presumptive eligibility automatically enroll in HIP Basic with 60 days to transfer to HIP Plus regardless of income.

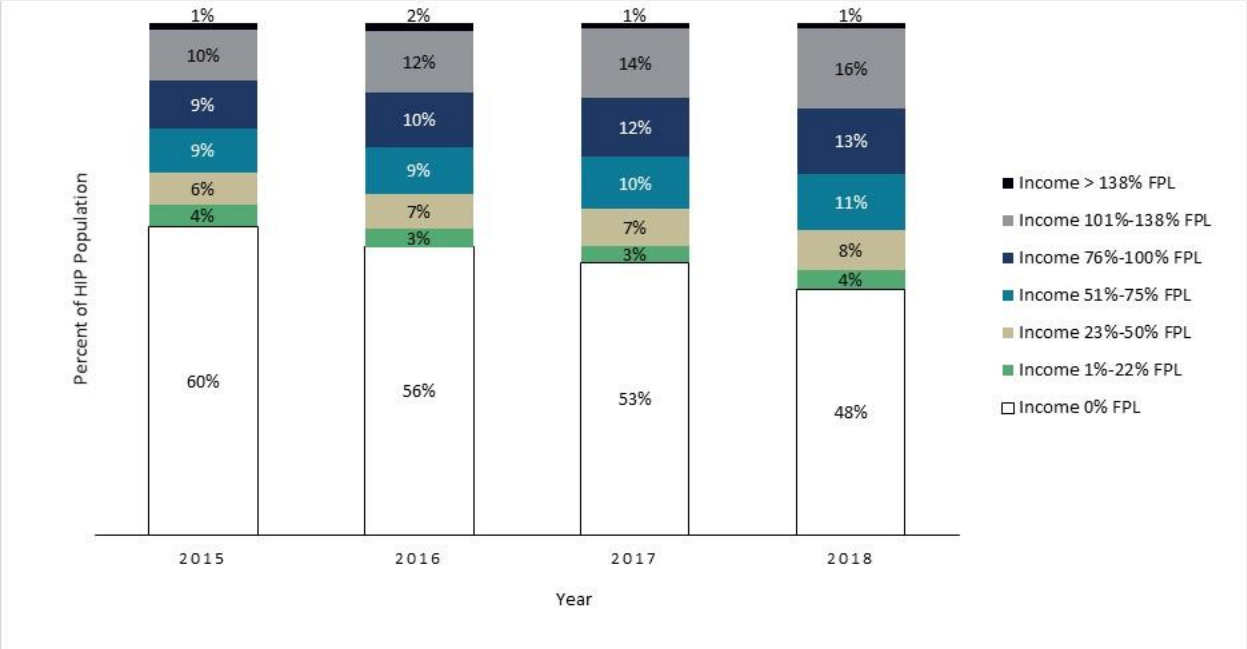
The proportion of HIP members at higher levels of income has increased from 2015 to 2018, specifically:

- The percent of HIP members at 101% of the FPL or above has increased from 11% in 2015 to 17% in 2018.
- The percent of HIP members from 76% to 100% of the FPL has increased from 9% in 2015 to 13% in 2018.
- The percent of HIP members with zero income has decreased from 60% in 2015 to 48% in 2018.

This change in the proportion of HIP members at higher income levels corresponds to a reduction in the statewide Indiana unemployment rate over the same period (5.4% in January 2015 compared to 3.3% in January 2018).[8]

We present the composition of the HIP population by income range in **Exhibits II.32 through II.37**; **Exhibits II.38 through 40** provide detail on the statewide Indiana unemployment rate.

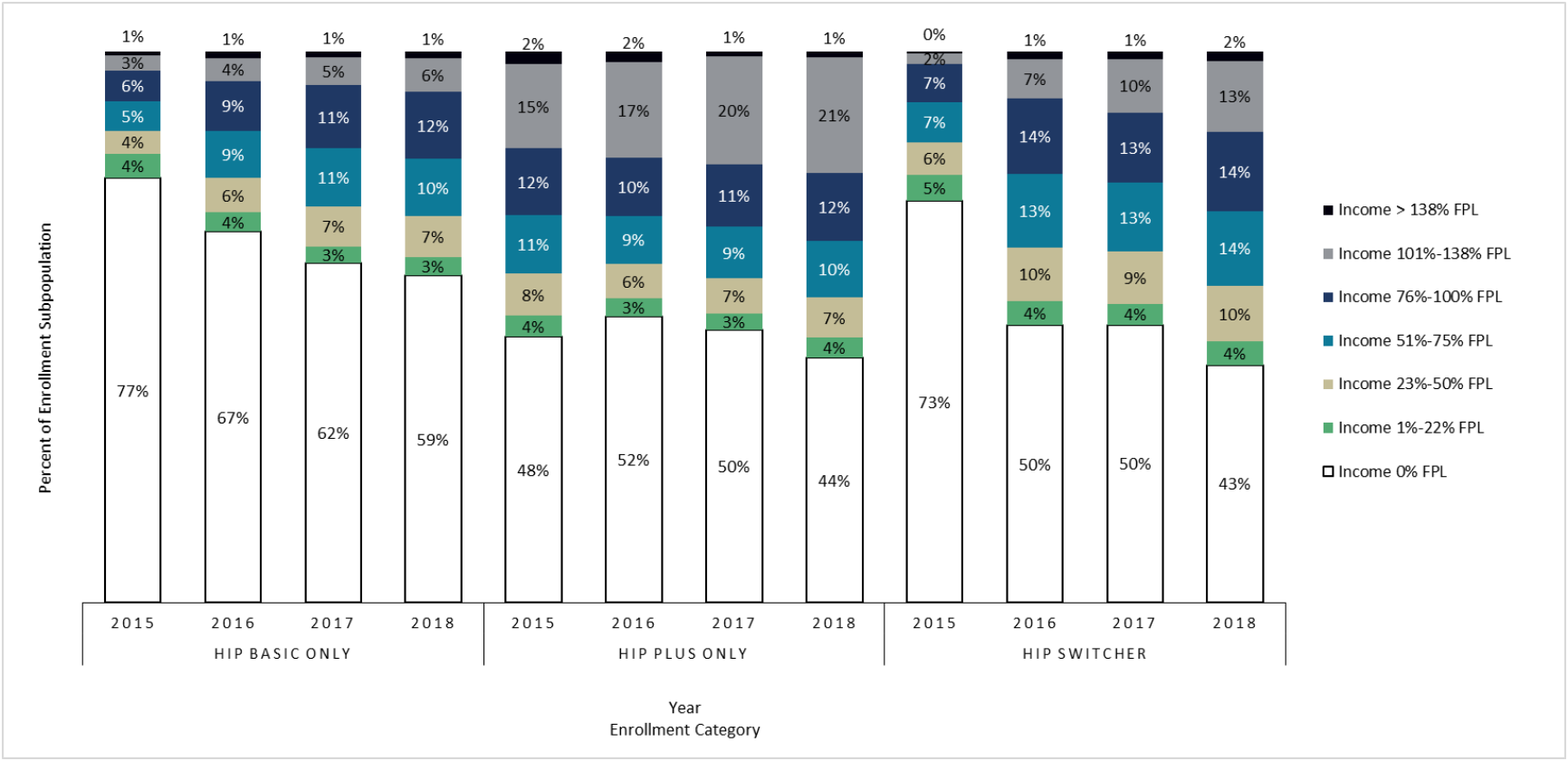
Exhibit II.32: HIP Population by Income Range (February 2015 – December 2018)



Source: HIP monthly enrollment files, February 2015 – December 2018.

[8] Bureau of Labor Statistics (2019). Local Area Unemployment Statistics. Retrieved from https://data.bls.gov/pdq/SurveyOutputServlet

Exhibit II.33: Composition of HIP Population by Income and Benefit Plan (February 2015 – December 2018)



Source: HIP monthly enrollment files, February 2015 – December 2018.

Exhibit II.34: Number and Percent of HIP Members by Income Range for All Members (February 2015 – December 2018)

Income Range	2015		2016		2017		2018	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent
0% FPL	234,805	60%	292,672	56%	296,201	53%	273,248	48%
1%- 22% FPL	16,169	4%	17,995	3%	17,425	3%	20,850	4%
23% - 50% FPL	24,798	6%	35,252	7%	40,194	7%	45,196	8%
51% - 75% FPL	33,643	9%	48,373	9%	56,546	10%	62,268	11%
76% - 100% FPL	37,007	9%	54,611	10%	64,761	12%	72,829	13%
101% - 138% FPL	37,997	10%	63,072	12%	75,894	14%	88,879	16%
> 138% FPL	5,565	1%	8,237	2%	5,442	1%	6,701	1%
Total	**389,984**	**100%**	**520,212**	**100%**	**556,463**	**100%**	**569,971**	**100%**

Source: HIP monthly enrollment files, February 2015 – December 2018.

Exhibit II.35: Number and Percent of HIP Members by Income Range for HIP Basic Only (February 2015 – December 2018)

Income Range	2015		2016		2017		2018	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent
0% FPL	86,488	77%	102,106	67%	100,865	62%	84,561	59%
1%- 22% FPL	5,016	4%	5,356	4%	5,067	3%	4,655	3%
23% - 50% FPL	4,624	4%	9,504	6%	11,926	7%	10,566	7%
51% - 75% FPL	6,064	5%	12,916	9%	17,253	11%	14,912	10%
76% - 100% FPL	6,284	6%	13,712	9%	18,805	11%	17,343	12%
101% - 138% FPL	3,047	3%	6,301	4%	8,193	5%	8,683	6%
> 138% FPL	705	1%	1,713	1%	1,620	1%	1,590	1%
Total	**112,228**	**100%**	**151,608**	**100%**	**163,729**	**100%**	**142,310**	**100%**

Source: HIP monthly enrollment files, February 2015 – December 2018.

Exhibit II.36: Number and Percent of HIP Members by Income Range for HIP Plus Only (February 2015 – December 2018)

Income Range	2015		2016		2017		2018	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent
0% FPL	106,079	48%	154,547	52%	149,395	50%	139,596	44%
1%- 22% FPL	8,409	4%	9,502	3%	8,919	3%	11,392	4%
23% - 50% FPL	16,779	8%	18,702	6%	19,637	7%	23,032	7%
51% - 75% FPL	23,331	11%	25,956	9%	27,869	9%	31,967	10%
76% - 100% FPL	26,750	12%	31,059	10%	34,322	11%	39,116	12%
101% - 138% FPL	33,840	15%	51,646	17%	58,931	20%	65,542	21%
> 138% FPL	4,697	2%	5,608	2%	2,612	1%	3,257	1%
Total	**219,885**	**100%**	**297,020**	**100%**	**301,685**	**100%**	**313,902**	**100%**

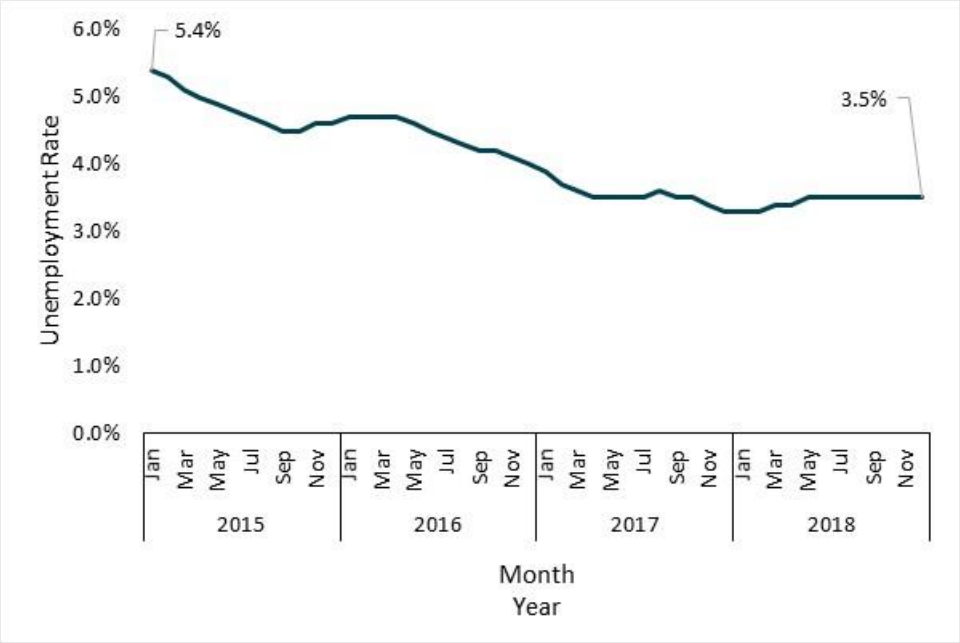
Source: HIP monthly enrollment files, February 2015 – December 2018.

Exhibit II.37 Number and Percent of HIP Members by Income Range for HIP Switchers (February 2015 – December 2018)

Income Range	2015		2016		2017		2018	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent
0% FPL	42,238	73%	36,019	50%	45,941	50%	49,091	43%
1%- 22% FPL	2,744	5%	3,137	4%	3,439	4%	4,803	4%
23% - 50% FPL	3,395	6%	7,046	10%	8,631	9%	11,598	10%
51% - 75% FPL	4,248	7%	9,501	13%	11,424	13%	15,389	14%
76% - 100% FPL	3,973	7%	9,840	14%	11,634	13%	16,370	14%
101% - 138% FPL	1,110	2%	5,125	7%	8,770	10%	14,654	13%
> 138% FPL	163	0%	916	1%	1,210	1%	1,854	2%
Total	**57,871**	**100%**	**71,584**	**100%**	**91,049**	**100%**	**113,759**	**100%**

Source: HIP monthly enrollment files, February 2015 – December 2018.

Exhibit II.38: Statewide Unemployment in Indiana (January 2015 – December 2018)



Source: Bureau of Labor Statistics (2019, September 10). Local Area Unemployment Statistics. Retrieved from https://data.bls.gov/pdq/SurveyOutputServlet

Exhibit II.39: Statewide Indiana Unemployment Rate by Month (January 2015 – December 2018)

Year	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
2015	5.4%	5.3%	5.1%	5.0%	4.9%	4.8%	4.7%	4.6%	4.5%	4.5%	4.6%	4.6%
2016	4.7%	4.7%	4.7%	4.7%	4.6%	4.5%	4.4%	4.3%	4.2%	4.2%	4.1%	4.0%
2017	3.9%	3.7%	3.6%	3.5%	3.5%	3.5%	3.5%	3.6%	3.5%	3.5%	3.4%	3.3%
2018	3.3%	3.3%	3.4%	3.4%	3.5%	3.5%	3.5%	3.5%	3.5%	3.5%	3.5%	3.5%

Source: Bureau of Labor Statistics (2019, September 10). Local Area Unemployment Statistics. Retrieved from https://data.bls.gov/pdq/SurveyOutputServlet

Exhibit II.40: Statewide Indiana Unemployment Rate, Averaged Over All Months (February 2015 – December 2018)

Year	Average Unemployment Rate
2015	4.8%
2016	4.4%
2017	3.5%
2018	3.5%

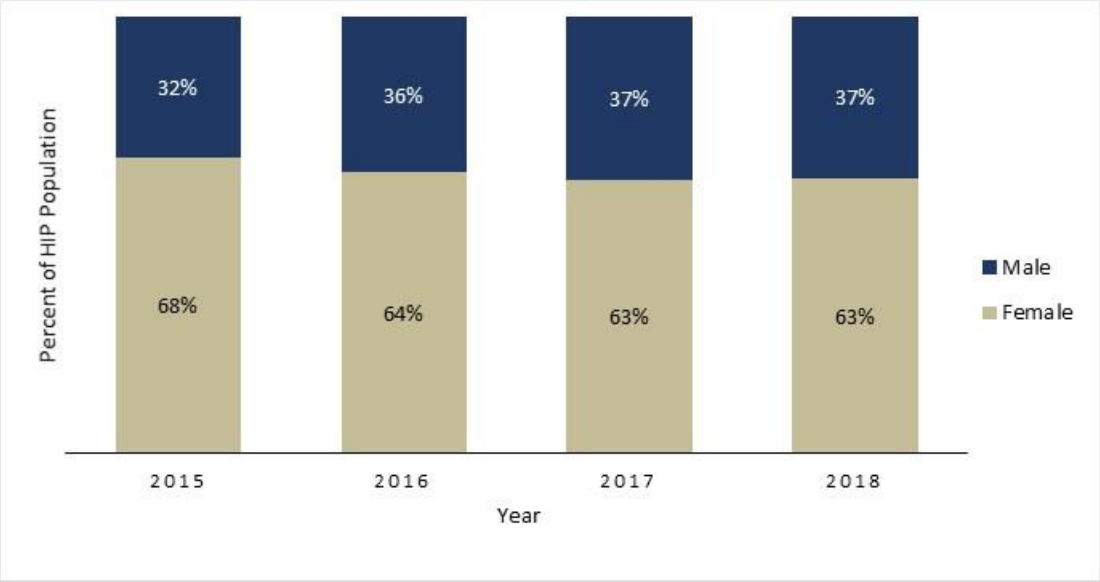
Source: Bureau of Labor Statistics (2019, September 10). Local Area Unemployment Statistics. Retrieved from https://data.bls.gov/pdq/SurveyOutputServlet

Gender

Lewin identified the gender of HIP members based on information reported at the first month of enrollment. The majority of HIP members are female (overall and by benefit plan type). HIP Plus Only members are more likely to be female as compared to HIP Basic Only members (60% in 2018 as compared to 56%). From 2015 to 2018, the percentage of HIP Basic Only male members increased from 31% to 44% while the percentage of HIP Plus Only male members stayed approximately the same (38% in 2016 and 40% in 2017 and 2018). HIP Switcher members were much more likely to be female (80% in 2018) as this population included pregnant women.

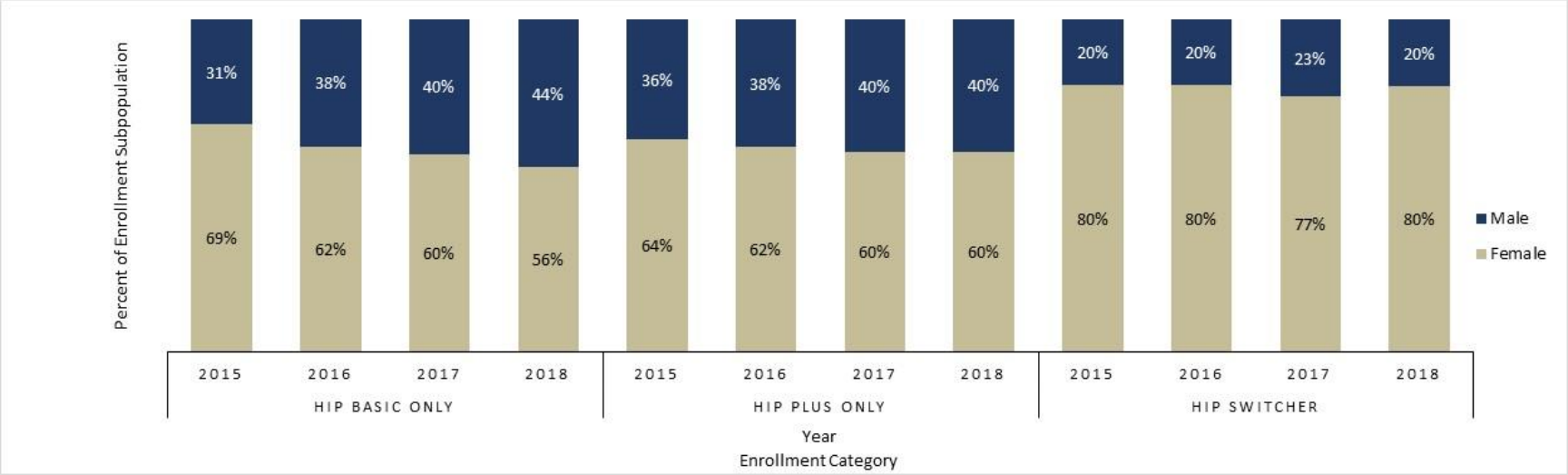
We present the composition of the HIP population by gender in **Exhibits II.41 through II.46**.

Exhibit II.41: Composition of HIP Population by Gender (February 2015 – December 2018)



Source: HIP monthly enrollment files, February 2015 – December 2018.

Exhibit II.42: Composition of HIP Population by Gender and Benefit Plan (February 2015 – December 2018)



Source: HIP monthly enrollment files, February 2015 – December 2018.

Exhibit II.43: Number and Percent of HIP Members by Gender for All Members (February 2015 – December 2018)

Gender	2015		2016		2017		2018	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent
Female	264,144	68%	334,713	64%	349,622	63%	359,641	63%
Male	125,840	32%	185,498	36%	206,839	37%	210,329	37%
Unknown	0	0%	1	0%	2	0%	1	0%
Total	**389,984**	**100%**	**520,212**	**100%**	**556,463**	**100%**	**569,971**	**100%**

Source: HIP monthly enrollment files, February 2015 – December 2018.

Exhibit II.44: Number and Percent of HIP Members by Gender for HIP Basic Only (February 2015 – December 2018)

Gender	2015		2016		2017		2018	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent
Female	76,882	69%	93,835	62%	97,731	60%	79,144	56%
Male	35,346	31%	57,772	38%	65,996	40%	63,165	44%
Unknown	0	0%	1	0%	2	0%	1	0%
Total	**112,228**	**100%**	**151,608**	**100%**	**163,729**	**100%**	**142,310**	**100%**

Source: HIP monthly enrollment files, February 2015 – December 2018.

Exhibit II.45: Number and Percent of HIP Members by Gender for HIP Plus Only (February 2015 – December 2018)

Gender	2015		2016		2017		2018	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent
Female	140,722	64%	183,254	62%	181,805	60%	189,575	60%
Male	79,163	36%	113,766	38%	119,880	40%	124,327	40%
Total	**219,885**	**100%**	**297,020**	**100%**	**301,685**	**100%**	**313,902**	**100%**

Source: HIP monthly enrollment files, February 2015 – December 2018.

Exhibit II.46: Number and Percent of HIP Members by Gender for HIP Switchers (February 2015 – December 2018)

Gender	2015		2016		2017		2018	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent
Female	46,540	80%	57,624	80%	70,086	77%	90,922	80%
Male	11,331	20%	13,960	20%	20,963	23%	22,837	20%
Total	**57,871**	**100%**	**71,584**	**100%**	**91,049**	**100%**	**113,759**	**100%**

Source: HIP monthly enrollment files, February 2015 – December 2018.

Health Status

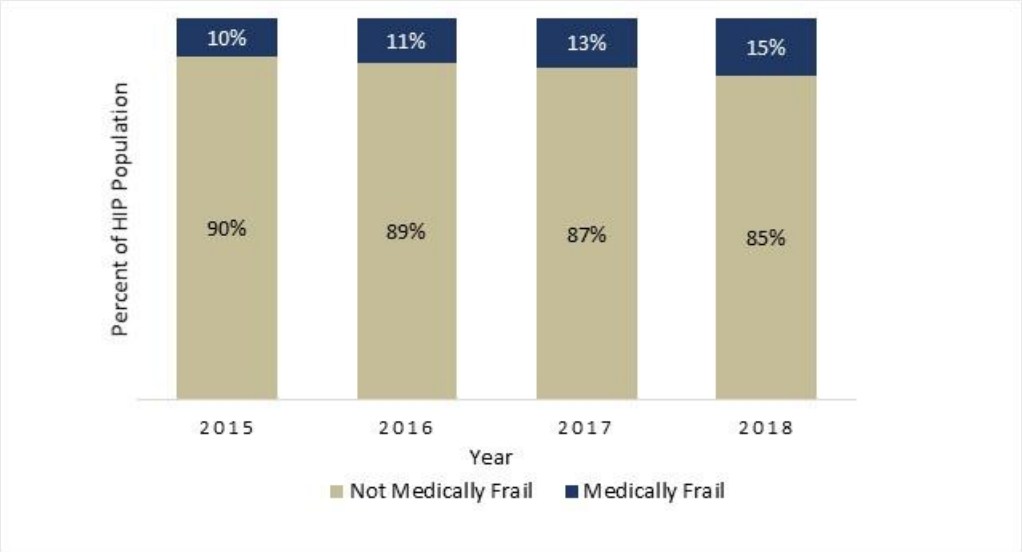
Lewin identified health status based on the medically frail indicator in the monthly HIP enrollment data. Medically frail refers to a federally required designation of members who have disabling mental disorders, including serious mental illness; chronic substance use disorders; serious or complex medical conditions; physical, intellectual or developmental disabilities that significantly impair the ability to perform one or more activities of daily living; or a disability determination based on Social Security Administration criteria. These members have a medically frail flag of Y in the monthly enrollment data. We designated HIP Members as medically frail if the member appears in the monthly enrollment data with a medically frail indicator value "Y" for at least one month of enrollment during the calendar year.

The proportion of medically frail HIP members has increased over time from 10% in 2015 to 15% in 2018. HIP Plus Only members were more likely to be medically frail than HIP Basic Only members by 5 to 7 percentage points from 2015 to 2018, specifically:

- Between 7% and 10% of members with only HIP Basic coverage were medically frail per year from 2015 to 2018.
- Between 12% and 17% of members with only HIP Plus coverage were medically frail per year from 2015 to 2018.
- HIP Switchers had similar proportions of medically frail members as HIP Plus Only, likely in part due to the inclusion of HIP Plus Copay members.

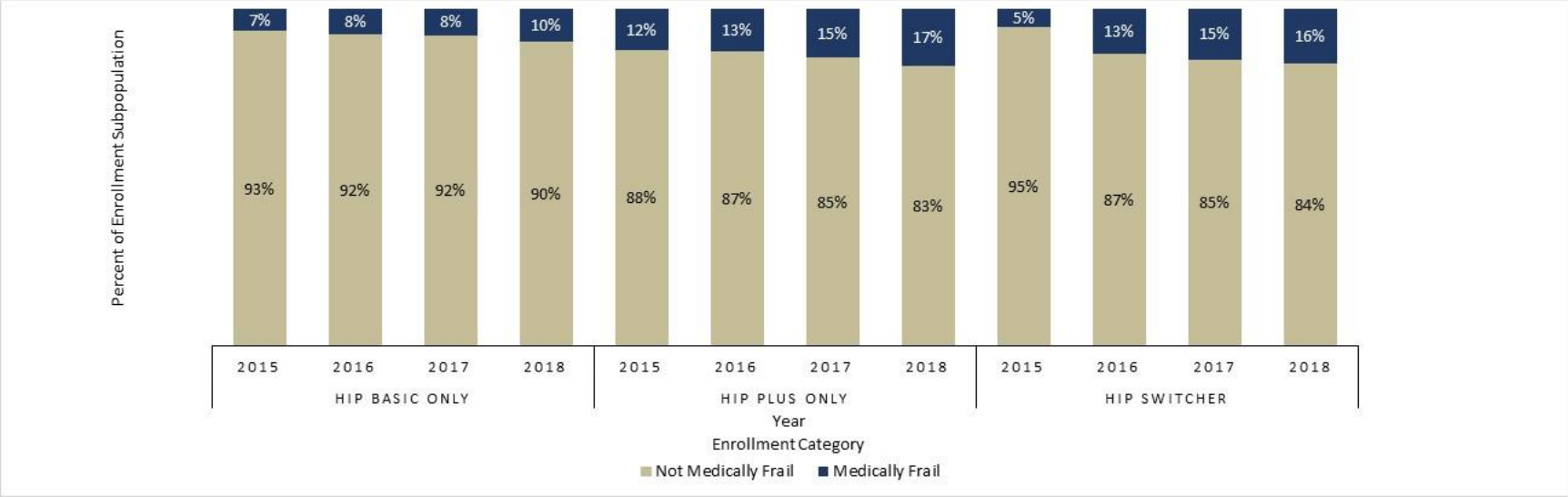
Exhibit II.47 through II.52 provide a breakdown of HIP members by benefit plan and medically frail status.

Exhibit II.47: Composition of HIP Population by Health Status (February 2015 – December 2018)



Source: HIP monthly enrollment files, February 2015 – December 2018.

Exhibit II.48: Composition of HIP Population by Enrollment Category and Health Status (February 2015 – December 2018)



Source: HIP monthly enrollment files, February 2015 – December 2018.

Exhibit II.49: Number and Percent of Medically Frail for All Members (February 2015 – December 2018)

Medically Frail Status	2015		2016		2017		2018	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent
Not Medically Frail	351,153	90%	460,496	89%	485,122	87%	483,597	85%
Medically Frail	37,987	10%	59,470	11%	71,270	13%	86,347	15%
Total	**389,140**	**100%**	**519,966**	**100%**	**556,392**	**100%**	**569,944**	**100%**

Source: HIP monthly enrollment files, February 2015 – December 2018.

Exhibit II.50: Number and Percent of Medically Frail for HIP Basic Only (February 2015 – December 2018)

Medically Frail Status	2015		2016		2017		2018	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent
Not Medically Frail	104,563	93%	139,605	92%	150,741	92%	128,116	90%
Medically Frail	7,585	7%	11,956	8%	12,975	8%	14,189	10%
Total	**112,148**	**100%**	**151,561**	**100%**	**163,716**	**100%**	**142,305**	**100%**

Source: HIP monthly enrollment files, February 2015 – December 2018.

Exhibit II.51: Number and Percent of Medically Frail for HIP Plus Only (February 2015 – December 2018)

Medically Frail Status	2015		2016		2017		2018	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent
Not Medically Frail	192,202	88%	258,881	87%	257,141	85%	260,284	83%
Medically Frail	27,245	12%	37,974	13%	44,493	15%	53,602	17%
Total	**219,447**	**100%**	**296,855**	**100%**	**301,634**	**100%**	**313,886**	**100%**

Source: HIP monthly enrollment files, February 2015 – December 2018.

Exhibit II.52: Number and Percent of Medically Frail for HIP Switchers (February 2015 – December 2018)

Medically Frail Status	2015		2016		2017		2018	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent
Not Medically Frail	54,388	95%	62,010	87%	77,240	85%	95,197	84%
Medically Frail	3,157	5%	9,540	13%	13,802	15%	18,556	16%
Total	**57,545**	**100%**	**71,550**	**100%**	**91,042**	**100%**	**113,753**	**100%**

Source: HIP monthly enrollment files, February 2015 – December 2018.

Attachment III: Description of Quantitative Data Sources Used in the Interim Report

Exhibit III.1: Description of Quantitative Data Sources

Data Type	Time Period	Data Description
Managed Care Entity (MCE) encounter data	February 2015 through December 2018	• Submitted by the four Indiana Healthy Indiana Plan (HIP) MCEs (i.e., Anthem, Managed Health Services (MHS), MDWise, and CareSource) to the Medicaid agency to detail specific services provided to a member by a provider. • Represents HIP-covered services with dates of service from February 2015 through December 2018 and paid through April 30, 2019. • Includes patient demographic information, diagnoses, procedure codes, revenue codes, and billing and rendering provider types.
Personal Wellness and Responsibility (POWER) Account reconciliation files	February 2015 through December 2018	• Provides a member's POWER Account experience by benefit period, including contributions, expenditures, and rollover status.
Monthly enrollment data	February 2015 through March 2019	• Provides member enrollment status by month and demographic characteristics (e.g., gender, race, income level). • Includes indicators/flags for the following: medically frail, pregnant, Transitional Medical Assistance (TMA) and Emergency Room services only.
Monthly disenrollment data	February 2015 through March 2019	• Provides member disenrollment by month, including enrollment status at time of disenrollment and reason(s) associated with disenrollment.
Fast Track data file	2017 – 2018	• Identifies members who made a Fast Track payment.
Presumptive eligibility file	February 2015 through December 2018	• Identifies members who used the presumptive eligibility enrollment process.
Tobacco use data file	October 2017 through December 2018	• Provides self-reported tobacco use by HIP members. • Reflects new enrollees or enrollees switching MCEs and self-reported member tobacco use during enrollment.
Tobacco surcharge data file	2019	• Identifies members that have received a tobacco surcharge levied by MCEs in 2019 for member tobacco use in 2018.
Gateway to Work referral file	January through June 2019	• Provides community engagement reporting status by month for each member.
Gateway to Work activity file	January through June 2019	• Provides community engagement activities reported by members, including reporting dates and the number of hours reported by type of activity.

Data Type	Time Period	Data Description
Gateway to Work exemption files	January through June 2019	• Provides community engagement reporting exemptions by member by month • Files include information from the State's eligibility system and information received from MCEs.
Rural-Urban Continuum Code (RUCC) file	2013 (last update)	• Provides geographic location indicator to characterize members' area of residence according to RUCC. • Developed by the United States Department of Agriculture.
Provider Lists	2019	• Contains provider information for both the facilities/clinics and the physicians associated with HIP. • Includes provider name, provider address, provider Medicaid ID and provider National Provider Identifier (NPI).
HIP 2.0 MCE Reporting Manual Section III-3: Quality Management and Improvement Report	2015-2018	• Provides MCE-specific annual Healthcare Effectiveness Data and Information Set (HEDIS®) results.
MCE Quarterly Reports	2015-2018	• Includes a wide variety of data that MCEs are required to report to the State. • Used to identify disease management enrollment.

Attachment IV: Service Utilization Reports (2015 – 2018)

Note: The service utilization reports in this attachment reflect members with enrollment status values of Regular Basic (RB), Regular Plus (RP), State Basic (SB), State Plus (SP), pregnant (MA), and Healthy Indiana Plan (HIP) Plus Copay (PC). We did not include months when an individual had conditional eligibility, or members that were eligible for Emergency Room services only.

Exhibit IV.1a: Any Services Participation Rate of HIP Members, by HIP Plus Only, HIP Basic Only, and HIP Switchers (February 2015 – December 2018)

Benefit Plan	Feb 2015 - Dec 2015			Jan - Dec 2016		
	Number of Members[a]	Number of Members Receiving Services[a]	Participation Rate (% Receiving Services)	Number of Members[a]	Number of Members Receiving Services[a]	Participation Rate (% Receiving Services)
HIP Basic Only	39,448	32,424	82.2%	55,143	42,593	77.2%
HIP Plus Only	72,700	68,515	94.2%	150,343	141,078	93.8%
HIP Switchers	34,166	32,129	94.0%	41,839	38,856	92.9%
Total	**146,314**	**133,068**	**90.9%**	**247,325**	**222,527**	**90.0%**

Benefit Plan	Jan - Dec 2017			Jan - Dec 2018		
	Number of Members[a]	Number of Members Receiving Services[a]	Participation Rate (% Receiving Services)	Number of Members[a]	Number of Members Receiving Services[a]	Participation Rate (% Receiving Services)
HIP Basic Only	60,990	46,849	76.8%	39,445	28,917	73.3%
HIP Plus Only	161,805	151,063	93.4%	154,874	144,340	93.2%
HIP Switchers	54,036	49,350	91.3%	55,429	51,557	93.0%
Total	**276,831**	**247,262**	**89.3%**	**249,748**	**224,814**	**90.0%**

Source: HIP monthly enrollment data and MCE encounter data (February 2015 – December 2018)

[a] The number of members used in the Participation Rate includes only members enrolled 11 or more months during the calendar year. We restricted the calculation of the 2015 participation rate to members with enrollment of at least 10 or more months as the 2015 encounter data only included 11 months (February – December 2015).

Exhibit IV.1b: Centers for Disease Control and Prevention (CDC)-Defined Preventive Services Utilization Rate of HIP Members, by HIP Plus Only, HIP Basic Only, and HIP Switchers
(February 2015 – December 2018)

Benefit Plan	Feb 2015 - Dec 2015				Jan - Dec 2016			
	Number of Members Receiving Services	Total Number of Visits	# of Member Months[a]	Utilization Rate (# Visits Per 1,000 Member Yrs)	Number of Members Receiving Services	Total Number of Visits	# of Member Months	Utilization Rate (# Visits Per 1,000 Member Yrs)
HIP Basic Only	27,587	49,408	765,756	774	38,206	69,392	1,146,919	726
HIP Plus Only	99,689	203,661	1,582,629	1,544	146,889	331,532	2,602,724	1,529
HIP Switchers	31,891	75,308	537,136	1,682	42,187	107,310	710,469	1,812
Total	**159,167**	**328,377**	**2,885,521**	**1,366**	**227,282**	**508,234**	**4,460,112**	**1,367**

Benefit Plan	Jan - Dec 2017				Jan - Dec 2018			
	Number of Members Receiving Services	Total Number of Visits	# of Member Months[a]	Utilization Rate (# Visits Per 1,000 Member Yrs)	Number of Members Receiving Services	Total Number of Visits	# of Member Months	Utilization Rate (# Visits Per 1,000 Member Yrs)
HIP Basic Only	41,888	77,243	1,261,002	735	30,832	54,476	948,582	689
HIP Plus Only	148,286	337,828	2,693,366	1,505	150,826	327,772	2,700,611	1,456
HIP Switchers	51,637	128,547	904,797	1,705	65,563	163,150	1,051,050	1,863
Total	**241,811**	**543,618**	**4,859,165**	**1,342**	**247,221**	**545,398**	**4,700,243**	**1,392**

Source: HIP monthly enrollment data and MCE encounter data (February 2015 – December 2018)

Exhibit IV.1c: CDC-Defined Preventive Services Participation Rate of HIP Members, by HIP Plus Only, HIP Basic Only, and HIP Switchers (February 2015 – December 2018)

Benefit Plan	Feb 2015 - Dec 2015			Jan - Dec 2016		
	Number of Members[a]	Number of Members Receiving Services[a]	Participation Rate (% Receiving Services)	Number of Members[a]	Number of Members Receiving Services[a]	Participation Rate (% Receiving Services)
HIP Basic Only	39,448	16,315	41.4%	55,143	21,629	39.2%
HIP Plus Only	72,700	46,278	63.7%	150,343	95,735	63.7%
HIP Switchers	34,166	21,455	62.8%	41,839	26,609	63.6%
Total	**146,314**	**84,048**	**57.4%**	**247,325**	**143,973**	**58.2%**

Benefit Plan	Jan - Dec 2017			Jan - Dec 2018		
	Number of Members[a]	Number of Members Receiving Services[a]	Participation Rate (% Receiving Services)	Number of Members[a]	Number of Members Receiving Services[a]	Participation Rate (% Receiving Services)
HIP Basic Only	60,990	23,797	39.0%	39,445	14,565	36.9%
HIP Plus Only	161,805	101,138	62.5%	154,874	97,358	62.9%
HIP Switchers	54,036	33,025	61.1%	55,429	36,409	65.7%
Total	**276,831**	**157,960**	**57.1%**	**249,748**	**148,332**	**59.4%**

Source: HIP monthly enrollment data and MCE encounter data (February 2015 – December 2018)

[a] The number of members used in the Participation Rate includes only members enrolled 11 or more months during the calendar year. We restricted the calculation of the 2015 participation rate to members with enrollment of at least 10 or more months as the 2015 encounter data only included 11 months (February – December 2015).

Exhibit IV.1d: Dental/Vision Preventive Services Utilization Rate of HIP Members, by HIP Plus Only, HIP Basic Only, and HIP Switchers (February 2015 – December 2018)

Benefit Plan	Feb 2015 - Dec 2015				Jan - Dec 2016			
	Number of Members Receiving Services	Total Number of Visits	Number of Member Months[a]	Utilization Rate (# Visits Per 1,000 Member Yrs)	Number of Members Receiving Services	Total Number of Visits	Number of Member Months	Utilization Rate (# Visits Per 1,000 Member Yrs)
HIP Basic Only	6,640	7,269	765,756	114	7,380	8,300	1,146,919	87
HIP Plus Only	55,277	64,241	1,582,629	487	73,008	89,583	2,602,724	413
HIP Switchers	11,929	13,623	537,136	304	13,611	15,638	710,469	264
Total	**73,846**	**85,133**	**2,885,521**	**354**	**93,999**	**113,521**	**4,460,112**	**305**

Benefit Plan	Jan - Dec 2017				Jan - Dec 2018			
	Number of Members Receiving Services	Total Number of Visits	Number of Member Months[a]	Utilization Rate (# Visits Per 1,000 Member Yrs)	Number of Members Receiving Services	Total Number of Visits	Number of Member Months	Utilization Rate (# Visits Per 1,000 Member Yrs)
HIP Basic Only	7,989	8,898	1,261,002	85	5,137	5,646	948,582	71
HIP Plus Only	71,319	88,995	2,693,366	397	71,449	87,712	2,700,611	390
HIP Switchers	16,404	18,871	904,797	250	19,904	22,616	1,051,050	258
Total	**95,712**	**116,764**	**4,859,165**	**288**	**96,490**	**115,974**	**4,700,243**	**296**

Source: HIP monthly enrollment data and MCE encounter data (February 2015 – December 2018)

Exhibit IV.1e: Dental/Vision Preventive Services Participation Rate of HIP Members, by HIP Plus Only, HIP Basic Only, and HIP Switchers (February 2015 – December 2018)

Benefit Plan	Feb 2015 - Dec 2015			Jan - Dec 2016		
	Number of Members[a]	Number of Members Receiving Services[a]	Participation Rate (% Receiving Services)	Number of Members[a]	Number of Members Receiving Services[a]	Participation Rate (% Receiving Services)
HIP Basic Only	39,448	4,868	12.3%	55,143	5,051	9.2%
HIP Plus Only	72,700	26,021	35.8%	150,343	48,275	32.1%
HIP Switchers	34,166	8,878	26.0%	41,839	9,448	22.6%
Total	**146,314**	**39,767**	**27.2%**	**247,325**	**62,774**	**25.4%**

Benefit Plan	Jan - Dec 2017			Jan - Dec 2018		
	Number of Members[a]	Number of Members Receiving Services[a]	Participation Rate (% Receiving Services)	Number of Members[a]	Number of Members Receiving Services[a]	Participation Rate (% Receiving Services)
HIP Basic Only	60,990	5,388	8.8%	39,445	2,872	7.3%
HIP Plus Only	161,805	50,852	31.4%	154,874	47,673	30.8%
HIP Switchers	54,036	11,443	21.2%	55,429	12,471	22.5%
Total	**276,831**	**67,683**	**24.4%**	**249,748**	**63,016**	**25.2%**

Source: HIP monthly enrollment data and MCE encounter data (February 2015 – December 2018)

[a] The number of members used in the Participation Rate includes only members enrolled 11 or more months during the calendar year. We restricted the calculation of the 2015 participation rate to members with enrollment of at least 10 or more months as the 2015 encounter data only included 11 months (February – December 2015).

Exhibit IV.2a: Primary Care Visits Utilization Rate of HIP Members, by HIP Plus Only, HIP Basic Only, and HIP Switchers (February 2015 – December 2018)

Benefit Plan	Feb 2015 - Dec 2015				Jan - Dec 2016			
	Number of Members Receiving Services	Total Number of Visits	Number of Member Months[a]	Utilization Rate (# Visits Per 1,000 Member Yrs)	Number of Members Receiving Services	Total Number of Visits	Number of Member Months	Utilization Rate (# Visits Per 1,000 Member Yrs)
HIP Basic Only	27,097	72,806	765,756	1,141	35,009	92,309	1,146,919	966
HIP Plus Only	97,365	311,737	1,582,629	2,364	140,457	503,818	2,602,724	2,323
HIP Switchers	29,488	98,183	537,136	2,193	37,134	119,717	710,469	2,022
Total	**153,950**	**482,726**	**2,885,521**	**2,008**	**212,600**	**715,844**	**4,460,112**	**1,926**

Benefit Plan	Jan - Dec 2017				Jan - Dec 2018			
	Number of Members Receiving Services	Total Number of Visits	Number of Member Months[a]	Utilization Rate (# Visits Per 1,000 Member Yrs)	Number of Members Receiving Services	Total Number of Visits	Number of Member Months	Utilization Rate (# Visits Per 1,000 Member Yrs)
HIP Basic Only	38,220	103,143	1,261,002	982	30,777	82,209	948,582	1,040
HIP Plus Only	139,753	488,079	2,693,366	2,175	150,638	521,055	2,700,611	2,315
HIP Switchers	44,482	142,898	904,797	1,895	58,403	184,348	1,051,050	2,105
Total	**222,455**	**734,120**	**4,859,165**	**1,813**	**239,818**	**787,612**	**4,700,243**	**2,011**

Source: HIP monthly enrollment data and MCE encounter data (February 2015 – December 2018)

Exhibit IV.2b: Primary Care Visits Participation Rate HIP Members, by HIP Plus Only, HIP Basic Only, and HIP Switchers (February 2015 – December 2018)

Benefit Plan	Feb 2015 - Dec 2015			Jan - Dec 2016		
	Number of Members[a]	Number of Members Receiving Services[a]	Participation Rate (% Receiving Services)	Number of Members[a]	Number of Members Receiving Services[a]	Participation Rate (% Receiving Services)
HIP Basic Only	39,448	16,598	42.1%	55,143	19,954	36.2%
HIP Plus Only	72,700	43,579	59.9%	150,343	88,723	59.0%
HIP Switchers	34,166	20,346	59.6%	41,839	24,176	57.8%
Total	**146,314**	**80,523**	**55.0%**	**247,325**	**132,853**	**53.7%**

Benefit Plan	Jan - Dec 2017			Jan - Dec 2018		
	Number of Members[a]	Number of Members Receiving Services[a]	Participation Rate (% Receiving Services)	Number of Members[a]	Number of Members Receiving Services[a]	Participation Rate (% Receiving Services)
HIP Basic Only	60,990	21,844	35.8%	39,445	14,465	36.7%
HIP Plus Only	161,805	93,422	57.7%	154,874	93,992	60.7%
HIP Switchers	54,036	29,362	54.3%	55,429	33,619	60.7%
Total	**276,831**	**144,628**	**52.2%**	**249,748**	**142,076**	**56.9%**

Source: HIP monthly enrollment data and MCE encounter data (February 2015 – December 2018)

[a] The number of members used in the Participation Rate includes only members enrolled 11 or more months during the calendar year. We restricted the calculation of the 2015 participation rate to members with enrollment of at least 10 or more months as the 2015 encounter data only included 11 months (February – December 2015).

Exhibit IV.3a: Specialty Care Services Utilization Rate of HIP Members, by HIP Plus Only, HIP Basic Only, and HIP Switchers (February 2015 – December 2018)

Benefit Plan	Feb 2015 - Dec 2015				Jan - Dec 2016			
	Number of Members Receiving Services	Total Number of Visits	Number of Member Months[a]	Utilization Rate (# Visits Per 1,000 Member Yrs)	Number of Members Receiving Services	Total Number of Visits	Number of Member Months	Utilization Rate (# Visits Per 1,000 Member Yrs)
HIP Basic Only	30,364	92,776	765,756	1,454	43,512	131,117	1,146,919	1,372
HIP Plus Only	99,973	408,785	1,582,629	3,100	151,513	714,103	2,602,724	3,292
HIP Switchers	30,609	119,904	537,136	2,679	40,635	154,743	710,469	2,614
Total	**160,946**	**621,465**	**2,885,521**	**2,584**	**235,660**	**999,963**	**4,460,112**	**2,690**

Benefit Plan	Jan - Dec 2017				Jan - Dec 2018			
	Number of Members Receiving Services	Total Number of Visits	Number of Member Months[a]	Utilization Rate (# Visits Per 1,000 Member Yrs)	Number of Members Receiving Services	Total Number of Visits	Number of Member Months	Utilization Rate (# Visits Per 1,000 Member Yrs)
HIP Basic Only	32,860	95,087	1,261,002	905	28,629	83,168	948,582	1,052
HIP Plus Only	129,949	570,875	2,693,366	2,543	139,877	618,799	2,700,611	2,750
HIP Switchers	38,159	139,511	904,797	1,850	51,325	187,041	1,051,050	2,135
Total	**200,968**	**805,473**	**4,859,165**	**1,989**	**219,831**	**889,008**	**4,700,243**	**2,270**

Source: HIP monthly enrollment data and MCE encounter data (February 2015 – December 2018)

Exhibit IV.3b: Specialty Care Services Participation Rate of HIP Members, by HIP Plus Only, HIP Basic Only, and HIP Switchers (February 2015 – December 2018)

Benefit Plan	Feb 2015 - Dec 2015			Jan - Dec 2016		
	Number of Members[a]	Number of Members Receiving Services[a]	Participation Rate (% Receiving Services)	Number of Members[a]	Number of Members Receiving Services[a]	Participation Rate (% Receiving Services)
HIP Basic Only	39,448	17,598	44.6%	55,143	24,028	43.6%
HIP Plus Only	72,700	45,306	62.3%	150,343	96,120	63.9%
HIP Switchers	34,166	21,020	61.5%	41,839	26,320	62.9%
Total	**146,314**	**83,924**	**57.4%**	**247,325**	**146,468**	**59.2%**

Benefit Plan	Jan - Dec 2017			Jan - Dec 2018		
	Number of Members[a]	Number of Members Receiving Services[a]	Participation Rate (% Receiving Services)	Number of Members[a]	Number of Members Receiving Services[a]	Participation Rate (% Receiving Services)
HIP Basic Only	60,990	18,805	30.8%	39,445	13,465	34.1%
HIP Plus Only	161,805	87,990	54.4%	154,874	88,921	57.4%
HIP Switchers	54,036	25,826	47.8%	55,429	29,764	53.7%
Total	**276,831**	**132,621**	**47.9%**	**249,748**	**132,150**	**52.9%**

Source: HIP monthly enrollment data and MCE encounter data (February 2015 – December 2018)

[a] The number of members used in the Participation Rate includes only members enrolled 11 or more months during the calendar year. We restricted the calculation of the 2015 participation rate to members with enrollment of at least 10 or more months as the 2015 encounter data only included 11 months (February – December 2015).

Exhibit IV.4a: Emergency Department (ED) Visits Utilization Rate of HIP Members, by HIP Plus Only, HIP Basic Only, and HIP Switchers (February 2015 – December 2018)

Benefit Plan	Feb 2015 - Dec 2015				Jan - Dec 2016			
	Number of Members Receiving Services	Total Number of Visits	Number of Member Months[a]	Utilization Rate (# Visits Per 1,000 Member Yrs)	Number of Members Receiving Services	Total Number of Visits	Number of Member Months	Utilization Rate (# Visits Per 1,000 Member Yrs)
HIP Basic Only	37,499	85,830	765,756	1,345	53,183	126,911	1,146,919	1,328
HIP Plus Only	65,691	137,998	1,582,629	1,046	100,449	230,756	2,602,724	1,064
HIP Switchers	26,559	65,355	537,136	1,460	35,793	94,242	710,469	1,592
Total	**129,749**	**289,183**	**2,885,521**	**1,203**	**189,425**	**451,909**	**4,460,112**	**1,216**

Benefit Plan	Jan - Dec 2017				Jan - Dec 2018			
	Number of Members Receiving Services	Total Number of Visits	Number of Member Months[a]	Utilization Rate (# Visits Per 1,000 Member Yrs)	Number of Members Receiving Services	Total Number of Visits	Number of Member Months	Utilization Rate (# Visits Per 1,000 Member Yrs)
HIP Basic Only	56,611	131,282	1,261,002	1,249	41,887	89,032	948,582	1,126
HIP Plus Only	100,148	225,157	2,693,366	1,003	97,898	207,984	2,700,611	924
HIP Switchers	44,638	116,880	904,797	1,550	52,975	131,134	1,051,050	1,497
Total	**201,397**	**473,319**	**4,859,165**	**1,169**	**192,760**	**428,150**	**4,700,243**	**1,093**

Source: HIP monthly enrollment data and MCE encounter data (February 2015 – December 2018)

Exhibit IV.4b: ED Visits Participation Rate of HIP Members, by HIP Plus Only, HIP Basic Only, and HIP Switchers (February 2015 – December 2018)

Benefit Plan	Feb 2015 - Dec 2015			Jan - Dec 2016		
	Number of Members[a]	Number of Members Receiving Services[a]	Participation Rate (% Receiving Services)	Number of Members[a]	Number of Members Receiving Services[a]	Participation Rate (% Receiving Services)
HIP Basic Only	39,448	19,145	48.5%	55,143	27,345	49.6%
HIP Plus Only	72,700	26,202	36.0%	150,343	60,668	40.4%
HIP Switchers	34,166	16,491	48.3%	41,839	22,451	53.7%
Total	**146,314**	**61,838**	**42.3%**	**247,325**	**110,464**	**44.7%**

Benefit Plan	Jan - Dec 2017			Jan - Dec 2018		
	Number of Members[a]	Number of Members Receiving Services[a]	Participation Rate (% Receiving Services)	Number of Members[a]	Number of Members Receiving Services[a]	Participation Rate (% Receiving Services)
HIP Basic Only	60,990	29,202	47.9%	39,445	16,888	42.8%
HIP Plus Only	161,805	62,201	38.4%	154,874	56,532	36.5%
HIP Switchers	54,036	28,402	52.6%	55,429	29,296	52.9%
Total	**276,831**	**119,805**	**43.3%**	**249,748**	**102,731**	**41.1%**

Source: HIP monthly enrollment data and MCE encounter data (February 2015 – December 2018)

[a] The number of members used in the Participation Rate includes only members enrolled 11 or more months during the calendar year. We restricted the calculation of the 2015 participation rate to members with enrollment of at least 10 or more months as the 2015 encounter data only included 11 months (February – December 2015).

Exhibit IV.5a: Urgent Care Visits Utilization Rate of HIP Members, by HIP Plus Only, HIP Basic Only, and HIP Switchers (February 2015 – December 2018)

Benefit Plan	Feb 2015 - Dec 2015				Jan - Dec 2016			
	Number of Members Receiving Services	Total Number of Visits	Number of Member Months[a]	Utilization Rate (# Visits Per 1,000 Member Yrs)	Number of Members Receiving Services	Total Number of Visits	Number of Member Months	Utilization Rate (# Visits Per 1,000 Member Yrs)
HIP Basic Only	3,045	4,562	765,756	71	6,040	9,454	1,146,919	99
HIP Plus Only	12,516	19,375	1,582,629	147	24,644	41,746	2,602,724	192
HIP Switchers	3,430	5,582	537,136	125	5,976	10,169	710,469	172
Total	**18,991**	**29,519**	**2,885,521**	**123**	**36,660**	**61,369**	**4,460,112**	**165**

Benefit Plan	Jan - Dec 2017				Jan - Dec 2018			
	Number of Members Receiving Services	Total Number of Visits	Number of Member Months[a]	Utilization Rate (# Visits Per 1,000 Member Yrs)	Number of Members Receiving Services	Total Number of Visits	Number of Member Months	Utilization Rate (# Visits Per 1,000 Member Yrs)
HIP Basic Only	7,619	12,315	1,261,002	117	5,799	8,752	948,582	111
HIP Plus Only	26,982	45,389	2,693,366	202	26,443	42,847	2,700,611	190
HIP Switchers	8,316	14,163	904,797	188	9,432	15,172	1,051,050	173
Total	**42,917**	**71,867**	**4,859,165**	**177**	**41,674**	**66,771**	**4,700,243**	**170**

Source: HIP monthly enrollment data and MCE encounter data (February 2015 – December 2018)

Exhibit IV.5b: Urgent Care Visits Participation Rate of HIP Members, by HIP Plus Only, HIP Basic Only, and HIP Switchers (February 2015 – December 2018)

Benefit Plan	Feb 2015 - Dec 2015			Jan - Dec 2016		
	Number of Members[a]	Number of Members Receiving Services[a]	Participation Rate (% Receiving Services)	Number of Members[a]	Number of Members Receiving Services[a]	Participation Rate (% Receiving Services)
HIP Basic Only	39,448	1,913	4.8%	55,143	3,440	6.2%
HIP Plus Only	72,700	5,757	7.9%	150,343	16,292	10.8%
HIP Switchers	34,166	2,439	7.1%	41,839	4,144	9.9%
Total	**146,314**	**10,109**	**6.9%**	**247,325**	**23,876**	**9.7%**

Benefit Plan	Jan - Dec 2017			Jan - Dec 2018		
	Number of Members[a]	Number of Members Receiving Services[a]	Participation Rate (% Receiving Services)	Number of Members[a]	Number of Members Receiving Services[a]	Participation Rate (% Receiving Services)
HIP Basic Only	60,990	4,482	7.3%	39,445	2,836	7.2%
HIP Plus Only	161,805	18,759	11.6%	154,874	17,216	11.1%
HIP Switchers	54,036	5,778	10.7%	55,429	5,887	10.6%
Total	**276,831**	**29,019**	**10.5%**	**249,748**	**25,939**	**10.4%**

Source: HIP monthly enrollment data and MCE encounter data (February 2015 – December 2018)

[a] The number of members used in the Participation Rate includes only members enrolled 11 or more months during the calendar year. We restricted the calculation of the 2015 participation rate to members with enrollment of at least 10 or more months as the 2015 encounter data only included 11 months (February – December 2015).

Exhibit IV.6a: Avoidable ED Utilization for All HIP Members (February 2015 – December 2018)

Utilization		Feb - Dec 2015	Jan - Dec 2016	Jan - Dec 2017	Jan - Dec 2018
Total	Total Number of Members	389,984	520,212	556,463	569,971
	Total Number Members Using ED	129,749	189,425	201,397	192,760
	Total Number of ED Visits	289,183	451,909	473,319	428,150
Avoidable ED Visit Classification Distribution	Non-Emergent	23.83%	21.23%	20.66%	19.70%
	Emergent/Primary Care Treatable	25.63%	25.00%	25.44%	25.38%
	Emergent - ED Care Needed - Preventable/Avoidable	6.74%	6.90%	7.18%	6.97%
	Emergent - ED Care Needed - Not Preventable/Avoidable	16.53%	16.18%	16.62%	17.16%
	Due to Injury	17.50%	17.86%	12.97%	11.86%
	Due to Mental Health Problems	3.01%	3.34%	3.80%	3.83%
	Due to Alcohol or Substance Abuse	2.31%	2.98%	3.44%	3.62%
	Unclassified	4.45%	6.52%	9.89%	11.48%

Source: MCE encounter data (February 2015 – December 2018)

Exhibit IV.6b: Avoidable ED Utilization for HIP Basic Only Members (February 2015 – December 2018)

Utilization		Feb - Dec 2015	Jan - Dec 2016	Jan - Dec 2017	Jan - Dec 2018
Total	Total Number of Members	112,228	151,608	163,729	142,310
	Total Number Members Using ED	37,499	53,183	56,611	41,887
	Total Number of ED Visits	85,830	126,911	131,282	89,032
Avoidable ED Visit Classification Distribution	Non-Emergent	24.34%	22.15%	21.49%	20.51%
	Emergent/Primary Care Treatable	26.20%	25.46%	25.94%	25.74%
	Emergent - ED Care Needed - Preventable/Avoidable	7.09%	7.07%	7.25%	7.30%
	Emergent - ED Care Needed - Not Preventable/Avoidable	15.07%	14.29%	14.97%	15.30%
	Due to Injury	18.07%	19.20%	14.12%	13.48%
	Due to Mental Health Problems	2.93%	3.27%	3.82%	4.19%
	Due to Alcohol or Substance Abuse	2.73%	3.34%	3.80%	4.54%
	Unclassified	3.57%	5.22%	8.62%	8.93%

Source: MCE encounter data (February 2015 – December 2018)

Exhibit IV.6c: Avoidable ED Utilization for HIP Plus Only Members (February 2015 – December 2018)

Utilization		Feb - Dec 2015	Jan - Dec 2016	Jan - Dec 2017	Jan - Dec 2018
Total	Total Number of Members	219,885	297,020	301,685	313,902
	Total Number Members Using ED	65,691	100,449	100,148	97,898
	Total Number of ED Visits	137,998	230,756	225,157	207,984
Avoidable ED Visit Classification Distribution	Non-Emergent	22.63%	20.53%	20.08%	19.56%
	Emergent/Primary Care Treatable	25.37%	24.59%	25.18%	25.60%
	Emergent - ED Care Needed - Preventable/Avoidable	6.82%	7.07%	7.39%	7.30%
	Emergent - ED Care Needed - Not Preventable/Avoidable	17.74%	17.59%	18.15%	18.68%
	Due to Injury	18.01%	18.26%	13.24%	12.46%
	Due to Mental Health Problems	3.17%	3.58%	3.99%	3.97%
	Due to Alcohol or Substance Abuse	2.36%	3.14%	3.64%	3.63%
	Unclassified	3.89%	5.24%	8.32%	8.80%

Source: MCE encounter data (February 2015 – December 2018)

Exhibit IV.6d: Avoidable ED Utilization for HIP Switchers (February 2015 – December 2018)

Utilization		Feb - Dec 2015	Jan - Dec 2016	Jan - Dec 2017	Jan - Dec 2018
Total	Total Number of Members	57,871	71,584	91,049	113,759
	Total Number Members Using ED	26,559	35,793	44,638	52,975
	Total Number of ED Visits	65,355	94,242	116,880	131,134
Avoidable ED Visit Classification Distribution	Non-Emergent	25.75%	21.72%	20.84%	19.36%
	Emergent/Primary Care Treatable	25.43%	25.41%	25.39%	24.77%
	Emergent - ED Care Needed - Preventable/Avoidable	6.07%	6.22%	6.68%	6.21%
	Emergent - ED Care Needed - Not Preventable/Avoidable	15.86%	15.23%	15.48%	15.95%
	Due to Injury	15.64%	14.98%	11.14%	9.75%
	Due to Mental Health Problems	2.77%	2.80%	3.39%	3.35%
	Due to Alcohol or Substance Abuse	1.65%	2.05%	2.63%	2.95%
	Unclassified	6.83%	11.59%	14.46%	17.66%

Source: MCE encounter data (February 2015 – December 2018)

Attachment V: Goal 4 Analytic Tables

Analytic Tables By Federal Poverty Level (2015 – 2018)

This section contains detailed results by federal poverty level (FPL) in support of the results presented for **Goal 4**.

Exhibit V.1: Disenrollment Reasons for HIP Plus Members by FPL (February 2015 – December 2018)

*Note: Analyses use the **Goal 4** definition of Healthy Indiana Plan (HIP) member categories, as described in **Section F, Exhibit F.4.1***

Time Period	Payment Tier	All Goal 4 HIP Plus Members[a]	Goal 4 HIP Plus Members Disenrolled[b]		Goal 4 HIP Plus Members Disenrolled Due to Non-Payment		Goal 4 HIP Members Disenrolled Due to Income		Goal 4 HIP Plus Members Disenrolled Due to Disability or Pregnancy[c]		Goal 4 HIP Plus Members Disenrolled Due to Other Administrative Reasons[d]	
			Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent
Feb 2015 - Dec 2015	0%-22% FPL	149,551	20,256	13.5%	876	0.6%	8,696	5.8%	3,280	2.2%	7,294	4.9%
	23%-50% FPL	19,537	2,257	11.6%	35	0.2%	980	5.0%	348	1.8%	901	4.6%
	51%-75% FPL	26,934	3,209	11.9%	62	0.2%	1,586	5.9%	503	1.9%	1,085	4.0%
	76%-100% FPL	30,165	3,782	12.5%	123	0.4%	1,918	6.4%	532	1.8%	1,227	4.1%
	101%-138 FPL	34,561	4,526	13.1%	1,018	2.9%	1,928	5.6%	503	1.5%	1,118	3.2%
	> 138% FPL	4,652	871	18.7%	19	0.4%	829	17.8%	7	0.2%	14	0.3%
	Total	**265,400**	**34,901**	**13.2%**	**2,133**	**0.8%**	**15,937**	**6.0%**	**5,173**	**1.9%**	**11,639**	**4.4%**
Jan 2016 - Dec 2016	0%-22% FPL	192,326	43,688	22.7%	3,055	1.6%	14,264	7.4%	5,681	3.0%	21,022	10.9%
	23%-50% FPL	23,431	4,147	17.7%	130	0.6%	1,238	5.3%	590	2.5%	2,304	9.8%
	51%-75% FPL	32,974	6,038	18.3%	266	0.8%	2,042	6.2%	854	2.6%	3,036	9.2%
	76%-100% FPL	38,696	7,790	20.1%	493	1.3%	2,974	7.7%	974	2.5%	3,508	9.1%
	101%-138 FPL	54,776	14,750	26.9%	3,655	6.7%	5,930	10.8%	1,157	2.1%	4,174	7.6%
	> 138% FPL	4,521	3,254	72.0%	63	1.4%	3,062	67.7%	46	1.0%	112	2.5%
	Total	**346,724**	**79,667**	**23.0%**	**7,662**	**2.2%**	**29,510**	**8.5%**	**9,302**	**2.7%**	**34,156**	**9.9%**
Jan 2017 - Dec 2017	0%-22% FPL	197,021	47,755	24.2%	918	0.5%	14,343	7.3%	5,690	2.9%	27,542	14.0%
	23%-50% FPL	26,070	5,292	20.3%	228	0.9%	1,789	6.9%	539	2.1%	2,860	11.0%
	51%-75% FPL	36,543	7,745	21.2%	419	1.1%	2,817	7.7%	884	2.4%	3,827	10.5%
	76%-100% FPL	43,500	10,187	23.4%	694	1.6%	4,319	9.9%	1,146	2.6%	4,266	9.8%
	101%-138 FPL	65,237	21,369	32.8%	4,458	6.8%	9,768	15.0%	1,400	2.1%	6,009	9.2%
	> 138% FPL	1,714	564	32.9%	64	3.7%	335	19.5%	41	2.4%	131	7.6%
	Total	**370,085**	**92,912**	**25.1%**	**6,781**	**1.8%**	**33,371**	**9.0%**	**9,700**	**2.6%**	**44,635**	**12.1%**

Time Period	Payment Tier	All Goal 4 HIP Plus Members[a]	Goal 4 HIP Plus Members Disenrolled[b]		Goal 4 HIP Plus Members Disenrolled Due to Non-Payment		Goal 4 HIP Members Disenrolled Due to Income		Goal 4 HIP Plus Members Disenrolled Due to Disability or Pregnancy[c]		Goal 4 HIP Plus Members Disenrolled Due to Other Administrative Reasons[d]	
			Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent
Jan 2018 - Dec 2018	0%-22% FPL	192,457	57,785	30.0%	511	0.3%	22,242	11.6%	4,906	2.5%	31,305	16.3%
	23%-50% FPL	30,964	9,104	29.4%	152	0.5%	3,426	11.1%	531	1.7%	5,217	16.8%
	51%-75% FPL	42,697	12,865	30.1%	327	0.8%	4,987	11.7%	894	2.1%	6,975	16.3%
	76%-100% FPL	50,613	16,060	31.7%	628	1.2%	6,754	13.3%	1,107	2.2%	7,965	15.7%
	101%-138 FPL	73,998	28,786	38.9%	3,812	5.2%	13,195	17.8%	1,463	2.0%	10,814	14.6%
	> 138% FPL	2,330	895	38.4%	70	3.0%	524	22.5%	39	1.7%	286	12.3%
	Total	**393,059**	**125,495**	**31.9%**	**5,500**	**1.4%**	**51,128**	**13.0%**	**8,940**	**2.3%**	**62,562**	**15.9%**

[a] Represents HIP Plus members having at least one month of HIP Plus coverage in the calendar year regardless of other enrollment status (this is not the same as "HIP Plus Only").

[b] Unique count of members having disenrollment in the calendar year. Members can have multiple reasons for disenrollment. Additionally, members can have multiple disenrollments in a year. Adding counts of members for different reasons for disenrollment is not recommended to obtain the number of disenrollments.

[c] Approximately 2% of the members with disenrollment reason "Disability or Pregnancy" have HIP enrollment aid category of HIP Plus Copay (PC) or Pregnant (MA) in the same calendar year. The majority of the HIP Plus members with a PC or MA enrollment status do not have disenrollment. Approximately 5% of the members with this disenrollment reason reenroll within next month and 25% reenroll within the same calendar year with Regular or State Basic or Plus benefit plan.

[d] Includes disenrollment codes 006 – Moved out of state, 007 – Did not submit paperwork for redetermination, 008 – Failure to verify information, and 009 – Other (e.g. "deceased," "incarcerated," etc.).

Source: HIP enrollment data files, February 2015 through December 2018

Exhibit V.2: Movement between Member Benefit Plan, by FPL (February 2015 – December 2018)

*Note: Analyses use the **Goal 4** definition of HIP member categories, as described in **Section F, Exhibit F.4.1***

Time Period	FPL Level[a]	Goal 4 HIP Plus [b]	Goal 4 HIP Basic [b]	Moved from HIP Basic to HIP Plus[c]		Moved from HIP Plus to HIP Basic[c]	
				Number	Percent of HIP Basic	Number	Percent of HIP Plus
2015	0%-22% FPL	149,551	130,888	26,322	20.1%	7,324	4.9%
	23%-50% FPL	19,537	7,209	180	2.5%	2,231	11.4%
	51%-75% FPL	26,934	9,444	228	2.4%	2,964	11.0%
	76%-100% FPL	30,165	9,430	218	2.3%	2,787	9.2%
	101%-138 FPL	34,561	3,464	55	1.6%	317	0.9%
	> 138% FPL	4,652	719	4	0.6%	6	0.1%
	Total	**265,400**	**161,154**	**27,007**	**16.8%**	**15,629**	**5.9%**
2016	0%-22% FPL	192,326	135,970	13,008	9.6%	8,916	4.6%
	23%-50% FPL	23,431	14,256	1,804	12.7%	3,110	13.3%
	51%-75% FPL	32,974	19,778	2,458	12.4%	4,828	14.6%
	76%-100% FPL	38,696	21,241	2,488	11.7%	5,391	13.9%
	101%-138 FPL	54,776	8,331	1,470	17.6%	699	1.3%
	> 138% FPL	4,521	1,046	84	8.0%	96	2.1%
	Total	**346,724**	**200,622**	**21,312**	**10.6%**	**23,040**	**6.6%**
2017	0%-22% FPL	197,021	145,541	18,675	12.8%	15,846	8.0%
	23%-50% FPL	26,070	18,543	3,003	16.2%	3,081	11.8%
	51%-75% FPL	36,543	25,982	3,968	15.3%	4,245	11.6%
	76%-100% FPL	43,500	27,982	4,129	14.8%	4,434	10.2%
	101%-138 FPL	65,237	12,842	2,506	19.5%	1,501	2.3%
	> 138% FPL	1,714	778	88	11.3%	67	3.9%
	Total	**370,085**	**231,668**	**32,369**	**14.0%**	**29,174**	**7.9%**
2018	0%-22% FPL	192,457	132,518	24,777	18.7%	11,732	6.1%
	23%-50% FPL	30,964	18,274	5,073	27.8%	2,865	9.3%
	51%-75% FPL	42,697	25,257	6,641	26.3%	4,038	9.5%
	76%-100% FPL	50,613	28,483	6,810	23.9%	4,443	8.8%
	101%-138 FPL	73,998	14,889	3,608	24.2%	1,955	2.6%
	> 138% FPL	2,330	1,054	268	25.4%	124	5.3%
	Total	**393,059**	**220,475**	**47,177**	**21.4%**	**25,157**	**6.4%**

[a] FPL is based on the FPL observed in first month of enrollment in the calendar year (refer Section F, Goal 4 subsection "Identification of FPL" for details).

[b] HIP Plus represents members having at least one month HIP Plus in the calendar year regardless of other enrollment status and HIP Basic represents members having at least one month HIP Plus in the calendar year regardless of other enrollment status (this is not the same as "HIP Plus Only" or "HIP Basic Only"). There are some members who are included in both HIP Plus and HIP Basic totals as they have switched between the benefit plans. As such, adding the two columns to get the total HIP membership population is not recommended.

[c] Members can switch plans multiple times in a calendar year. There are a few members with more than two switches between HIP Basic and HIP Plus. Counts reported are unique member counts for each direction of the move between coverage plans and is not the count of the number of moves (for members with multiple plan changes).

Source: HIP monthly enrollment files, February 2015 – December 2018.

Exhibit V.3: HIP Plus Members Disenrollment Rate By Not Receiving / Receiving Rollover (January 2017 – December 2018)

*Note: Analyses use the **Goal 4** definition of HIP member categories, as described in **Section F, Exhibit F.4.1***

Time Period [a,b]	Received Rollover	FPL[c]	All Goal 4 HIP Plus Members[d]	Goal 4 HIP Plus Members Disenrolled[e]		Goal 4 HIP Plus Members Disenrolled Due to Non-Payment		Goal 4 HIP Members Disenrolled Due to Income		Goal 4 HIP Plus Members Disenrolled Due to Disability or Pregnancy[f]		Goal 4 HIP Plus Members Disenrolled Due to Other Administrative Reasons[g]	
				Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent
Jan 2017 - Dec 2017	Yes	0%-22% FPL	58,774	10,570	18.0%	243	0.4%	3,308	5.6%	985	1.7%	6,182	10.5%
		23%-50% FPL	9,778	1,473	15.1%	57	0.6%	532	5.4%	132	1.3%	771	7.9%
		51%-75% FPL	13,759	2,138	15.5%	110	0.8%	821	6.0%	238	1.7%	1,019	7.4%
		76%-100% FPL	15,996	2,881	18.0%	197	1.2%	1,266	7.9%	334	2.1%	1,127	7.0%
		101%-138 FPL	21,065	5,558	26.4%	1,196	5.7%	2,735	13.0%	295	1.4%	1,400	6.6%
		> 138% FPL	475	160	33.7%	21	4.4%	99	20.8%	15	3.2%	29	6.1%
		Total	**119,847**	**22,780**	**19.0%**	**1,824**	**1.5%**	**8,761**	**7.3%**	**1,999**	**1.7%**	**10,528**	**8.8%**
	No	0%-22% FPL	138,247	37,185	26.9%	675	0.5%	11,035	8.0%	4,705	3.4%	21,360	15.5%
		23%-50% FPL	16,292	3,819	23.4%	171	1.0%	1,257	7.7%	407	2.5%	2,089	12.8%
		51%-75% FPL	22,784	5,607	24.6%	309	1.4%	1,996	8.8%	646	2.8%	2,808	12.3%
		76%-100% FPL	27,504	7,306	26.6%	497	1.8%	3,053	11.1%	812	3.0%	3,139	11.4%
		101%-138 FPL	44,172	15,811	35.8%	3,262	7.4%	7,033	15.9%	1,105	2.5%	4,609	10.4%
		> 138% FPL	1,239	404	32.6%	43	3.5%	236	19.0%	26	2.1%	102	8.2%
		Total	**250,238**	**70,132**	**28.0%**	**4,957**	**2.0%**	**24,610**	**9.8%**	**7,701**	**3.1%**	**34,107**	**13.6%**

Time Period [a,b]	Received Rollover	FPL[c]	All Goal 4 HIP Plus Members[d]	Goal 4 HIP Plus Members Disenrolled[e]		Goal 4 HIP Plus Members Disenrolled Due to Non-Payment		Goal 4 HIP Members Disenrolled Due to Income		Goal 4 HIP Plus Members Disenrolled Due to Disability or Pregnancy[f]		Goal 4 HIP Plus Members Disenrolled Due to Other Administrative Reasons[g]	
				Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent
Jan 2018 - Dec 2018	Yes	0%-22% FPL	72,833	25,136	34.5%	221	0.3%	9,148	12.6%	1,515	2.1%	14,804	20.3%
		23%-50% FPL	14,324	4,636	32.4%	73	0.5%	1,655	11.6%	199	1.4%	2,808	19.6%
		51%-75% FPL	19,901	6,643	33.4%	147	0.7%	2,476	12.4%	393	2.0%	3,791	19.0%
		76%-100% FPL	23,685	8,426	35.6%	243	1.0%	3,455	14.6%	473	2.0%	4,447	18.8%
		101%-138 FPL	33,630	14,657	43.6%	1,499	4.5%	6,995	20.8%	581	1.7%	5,803	17.3%
		> 138% FPL	911	400	43.9%	26	2.9%	242	26.6%	13	1.4%	129	14.2%
		Total	**165,284**	**59,898**	**36.2%**	**2,209**	**1.3%**	**23,971**	**14.5%**	**3,174**	**1.9%**	**31,782**	**19.2%**
	No	0%-22% FPL	119,624	32,649	27.3%	290	0.2%	13,094	10.9%	3,391	2.8%	16,501	13.8%
		23%-50% FPL	16,640	4,468	26.9%	79	0.5%	1,771	10.6%	332	2.0%	2,409	14.5%
		51%-75% FPL	22,796	6,222	27.3%	180	0.8%	2,511	11.0%	501	2.2%	3,184	14.0%
		76%-100% FPL	26,928	7,634	28.3%	385	1.4%	3,299	12.3%	634	2.4%	3,518	13.1%
		101%-138 FPL	40,368	14,129	35.0%	2,313	5.7%	6,200	15.4%	882	2.2%	5,011	12.4%
		> 138% FPL	1,419	495	34.9%	44	3.1%	282	19.9%	26	1.8%	157	11.1%
		Total	**227,775**	**65,597**	**28.8%**	**3,291**	**1.4%**	**27,157**	**11.9%**	**5,766**	**2.5%**	**30,780**	**13.5%**

[a] "Received rollover" column includes members that earned rollover benefit in prior year and were enrolled in current year. For purposes of this report, we identified any member having earned rollover in calendar year 2016 and having enrollment in 2017 as receiving rollover in 2017. Likewise, we identified any member having earned rollover in 2017 and enrolled in 2018 as receiving rollover in 2018.

[b] Rollover estimates between 2017 and 2018 should not be compared due to a change in the definition of the member benefit period. Starting in 2018, the State made all member benefit periods equal to the calendar year. Prior to 2017, members enrolling multiple times within a year had multiple Personal Wellness and Responsibility (POWER) Accounts and the State applied rollover based on the individual member benefit period (based on the dates the member enrolled).

[c] FPL is based on the FPL observed in first month of enrollment in the calendar year (refer Section F, Goal 4 subsection "Identification of FPL" for details)

[d] Represents members having at least one month HIP Plus benefit in the calendar year regardless of other enrollment status (this is not the same as "HIP Plus Only").

[e] Unique count of members having disenrollment in the calendar year. Members can have multiple reasons for disenrollment. Additionally, members can have multiple disenrollments in a year. Adding counts of members for different reasons for disenrollment is not recommended to obtain the number of disenrollments.

[f] Approximately 2% of the members with disenrollment reason "Disability or Pregnancy" have HIP enrollment aid category of HIP Plus Copay (PC) or Pregnant (MA) in the same calendar year. The majority of the HIP Plus members with PC or MA enrollment status do not have disenrollment. Approximately 5% of the members with this disenrollment reason reenroll within next month and 25% reenroll within the same calendar year with Regular or State Basic or Plus benefit plan.

[g] Includes disenrollment codes 006 – Moved out of state, 007 – Did not submit paperwork for redetermination, 008 – Failure to verify information, and 009 – Other (e.g. "deceased," "incarcerated," etc.).

Source: HIP enrollment data files, February 2016 through December 2018

Statistical Methodology

For purposes of the Interim Evaluation Report, the primary focus for **Goal 4** was developing a baseline perspective on **Goal 4's** outcome measures based on program data available at the time of analysis. As part of the analyses performed, we studied the association between the measures of interest and selected sociodemographic characteristics using multivariate regressions. The purpose of these regressions was to provide an initial overview of selected sociodemographic factors that had (and can have) impact on outcome measures of interest. The Summative Evaluation Report will build on these baseline analyses to develop estimates for measures of interest adjusting for confounding effects. In this section we provide a summary of our approach to developing the models and highlight some initial observations.

The three outcome measures of interest for **Goal 4** Hypothesis 2 Research Question 2.2 were:

- Probability of disenrollment with non-payment
- Probability of moving to HIP Basic from HIP Plus
- Probability of moving to HIP Plus from HIP Basic

We estimated individual multivariate logistic regressions with selected beneficiary and demographic characteristics as explanatory factors. This approach controls for beneficiary, geographic, and time (program year) differences. The summary statistics presented in this report and **Goal 4's** regression models both used HIP monthly enrollment data. The discussion below outlines the identification of the dependent variable for each model, construction of the analytical data, and model development and results.

Probability of disenrollment with non-payment – dependent variable

Members can have multiple disenrollments and multiple reasons for disenrollment. Based on analyses of member disenrollment (presented in the main report), the proportion of members having non-payment as reason for disenrollment is comparatively low at 1.4% in 2018 (and highest at 2.2% in 2016) in comparison to the overall disenrollment rate (31.9% for 2018, 25.1% for 2017 and 23% for 2016) which includes additional reasons for disenrollment. From the perspective of studying disenrollment due to non-payment, members can have three possible disenrollment outcomes:

- Disenrollment with non-payment as a reason
- Disenrollment but non-payment is not a reason (other reasons)
- No disenrollment

We developed a multinomial logistic model to study the relationship between member probability to disenroll with non-payment as reason and associated sociodemographic characteristics. The outcome variable for this model is a categorical variable with three types of disenrollment (as outlined above) as possible values and the explanatory factors were the available sociodemograhic characteristics (discussed later in the *Analytical Data Development* subsection).

Probability of moving to HIP Plus from HIP Basic, Probability of moving to HIP Basic from HIP Plus – dependent variables

Based on analyses of member enrollment data (**Exhibit V.2**) , members may move from HIP Plus to HIP Basic and from HIP Basic to HIP Plus during a calendar year. Members can also continue to stay with the same plan or disenroll. We used a regression-based approach to study whether members before and

after the implementation of the payment tier policy in 2018 had a higher or lower propensity to change benefit plans adjusting for potential variabilities due to multiple sociodemographic factors. For purposes of understanding factors that can impact member movement between benefit plan, it can be conceptualized that:

- Members having HIP Basic can have two possible outcomes – moves to HIP Plus or does not
- Members having HIP Plus can have two possible outcomes – moves to HIP Basic or does not

We developed multivariate logistic models to estimate the impact of sociodemographic factors on each of the movements – HIP Basic to HIP Plus and HIP Plus to HIP Basic.

Analytical data for model estimation

We used member demographics available in the state administrative enrollment data (age, gender, race, income, household size, marital status, geography) as explanatory factors. We also included the county level unemployment rate as a potential indicator. Calendar year of enrollment was used as factor to control for program year variation.

We constructed two types of longitudinal data capturing information of member enrollment and disenrollment using state administrative data from February 2015 through December 2018:

- Member/month level
- Member/year level

We identified the member population based on criteria defined for **Goal 4** (discussed in **Exhibit F.4.1**).

Use of member/month level data was aimed at capturing the more granular monthly member characteristics and benefit plan. This data is based on the state administrative monthly enrollment and disenrollment data. We based values for member characteristics on the available information in the data for each month. For instances with missing data for a month, where possible, we imputed with the 'last known' value prior to the month. The benefit plan information reflected the benefit plan the member was enrolled in for the month. We identified member movement from HIP Basic to HIP Plus or HIP Plus to HIP Basic based on the benefit plan for consecutive months. The data included an indicator to identify disenrollment for the month when the member disenrolled from a plan as well as the associated disenrollment reason code.

The member/year data captures a calendar year perspective of members' outcome measures of interest and sociodemographic characteristics including HIP plan membership. For this analysis, we aggregated monthly level member enrollment data to the calendar year level. A member was identified as HIP Plus (ever_Plus) if the member was fully enrolled in either Regular Plus (RP) or State Plus (SP) at any point in the calendar year. Similarly a member was identified as HIP Basic (ever_Basic) if the member was fully enrolled in either Regular Basic (RB) or State Basic (SB) benefit plan at any point in the calendar year. Members who moved between HIP Plus and HIP Basic (HIP Switchers) were identified both as ever_Plus and ever_Basic. If a member had at least one move from HIP Basic to HIP Plus, the member was identified as "HIP Basic to HIP Plus" and similarly if a member had at least one move from HIP Plus to HIP Basic, the member was identified as "HIP Plus to HIP Basic".

Members can have multiple disenrollments and multiple reasons for disenrollment. Disenrollment reason flags captured the information for all disenrollment reasons a member had in the year. A

member can have multiple income and FPL changes over time (refer **Section F, Goal 4** subsection *Identification of FPL* for more details). For member/year data we identified FPL and other characteristics (like age, gender, race, geography, marital status) based on available information in the first month the member was enrolled in the calendar year. A member identified as medically frail (based on medically frail flag) for at least one month was identified as being medically frail in the year-level aggregation

Model development

For this baseline study, we included the explanatory variables (sociodemographic characteristics) as main effects (with no interaction effects or transformations) in the model estimation process. We used the PROC LOGISTIC procedure available in SAS to estimate the models. We considered both backward and forward stepwise method for selecting the significant variables.

The following main effects models were developed using both the member/ month and member/year level data for **Goal 4** Hypothesis 2 Research Question 2.2:

- Model 1: Probability of disenrollment with non-payment as reason

$$\log\left(\frac{\text{Prob(Disenrollment nonpayment as reason)}}{\text{Prob(not disenrolled)}}\right) = f(\text{sociodemographic characteristics})$$

$$\log\left(\frac{\text{Prob(Disenrollment other reasons)}}{\text{Prob(not disenrolled)}}\right) = g(\text{sociodemographic characteristics})$$

  where f() and g() are linear combination of sociodemographic factors.[9] We used all HIP Plus member data to estimate the model.[10]

- Model 2: Probability of moving from HIP Basic to HIP Plus

$$\log\left(\frac{\text{Prob(Move to Plus)}}{\text{1-Prob(Move to Plus)}}\right) = f_1(\text{sociodemographic characteristics})$$

  where $f_1()$ near combination of sociodemographic factors. For model estimation, we restricted the data to the HIP Basic member population.

- Model 3: Probability of moving from HIP Plus to HIP Basic

$$\log\left(\frac{\text{Prob(Move to Basic)}}{\text{1-Prob(Move to Basic)}}\right) = f_2(\text{sociodemographic characteristics})$$

  where $f_2()$ is a linear combination of sociodemographic factors. For model estimation, we restricted the data to the HIP Plus member population.

Initial observations

There was no difference in findings (factors affecting the outcome measures of interest) between models using member/month and member/year data. The results presented in this report are based of models estimated using member/year data. All sociodemographic variables considered for this baseline

[9] For example, f(age, gender) = α + β1 age + β2 gender.

[10] We eliminated data points with missing values during the estimation process.

analyses were identified to have impact on the outcome for both disenrollment and Basic to Plus movement – irrespective of the model selection technique. For Plus to Basic movement, result presented in this report is based of model estimated using backward selection technique (better model fit compared to other techniques). **Exhibit V.4, Exhibit V.5,** and **Exhibit V.6** display the parameter estimates for the three models and likelihood of each of the selected factor's impact on the outcome.

The benefit year, region, gender, age, race, frailty status, and income (in unadjusted dollars and in % FPL) were identified as significant factors (p-value <= 0.01) for all the models. This initial study shows that there are significant differences in the outcome measures by year (controlling for other sociodemographic characteristics). While members in 2018 have much higher odds of disenrollment, they have lower odds of disenrollment due to non-payment compared to 2017 (**Exhibit V.4**). Black members appear to have higher odds of disenrolling compared to non-Hispanic White members and members age 30 years or older appear less likely to disenroll due to non-payment compared to members age 29 year or younger. Members in 2018 had lower odds of transitioning from HIP Plus to HIP Basic and HIP Basic members had higher odds of transitioning to HIP Plus compared to 2017.

Although the models provide some insight into potential factors that can affect member outcome (disenrollment due to non-payment, movement between benefit plans), since the POWER Account Contribution payment tiers were implemented in 2018, these models do not provide any conclusive inferences at this time. Lessons learned from the study will be used as baseline to build on for the Summative Evaluation Report analytics.

Exhibit V.4: Estimated Logistic Model for Probability to Disenroll With Non-payment or Other Reason

Factors (and Levels)		Non-payment as Reason		Other Reasons		Odds Ratio	
		Estimate	StdErr	Estimate	StdErr	Non-payment as Reason	Other Reasons
Year (Ref: 2017)	2015	-1.008	0.028	-0.68	0.008	0.370	0.510
	2016	0.180	0.019	-0.02	0.006	1.200	0.980
	2018	-0.176	0.018	0.35	0.005	0.840	1.420
HIP Member Category (Ref: Plus Only)	Switcher	-0.015	0.018	0.07	0.005	0.980	1.070
Region (Ref: Metro)	Non-metro (2,500 - 19,999)	-0.023	0.020	-0.02	0.006	0.980	0.980
	Non-metro (20,000 or more)	0.100	0.027	-0.01	0.008	1.100	0.990
	Non-metro (Rural, less than 2,500)	-0.026	0.074	-0.04	0.022	0.970	0.960
Gender (Ref: Male)	Female	0.007	0.015	-0.17	0.004	1.010	0.850
Age Category (Ref: Age 19-29)	Age 30-39	-0.278	0.017	-0.26	0.006	0.760	0.770
	Age 40-49	-0.345	0.020	-0.34	0.006	0.710	0.720
	Age 50-59	-0.540	0.024	-0.37	0.007	0.580	0.690
	Age 60-66	-0.926	0.039	-0.13	0.009	0.400	0.880

Factors (and Levels)		Non-payment as Reason		Other Reasons		Odds Ratio	
		Estimate	StdErr	Estimate	StdErr	Non-payment as Reason	Other Reasons
Race Category (Ref: Non-Hispanic White)	Asian or Pacific Islander	-1.045	0.050	-0.07	0.013	0.350	0.930
	Black	0.566	0.017	0.24	0.006	1.760	1.280
	Hispanic	-0.065	0.030	0.07	0.010	0.940	1.070
	Other	-0.278	0.054	0.01	0.014	0.760	1.010
Marital Status (Ref: Single)	Married	-0.660	0.019	0.03	0.006	0.520	1.030
	Other	-0.015	0.018	0.08	0.005	0.990	1.090
Frail Indicator (Ref: Not Frail)	Frail	-1.256	0.028	0.10	0.005	0.280	1.110
FPL		0.004	0.000	0.00	0.000	1.000	1.000
Average monthly income		0.001	0.000	0.00	0.000	1.000	1.000
Unemployment rate		0.018	0.009	-0.11	0.003	1.020	0.900

Note: Reference outcome measure for this multinomial logit model is members not disenrolled. All effects were significant with p-value < 0.01.

Exhibit: V.5: Estimated Logit Model for Probability to Move from HIP Plus to HIP Basic

Factors (and Levels)		HIP Basic		Odds Ratio
		Estimate	StdErr	
Year (Ref: 2017)	2015	-0.414	0.012	0.661
	2016	-0.238	0.010	0.788
	2018	-0.236	0.009	0.790
Gender (Ref: Male)	Female	0.083	0.007	1.087
Age Category (Ref: Age 19-29)	Age 30-39	0.076	0.009	1.079
	Age 40-49	-0.196	0.010	0.822
	Age 50-59	-0.744	0.012	0.475
	Age 60-66	-1.352	0.023	0.259
Race Category (Ref: Non-Hispanic White)	Asian or Pacific Islander	-0.835	0.033	0.434
	Black	0.485	0.009	1.625
	Hispanic	-0.017	0.017	0.983
	Other	-0.205	0.027	0.815
Marital Status (Ref: Single)	Married	-0.012	0.009	0.988
	Other	0.109	0.009	1.115
Frail Indicator (Ref: Not Frail)		0.220	0.008	1.247
FPL		-0.001	0.000	0.999
Unemployment rate		0.054	0.005	1.055

Note: Event being modeled is "move to HIP Basic". Reference group for this logit model is all other (includes members not moving to HIP Plus). All effects were significant with p-value < 0.01.

Exhibit: V.6: Estimated Logit Model for Probability to Move from HIP Basic to HIP Plus

Factors (and Levels)		HIP Plus		Odds Ratio
		Estimate	StdErr	
Year (Ref: 2017)	2015	0.197	0.011	1.218
	2016	-0.315	0.011	0.730
	2018	0.514	0.008	1.673
Region (Ref: Metro)	Non-metro (2,500 - 19,999)	0.070	0.010	1.072
	Non-metro (20,000 or more)	-0.018	0.013	0.982
	Non-metro (Rural, less than 2,500)	0.048	0.036	1.049
Gender (Ref: Male)	Female	0.382	0.007	1.466
Age Category (Ref: Age 19-29)	Age 30-39	0.222	0.008	1.249
	Age 40-49	0.482	0.009	1.619
	Age 50-59	0.739	0.011	2.095
	Age 60-66	0.731	0.021	2.077
Race Category (Ref: Non-Hispanic White)	Asian or Pacific Islander	0.360	0.026	1.433
	Black	-0.186	0.008	0.831
	Hispanic	-0.023	0.015	0.977
	Other	-0.166	0.025	0.847
Marital Status (Ref: Single)	Married	0.064	0.009	1.066
	Other	-0.027	0.008	0.974
Frail Indicator (Ref: Not Frail)	Frail	0.579	0.008	1.784
FPL		-0.001	0.000	0.999
Average monthly income		0.000	0.000	1.000
Unemployment rate		0.070	0.004	1.072

Note: Event being modeled is "move to HIP Plus". Reference group for this logit model is all other (includes members not moving to HIP Basic). All effects were significant with p-value < 0.01.

Attachment VI: Healthy Indiana Plan Evaluation FSSA Key Informant Interview Questions

[NAME] conducted separate 45-60 minute interviews with Family and Social Services Administration (FSSA) officials and tailored the sample question list based on role.

Sample Question List

- Thinking back to the beginning of 2018, what aspects of the Healthy Indiana Plan (HIP) have been the most effective, and why?
- Thinking back to the beginning of 2018, what have been the main challenges related to HIP? How is FSSA addressing those challenges?
- What themes has FSSA noted when reviewing information on HIP member satisfaction?
- What are the main components of FSSA's communication strategy regarding the HIP program and policies?
- How does FSSA involve/coordinate with the Managed Care Entities (MCEs) regarding HIP-related communications?
- What are the key strategies used to support member understanding of Personal Wellness and Responsibility (POWER) Account payment requirements and rollover?
- How has the implementation of the tiered POWER Account payment structure affected MCEs operations/processes, if at all?
- What are the main challenges for successful HIP implementation and monitoring going forward? How are those different from today?
- To what extent has FSSA developed strategies to re-engage members who do not meet Gateway to Work reporting requirements and have eligibility suspended, particularly as the reporting requirements are fully phased-in?
- What new initiatives or programs in Indiana does FSSA anticipate will impact the HIP eligible population and their participation in HIP or other insurance options (e.g., Bridge program)?
- What would you like to improve about HIP?
- Is there anything else you would like to add?

Attachment VII: Healthy Indiana Plan Evaluation Managed Care Entity Interviews: General and Tobacco Cessation

Managed Care Entity Interview: General

The questions below are for the general Managed Care Entity (MCE) interviews. [NAME] met with the four MCEs separately for 30-45 minute interviews. Tobacco questions were omitted as the [NAME] will conduct separate tobacco specific interviews with the MCEs. The questions were sent to each MCE before the call so they could identify the appropriate staff to attend. MCE interviewees were asked to think about current and future challenges/successes for the Healthy Indiana Plan (HIP) as they responded to these questions.

Overall

1. What has been your organization's overall experience with HIP?
2. What do you see as the key successes for your organization related to implementation and administration of HIP?
3. What do you see as the main short- and long-term challenge for your organization related to successful implementation and administration of HIP?

Gateway to Work

4. Overall, what is your organization's strategy for implementing and administering the Gateway to Work program?
5. What have been the greatest successes and challenges related to Gateway to Work?
6. Please describe your member reporting process for Gateway to Work, including how you address member reporting burden.
7. Please describe the strategies your organization uses to support member understanding of the Gateway to Work program.

Personal Wellness and Responsibility (POWER) Account

8. Overall, what is your organization's strategy for collecting member POWER Account Contributions?
9. What have been the greatest successes and challenges related to collecting member POWER Account Contributions?
10. Overall, what is your organization's strategy for implementing and administering POWER Accounts, including rollover policies?
11. What have been the greatest successes and challenges related to POWER Accounts, including rollover?
12. Please describe the strategies your organization uses to support member understanding of POWER Accounts, including contributions and rollover.

Member Satisfaction

13. What areas are members most satisfied with? Least satisfied? (e.g., related to access, perceived barriers, cost, communication and transition between plans)
14. Do you have any special or unique initiatives to support member satisfaction/address areas of concern (beyond what is contractually required)?
15. How is HIP impacting member health?

Closing Thoughts

16. What would you improve about HIP?
17. Is there anything else you would like to add?

Managed Care Entity Interview: Tobacco Cessation

The questions below are for the tobacco cessation MCE interviews. [NAME] met with the four MCEs separately for 30-45 minute interviews. The questions were sent to each MCE before the call so they could identify the appropriate staff to attend. MCE interviewees were asked to think about current and future challenges/successes for HIP as they responded to these questions.

Overall

1. What is your role at [MCE]?
2. How does your plan identify tobacco users? How often is this information collected?
3. What percent of your HIP 2.0 members have you identified as tobacco users?

Cessation services/initiatives through MCE

4. [What changes has [MCE] made to tobacco cessation coverage, services, or other initiatives as a result of the Medicaid HIP renewal that was effective in January 2018?
    a. Explain scope and timing (start date, implementation period, etc.)
5. How has [MCE] communicated changes in cessation coverage, services, or other initiatives to members?
    a. What is the general awareness of members regarding tobacco cessation coverage, services, and other initiatives?
    b. Are there any specific activities that [MCE] has done to promote, support, or encourage use of tobacco cessation services?
6. How are you tracking the use of, or participation in, these services and initiatives?
    a. What, if any, data are collected for these purposes?
    b. Have there been changes to physician billing for these services?
    c. Have you seen changes in the utilization of tobacco cessation services as a result of the Medicaid HIP renewal?
    d. What do you think are the reasons members do not use tobacco cessation services?
7. What challenges have you experienced in implementing changes to tobacco cessation coverage, services, or initiatives relevant to the HIP renewal?
    a. Successes?
    b. Any future plans?

Tobacco premium surcharge

8. In addition to communication regarding tobacco cessation services/initiatives, how has [MCE] communicated information to members about the tobacco premium surcharge?
    a. What is the general awareness and understanding by members regarding the tobacco premium surcharge?
9. Other than changes to cessation services, how has [MCE] been affected by the premium surcharge for tobacco users?
    a. Were any new processes required?
10. What are some challenges or successes that you've experienced in implementing changes related to the tobacco premium surcharge?
    a. Any future plans?

Attachment VIII: Healthy Indiana Plan Evaluation Provider Interviews: Administrators, Eligibility, and Practitioners

Healthy Indiana Plan Provider Interview: Administrators

DESCRIPTION: This key informant interview guide applies to administrative staff for providers that serve Healthy Indiana Plan members.

Introduction and Overview of Purpose

Hello, my name is [NAME] calling from [NAME] on behalf of the Healthy Indiana Plan, also known as HIP. May I please speak with [INSERT NAME FROM SAMPLE]?

[OBTAIN CORRECT RESPONDENT; REINTRODUCE IF NECESSARY]

You should have received an email from the Indiana Family and Social Services Administration informing you or your practice about this provider interview.

Again, my name is [NAME]. I am from [NAME] and am working with [NAME] to conduct this interview. [NAME] was hired by the Indiana Family and Social Services Administration to perform a federally-required independent evaluation of the HIP program. The purpose of this interview is to talk with you about your experiences with HIP and your understanding of member satisfaction with HIP.

You have been invited because your [hospital/organization/practice] provides services to HIP members.

Over the next 20 to 30 minutes, I will ask you about your role, satisfaction of HIP members you work with, and overall thoughts on HIP. We are having several other interviews like this one in Indiana. Hearing about your experience will help us better evaluate the program. The information from our evaluation will help Indiana assess HIP and identify potential changes to improve the care that HIP members receive. Your participation is voluntary and your responses will remain confidential.

Your responses to our questions will be combined with responses from conversations we are having with other administrators. As a result, neither you nor any other person we are speaking with will be identifiable from your answers. Your combined responses will be used to write an interim evaluation report, available for public comment at the end of 2019. [NAME] will conduct additional interviews as part of the development of a final evaluation report due in 2022, which will also be available for public comment. You may choose not to answer any question, and you may choose, at any time, to stop the conversation for any reason.

What questions do you have before we continue? [Interviewer: pause for questions]

[If have questions, refer to the frequent questions document or read from it then ask again]

Can we begin? [Interviewer: pause for confirmation]

[If consent] I'd like to begin by thanking you for taking time out of your day to meet with me about HIP. I appreciate it.

[If do NOT consent] Thank you for taking time today, have a great day.

Participant Information

Q1. What is your role in the practice?

[Confirm role is administrator]
Do you also provide direct care services?

Enter text here:

Q2. Your organization/practice may only participate with certain plans. Which of the following Indiana programs does your practice/organization participate in?

- ☐ HOOSIER HEALTHWISE (HHW)
- ☐ HEALTHY INDIANA PLAN (HIP) → IF THIS OPTION OR "NOT SURE BUT ACCEPT MEDICAID" OR "TRADITIONAL MEDICAID" NOT SELECTED, GO TO CLOSE
- ☐ HOOSIER CARE CONNECT (HCC)
- ☐ FEE-FOR-SERVICE (TRADITIONAL MEDICAID)
- ☐ NOT SURE BUT ACCEPT MEDICAID
- ☐ OTHER (SPECIFY)

Enter text here:

Q3. What is your practice setting?

- ☐ SOLO/ INDIVIDUAL PRACTICE
- ☐ SINGLE-SPECIALTY GROUP (THIS CAN BE EITHER PRIMARY CARE OR SPECIALISTS)
- ☐ MULTI-SPECIALTY GROUP (THIS CAN INCLUDE BOTH PRIMARY CARE AND SPECIALISTS)
- ☐ ACUTE CARE HOSPITAL OR PHYSICIAN HOSPITAL ORGANIZATION (PHO)
- ☐ REHABILITATION FACILITY
- ☐ AMBULATORY SURGICAL CENTER (ASC)
- ☐ FEDERALLY QUALIFIED HEALTH CENTER (FQHC)
- ☐ RURAL HEALTH CENTER (RHC)
- ☐ OUTPATIENT MENTAL HEALTH CLINIC
- ☐ COMMUNITY MENTAL HEALTH CENTER (CMHC)
- ☐ OTHER (SPECIFY)

Enter text here:

Q4. How long has your practice/organization provided services to HIP members?

[If do not provide immediate response, probe for range]

- ☐ SINCE 2008 [For Interviewer: HIP 1.0, HIP 2.0, and Current HIP]
- ☐ SINCE 2015 [For Interviewer: HIP 2.0 and Current HIP]
- ☐ FROM 2018 TO PRESENT [For Interviewer: Current HIP only]
- ☐ OTHER (SPECIFY)

Enter text here:

Member Satisfaction with HIP

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

Q5. Please describe feedback you have heard from members about what areas of HIP they are most satisfied with.

Enter text here:

Q6. Please describe feedback you have heard from members about what areas of HIP they are least satisfied with.

Enter text here:

Q7. On a scale from very satisfied to very dissatisfied, how satisfied do you think members are with HIP?

- ☐ VERY SATISFIED
- ☐ SOMEWHAT SATISFIED
- ☐ SOMEWHAT DISSATISFIED
- ☐ VERY DISSATISFIED
- ☐ DON'T KNOW
- ☐ REFUSED
- ☐ OTHER (SPECIFY)

Enter text here:

Q8. What kind of feedback, if any, have you received from members or via staff at your organization regarding HIP members' ability to understand and make monthly HIP payments or copayments?

[If context is needed: Some HIP members are required to make monthly payments (based on income and tobacco use status, also known as Personal Wellness and Responsibility (POWER) Account Contributions) to maintain enrollment in the HIP program. Some HIP members must make copayments for certain services.

If more context is needed:

HIP members with family incomes over 100 percent of the federal poverty level (FPL) must pay a fixed monthly contribution (also known as POWER Account Contribution) which varies from $1 to $30 based on their family income and tobacco user status. If they (or in some cases their employer or non-profit organization) do not make these payments, their HIP coverage is closed. These members receive the "HIP Plus" benefit package.

HIP members with family incomes less than 100 percent of the FPL are not required to make monthly payments but do pay copayments for certain services. These members receive the "HIP Basic" benefit package.]

Enter text here:

Q9. What kind of feedback, if any, have you received from members or via staff at your organization regarding HIP members' ability to understand and comply with HIP Gateway to Work requirements?

[If context is needed: Gateway to Work connects HIP members with ways to look for work, train for jobs, finish school, and volunteer. Some HIP members are required to participate in Gateway to Work activities to keep HIP benefits, other members may be exempt. The number of activity hours required for Gateway to Work began at zero in January 2019 to allow members time to learn about the program, and increases incrementally from 20 hours per month in July 2019 to 80 hours per month in July 2020.]

Enter text here:

Provider Perspective

The next set of questions will ask about overall HIP impact, member ability to pay copayments, and uncompensated care.

Q10. To what extent are you able to obtain the necessary information/approvals for HIP service delivery?

- ☐ ALWAYS
- ☐ MOST OF THE TIME
- ☐ NOT VERY OFTEN
- ☐ NEVER
- ☐ DON'T KNOW
- ☐ REFUSED
- ☐ OTHER (SPECIFY)

Enter text here:

Q11. Are you charging copayments to HIP members?

- ☐ YES
- ☐ NO
- ☐ SOMETIMES
- ☐ DON'T KNOW
- ☐ REFUSED

Q12. Do you pursue collections on unpaid copays?

- ☐ YES
- ☐ NO
- ☐ SOMETIMES
- ☐ DON'T KNOW
- ☐ REFUSED

Q13. For those HIP members who are required to pay copayments, what percent of them are making their copayments to you? Would you say it is... (READ LIST)

- ☐ LESS THAN 25 PERCENT
- ☐ 25 TO 49 PERCENT
- ☐ 50 TO 74 PERCENT
- ☐ 75 TO 99 PERCENT
- ☐ 100 PERCENT
- ☐ DON'T KNOW
- ☐ REFUSED

Q14. Have you seen a decline in the number of requests for charity care cases for your organization since 2018?

- ☐ YES – IT DECREASED
- ☐ NO – IT INCREASED
- ☐ NO – IT STAYED THE SAME
- ☐ DON'T KNOW

Q15. Are there any aspects of the HIP program that you think work especially well? If so, please describe. [Note: Listen for how it affects health status or health care in Indiana]

Enter text here:

Q16. Have you encountered any challenges with the HIP program? If so, please describe. [Note: Listen for claims payment and prior authorization issues, relationship with MCEs]

Enter text here:

Q17. What would you improve about HIP?

Enter text here:

Q18. Thank you again for taking the time to meet today, is there anything else you would like to add?

Enter text here:

CLOSE:	**On behalf of the Healthy Indiana Plan, we thank you for participating in this survey. Your answers will help improve the program. If you have any questions about HIP, please call 1-877-438-4479.**

Healthy Indiana Plan Provider Interview: Eligibility

DESCRIPTION: This key informant interview guide applies to staff determining eligibility for the Healthy Indiana Plan.

Introduction and Overview of Purpose

Hello, my name is [NAME] calling from [NAME] on behalf of the Healthy Indiana Plan, also known as HIP. May I please speak with [INSERT NAME FROM SAMPLE]?

[OBTAIN CORRECT RESPONDENT; REINTRODUCE IF NECESSARY]

You should have received an email from the Indiana Family and Social Services Administration informing you or your [practice/organization] about this provider interview.

Again, my name is [NAME]. I am from [NAME] and am working with [NAME] to conduct this interview. [NAME] was hired by the Indiana Family and Social Services Administration to perform a federally-required independent evaluation of the HIP program. The purpose of this interview is to talk with you about your experiences with HIP and your understanding of member satisfaction with HIP.

You have been contacted for this interview because you help individuals become eligible for HIP.

Over the next 20 to 30 minutes, I will ask you about your role, satisfaction of HIP members you work with, and overall thoughts on HIP. We are having several other interviews like this one in Indiana. Hearing about your experience will help us better evaluate the program. The information from our evaluation will help Indiana assess HIP and identify potential changes to improve the care that HIP members receive. Your participation is voluntary and your responses will remain confidential.

Your responses to our questions will be combined with responses from other conversations we are having with other eligibility staff. As a result, neither you nor any other person we are speaking with will be identifiable from your answers. Your combined responses will be used to write an interim evaluation report, available for public comment at the end of 2019. [NAME] will conduct additional interviews as part of the development of a final evaluation report due in 2022, which will also be available for public comment. You may choose not to answer any question, and you may choose, at any time, to stop the conversation for any reason.

What questions do you have before we continue? [Interviewer: pause for questions]

[If have questions, refer to the frequent questions document or read from it then ask again]

Can we begin? [Interviewer: pause for confirmation]

[If consent] I'd like to begin by thanking you for taking time out of your day to meet with me about HIP. I appreciate it.

[If do NOT consent] Thank you for taking time today, have a great day.

Participant Information

Q1. What is your role in the [practice/organization]?

[confirm that individual being interviewed determines eligibility and is part of application organization or is a certified navigator]

Enter text here:

Q2. What setting are you located in?

[Inquire if in a provider setting (e.g., hospital or clinic), or not, ask to specify]

Enter text here:

Gateway to Work Requirement

First, we'll ask a few questions about Gateway to Work, then Personal Wellness and Responsibility (POWER) Account Contributions, the eligibility process, and we'll end with general thoughts about HIP. Let's start with the community engagement requirements.

[If context is needed: Gateway to Work connects HIP members with ways to look for work, train for jobs, finish school, and volunteer. Some HIP members are required to participate in Gateway to Work activities to keep HIP benefits, other members may be exempt. The number of activity hours required for Gateway to Work began at zero in January 2019 to allow members time to learn about the program, and increases incrementally from 20 hours per month in July 2019 to 80 hours per month in July 2020.]

Q3. What is your understanding of the Gateway to Work Program requirements?

Enter text here:

Q4. What feedback have you received from members regarding HIP members' ability to understand and comply with Gateway to Work requirements?

Enter text here:

POWER Account Contributions

The next question will ask about POWER Account Contributions.

[If context is needed: Some HIP members are required to make monthly payments (based on income and tobacco use status, also known as POWER Account Contributions) to maintain enrollment in the HIP program. Some HIP members must make copayments for certain services.

If additional context is needed:

- HIP members with family incomes over 100 percent of the federal poverty level (FPL) must pay a fixed monthly contribution (also known as POWER Account Contribution) which varies from $1 to $30 based on their family income and tobacco user status. If they (or in some cases their employer or non-profit organization) do not make these payments, their HIP coverage is closed. These members receive the "HIP Plus" benefit package.
- HIP members with family incomes less than 100 percent of the FPL are not required to make monthly payments but do pay copayments for certain services. These members receive the "HIP Basic" benefit package.]

Q5. Please share feedback that individuals applying for HIP have given in regards to the POWER Account Contributions (e.g., overall amount, ability to understand how to make the contributions, ability to make payments).

Enter text here:

Eligibility

The next set of questions will ask about eligibility.

Q6. Are you a qualified Presumptive Eligibility provider?

- ☐ YES →GO TO Q7
- ☐ NO → SKIP TO Q11

Q7. If you are a qualified Presumptive Eligibility provider, which of the following types of Presumptive Eligibility processes do you conduct?

- ☐ PRESUMPTIVE ELIGIBILITY FOR PREGNANT WOMEN ONLY
- ☐ HOSPITAL
- ☐ REGULAR
- ☐ DON'T KNOW
- ☐ REFUSED

Q8. Thinking about the Presumptive Eligibility process, how would you rate the overall effectiveness of the Presumptive Eligibility process at eliminating gaps in health care coverage?

- ☐ VERY EFFECTIVE
- ☐ EFFECTIVE
- ☐ NOT THAT EFFECTIVE
- ☐ NOT EFFECTIVE AT ALL
- ☐ DON'T KNOW
- ☐ REFUSED

Q9. Do you track how many people who signed up for Presumptive Eligibility coverage went on to complete an application?

- ☐ YES
- ☐ NO

If yes, describe.
Enter text here:

Q10. What would you say is the success rate of your Presumptive Eligibility members getting full HIP coverage?

- ☐ LESS THAN 25 PERCENT
- ☐ 25 TO 49 PERCENT
- ☐ 50 TO 74 PERCENT
- ☐ 75 TO 99 PERCENT
- ☐ 100 PERCENT
- ☐ DON'T KNOW
- ☐ REFUSED

Q11. Thinking about the Fast Track process, how would you rate the overall effectiveness of the Fast Track process at eliminating gaps in health care coverage?

- ☐ VERY EFFECTIVE
- ☐ EFFECTIVE
- ☐ NOT THAT EFFECTIVE
- ☐ NOT EFFECTIVE AT ALL
- ☐ DON'T KNOW
- ☐ REFUSED

Q12. What would you say is the success rate of members that pay Fast Track getting full HIP coverage?

- ☐ LESS THAN 25 PERCENT
- ☐ 25 TO 49 PERCENT
- ☐ 50 TO 74 PERCENT
- ☐ 75 TO 99 PERCENT
- ☐ 100 PERCENT
- ☐ DON'T KNOW
- ☐ REFUSED

Q13. Does your organization make fast track payments on behalf of applicants?

- ☐ YES
- ☐ SOMETIMES
- ☐ NO
- ☐ REFUSED

If "yes" or "sometimes", describe the process for making payments.
Enter text here:

General Thoughts on HIP

The next set of questions will ask about your understanding of member satisfaction and overall effectiveness with the Healthy Indiana Plan eligibility process. Please think about your experience in 2018 and 2019 when responding.

Q14. Based on your experience enrolling individuals in HIP coverage, please describe feedback you have heard from people about their experience enrolling.
[Inquire about what areas enrollees are most and least satisfied with.]

Enter text here:

Q15. How would you rate the overall effectiveness of the HIP eligibility process?

- ☐ VERY EFFECTIVE
- ☐ EFFECTIVE
- ☐ NOT THAT EFFECTIVE
- ☐ NOT EFFECTIVE AT ALL
- ☐ DON'T KNOW
- ☐ REFUSED

Q16. If you rated the overall effectiveness less than "very effective", please describe challenges or barriers to effective enrollment that you have observed.

Enter text here:

Q17. Are there any aspects of the HIP enrollment process that you think work well? If so, please describe.

Enter text here:

Q18. What would you improve about HIP?

Enter text here:

Q19. Thank you again for taking the time to meet today, is there anything else you would like to add?

Enter text here:

CLOSE:	**On behalf of the Healthy Indiana Plan we thank you for participating in this survey. Your answers will help improve the program. If you have any questions about HIP, please call 1-877-438-4479.**

Healthy Indiana Plan Provider Interview: Practitioner

DESCRIPTION: This key informant interview guide applies to Healthy Indiana Plan physicians or other health care practitioners, including those that offer tobacco cessation services.

Introduction and Overview of Purpose – For Health Care Practitioners That May or May Not Offer Tobacco Cessation Services

Hello, my name is [NAME] calling from [NAME] on behalf of the Healthy Indiana Plan, also known as HIP. May I please speak with [INSERT NAME FROM SAMPLE]?

[OBTAIN CORRECT RESPONDENT; REINTRODUCE IF NECESSARY]

You should have received an email from the Indiana Family and Social Services Administration informing you or your practice about this provider interview.

Again, my name is [NAME]. I am from [NAME] and am working with [NAME] to conduct this interview. [NAME] was hired by the Indiana Family and Social Services Administration to perform a federally-required independent evaluation of the HIP program. The purpose of this interview is to talk with you about your experiences with HIP and your understanding of member satisfaction with HIP.

[If provider has delivered tobacco cessation services per the spreadsheet provided]
You have been invited because you have provided services to HIP members, including tobacco cessation services.

[If provider has NOT delivered tobacco cessation services per the spreadsheet provided] You have been invited because you have provided services to HIP members.

Over the next 20 to 30 minutes, I will ask you about your role, satisfaction of HIP members you work with, and overall thoughts on HIP. We are having several other interviews like this one in Indiana. Hearing about your experience will help us better evaluate the program. The information from our evaluation will help Indiana assess HIP and identify potential changes to improve the care that HIP members receive. Your participation is voluntary and your responses will remain confidential.

Your responses to our questions will be combined with responses from conversations we are having with other providers. As a result, neither you nor any other person we are speaking with will be identifiable from your answers. Your combined responses will be used to write an interim evaluation report, available for public comment at the end of 2019. [NAME] will conduct additional interviews as part of the development of a final evaluation report due in 2022, which will also be available for public comment. You may choose not to answer any question, and you may choose, at any time, to stop the conversation for any reason.

What questions do you have before we continue? [Interviewer: pause for questions]

[If have questions, refer to the frequent questions document or read from it then ask again]

Can we begin? [Interviewer: pause for confirmation]

[If consent] I'd like to begin by thanking you for taking time out of your day to meet with me about HIP. I appreciate it.

[If do NOT consent] Thank you for taking time today, have a great day.

Participant Information

Q1. **What is your role in the practice?** [Likely options if needed prompt, can select more than one.]

Enter text here:

- ☐ OFFICE MANAGER/PRACTICE ADMINISTRATOR
- ☐ CLINICIAN (ASK FOR SPECIALTY)
  - ☐ FAMILY MEDICINE
  - ☐ INTERNAL MEDICINE
  - ☐ OBSTETRICS/GYNECOLOGY
  - ☐ SURGEON
  - ☐ PSYCHIATRIST
  - ☐ CARDIOLOGIST
  - ☐ DERMATOLOGIST
  - ☐ ENDOCRINOLOGIST
  - ☐ GASTROENTEROLOGIST
  - ☐ ONCOLOGIST
  - ☐ NEUROLOGIST
  - ☐ PUMONOLOGIST
  - ☐ OTOLARNYNGOLOGIST (ENT)
  - ☐ OPTHAMOLOGIST
  - ☐ NEPHROLOGIST
  - ☐ INFECTIOUS DISEASE PHYSICIAN
  - ☐ THERAPIST (PHYSICAL, OCCUPATIONAL, SPEECH/HEARING)
  - ☐ PSYCHOLOGIST
  - ☐ SOCIAL WORKER
  - ☐ OTHER SPECIALTY (SPECIFY)

    Enter text here:

Q2. **Which of the following Indiana programs do you participate in?** [Note: Provider may only participate with certain plans.]

- ☐ HOOSIER HEALTHWISE (HHW)
- ☐ HEALTHY INDIANA PLAN (HIP) → IF THIS OPTION OR "NOT SURE BUT ACCEPT MEDICAID" OR "TRADITIONAL MEDICAID" NOT SELECTED, GO TO CLOSE
- ☐ HOOSIER CARE CONNECT (HCC)
- ☐ FEE-FOR-SERVICE (TRADITIONAL MEDICAID)
- ☐ NOT SURE BUT ACCEPT MEDICAID
- ☐ OTHER (SPECIFY)

  Enter text here:

Q3. What is your practice setting?

- ☐ SOLO/ INDIVIDUAL PRACTICE
- ☐ SINGLE-SPECIALTY GROUP (THIS CAN BE EITHER PRIMARY CARE OR SPECIALISTS)
- ☐ MULTI-SPECIALTY GROUP (THIS CAN INCLUDE BOTH PRIMARY CARE AND SPECIALISTS)
- ☐ ACUTE CARE HOSPITAL OR PHYSICIAN HOSPITAL ORGANIZATION (PHO)
- ☐ REHABILITATION FACILITY
- ☐ AMBULATORY SURGICAL CENTER (ASC)
- ☐ FEDERALLY QUALIFIED HEALTH CENTER (FQHC)
- ☐ RURAL HEALTH CENTER (RHC)
- ☐ OUTPATIENT MENTAL HEALTH CLINIC
- ☐ COMMUNITY MENTAL HEALTH CENTER (CMHC)
- ☐ OTHER (SPECIFY)

Enter text here:

Q4. How long has your practice provided services to HIP members?

[If do not provide immediate response, probe for range]

- ☐ SINCE 2008 [For Interviewer: HIP 1.0, HIP 2.0, and Current HIP]
- ☐ SINCE 2015 [For Interviewer: HIP 2.0 and Current HIP]
- ☐ SINCE 2018 [For Interviewer: Current HIP only]
- ☐ OTHER (SPECIFY)

Enter text here:

Member Satisfaction with HIP

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

Q5. Please describe feedback you have heard from members about what areas of HIP they are most satisfied with.

Enter text here:

Q6. Please describe feedback you have heard from members about what areas of HIP they are least satisfied with.

Enter text here:

Q7. On a scale from very satisfied to very dissatisfied, how satisfied do you think members are with HIP?

- ☐ VERY SATISFIED
- ☐ SOMEWHAT SATISFIED
- ☐ SOMEWHAT DISSATISFIED
- ☐ VERY DISSATISFIED
- ☐ DON'T KNOW
- ☐ REFUSED
- ☐ OTHER (SPECIFY)

Enter text here:

Q8. What kind of feedback, if any, have you received from members or via staff at your organization regarding HIP members' ability to understand and make monthly HIP payments or copayments?

[If context is needed: Some HIP members are required to make monthly payments (based on income and tobacco use status, also known as POWER Account Contributions) to maintain enrollment in the HIP program. Some HIP members must make copayments for certain services.

If additional context is needed:

- HIP members with family incomes over 100 percent of the federal poverty level (FPL) must pay a fixed monthly contribution (also known as POWER Account Contribution) which varies from $1 to $30 based on their family income and tobacco user status. If they (or in some cases their employer or non-profit organization) do not make these payments, their HIP coverage is closed. These members receive the "HIP Plus" benefit package.
- HIP members with family incomes less than 100 percent of the FPL are not required to make monthly payments but do pay copayments for certain services. These members receive the "HIP Basic" benefit package.]

Enter text here:

Q9. What kind of feedback, if any, have you received from members or via staff at your organization regarding HIP members' ability to understand and comply with HIP Gateway to Work requirements?

[If context is needed: Gateway to Work connects HIP members with ways to look for work, train for jobs, finish school, and volunteer. Some HIP members are required to participate in Gateway to Work activities to keep HIP benefits, other members may be exempt. The number of activity hours required for Gateway to Work began at zero in January 2019 to allow members time to learn about the program, and increases incrementally from 20 hours per month in July 2019 to 80 hours per month in July 2020.]

Enter text here:

Tobacco Cessation

The next set of questions will ask about tobacco cessation.

[If context is needed: Tobacco users will have to pay more for health coverage than non-tobacco users. HIP members have 12 months to stop using tobacco; HIP offers programs to help members quit smoking and provides easy access to tobacco cessation products and counseling services to help them be successful. If members do not quit, their POWER Account Contribution will be 50% higher for the next year.]

Q10. Have you provided HIP members with tobacco cessation services?

- ☐ YES → GO TO Q12
- ☐ NO
- ☐ DON'T KNOW → GO TO Q21
- ☐ REFUSED

Q11. What tobacco cessation services have you provided to HIP members? (Select one or more)

- ☐ COUNSELING
- ☐ INTENSIVE COUNSELING
- ☐ MEDICATIONS
- ☐ OTHER (SPECIFY)

Enter text here:

Q12. How do you approach offering tobacco cessation services to individuals identifying as tobacco users?

[if needed: Do you offer cessation services to all individuals that identify as tobacco users or a subset? Please describe how you engage individuals in the use of tobacco cessation services or medications.]

Enter text here:

Q13. What do you see as barriers for HIP members to engage in/start/begin tobacco cessation services?

Enter text here:

Q14. What do you see as barriers to success for HIP members to continue to receive tobacco cessation services?

Enter text here:

Q15. On a scale from very satisfied to very dissatisfied, how satisfied do you think that HIP members are with tobacco cessation services?

- ☐ VERY SATISFIED
- ☐ SOMEWHAT SATISFIED
- ☐ SOMEWHAT DISSATISFIED
- ☐ VERY DISSATISFIED
- ☐ DON'T KNOW
- ☐ REFUSED
- ☐ OTHER (SPECIFY)

Enter text here:

Q16. Have HIP members discussed a tobacco surcharge with you? Please describe those conversations.

Enter text here:

Q17. Have any HIP members discussed their ability to make monthly HIP payments once the tobacco surcharge is applied to these payments? Please describe those conversations.

Enter text here:

Q18. Have HIP members discussed the impact of the tobacco surcharge on attempting to quit? Please describe those conversations.

Enter text here:

Provider Perspective

The next set of questions will ask about overall HIP impact and your experience.

Q19. Are there any aspects of the HIP program that you think work especially well? If so, please describe.

Enter text here:

Q20. Have you encountered any challenges with the HIP program? If so, please describe. [Note: Listen for claims payment and prior authorization issues, relationship with MCEs]

Enter text here:

Q21. What would you improve about HIP?

Enter text here:

Q22. Thank you again for taking the time to meet today, is there anything else you would like to add?

Enter text here:

CLOSE:	**On behalf of the Healthy Indiana Plan we thank you for participating in this survey. Your answers will help improve the program. If you have any questions about HIP, please call 1-877-438-4479.**

Attachment IX: Healthy Indiana Plan Evaluation Member Interviews

DESCRIPTION: This key informant interview guide applies to Healthy Indiana Plan members.

Introduction and Overview of Purpose

Hello, my name is [NAME] calling from [NAME] on behalf of the Healthy Indiana Plan, also known as HIP. May I please speak with [INSERT NAME FROM SAMPLE]?

[OBTAIN CORRECT RESPONDENT; REINTRODUCE IF NECESSARY]

Again, my name is [name] from [NAME] and I am working with [NAME] to conduct this interview. Our team was hired by the Indiana Family and Social Services Administration to independently evaluate the HIP program.

IF NEEDED: You may know this program by the name of your health plan such as Anthem, CareSource, MDwise, or Managed Health Services (MHS).

Over the next 15 minutes or so, I will ask you about your experiences with the HIP program. We are having several other interviews like this one in Indiana. Your responses will be used to help evaluate and improve HIP. You may choose not to answer any question, and you may choose, at any time, to stop the conversation for any reason. Please remember that the answer that you provide today will NOT affect your benefits and all responses will remain anonymous. Your name was randomly picked from a list of all people who receive health care through HIP. Sharing your opinions will help Indiana improve HIP services for everyone

What questions do you have before we continue? [Interviewer: pause for questions]

Can we begin? [Interviewer: pause for confirmation]

[If consent] I'd like to begin by thanking you for taking time out of your day to talk with me about HIP.

[If do NOT consent] Thank you for taking time today, have a great day.

Participant Information and Access

Q1. The State of Indiana runs an insurance program called the Healthy Indiana Plan (or HIP) for Hoosiers age 19 to 64. Do you currently have HIP coverage or have you had HIP coverage recently?

- ☐ YES → **CONTINUE WITH THE INTERVIEW, GO TO Q3**
- ☐ NO
- ☐ DON'T KNOW → **GO TO Q2**
- ☐ REFUSED

Q2. Sorry, but just to confirm, based on the information we have from the State, it looks like you currently have HIP coverage or recently have had HIP coverage. You may know this program by the name of your health plan such as Anthem, CareSource, MDwise, or Managed Health Services (MHS). Is this correct?

- ☐ YES
- ☐ NO → GO TO CLOSE
- ☐ DON'T KNOW → GO TO CLOSE
- ☐ REFUSED → GO TO CLOSE

Q3. Which HIP plan are or were you on?

- ☐ HIP BASIC
- ☐ HIP PLUS
- ☐ DON'T KNOW
- ☐ REFUSED

Q4. How long have you been/were you enrolled in HIP?

- ☐ LESS THAN 3 MONTHS
- ☐ 3 MONTHS TO LESS THAN 6 MONTHS
- ☐ 6 – 12 MONTHS
- ☐ MORE THAN 12 MONTHS
- ☐ DON'T KNOW
- ☐ REFUSED

Q5. Have you been able to get the health care services you need through the HIP program?

- ☐ YES
- ☐ NO
  PLEASE DESCRIBE
  Enter text here:
- ☐ REFUSED

Overall Awareness and Eligibility Process

The next set of questions asks about your experience signing up for HIP and overall awareness of the program.

Q6. Are you aware of the different aspects of HIP, specifically the Gateway to Work Program, Personal Wellness and Responsibility (POWER) Accounts, and tobacco cessation services and the tobacco surcharge? [Individuals identifying as HIP Basic in Q3 might not know about the tobacco surcharge.]

- ☐ YES, I AM AWARE OF ALL OF THEM
- ☐ NO, I DON'T KNOW ABOUT ANY OF THEM

I AM ONLY AWARE OF….[can select more than one answer]

- ☐ GATEWAY TO WORK PROGRAM
- ☐ POWER ACCOUNTS
- ☐ TOBACCO CESSATION SERVICES AND THE TOBACCO SURCHARGE
- ☐ REFUSED

Q7. How did you find out about the different aspects of HIP?

[Can select more than one answer]

- ☐ HIP WEBSITE
- ☐ HEALTH PLAN WEBSITE
- ☐ HEALTH PLAN MEMBER HOTLINE
- ☐ THE PERSON WHO HELPED ME SIGN UP FOR HIP
- ☐ A HEALTH CARE PROFESSIONAL
- ☐ WRITTEN MATERIALS SUCH AS A MEMBER HANDBOOK
- ☐ FAMILY OR FRIENDS
- ☐ OTHER (PLEASE DESCRIBE)
  Enter Text Here:
- ☐ NO ONE EXPLAINED HIP TO ME
- ☐ REFUSED

Q8. How would you rate the overall process of signing up for HIP?

- ☐ VERY EASY
- ☐ GENERALLY EASY
- ☐ NOT EASY AT ALL
- ☐ DON'T KNOW
- ☐ REFUSED

Q9. Please describe challenges or barriers to signing up for HIP.

Enter Text Here:

Q10. Please describe what parts of signing up for HIP worked well.

Enter Text Here:

Gateway to Work

The next set of questions asks about your experience with the Gateway to Work program.

[If context is needed: Gateway to Work is a part of the HIP. It connects HIP members like you with ways to look for work, train for jobs, finish school and volunteer. Starting in 2019, you might be required to do Gateway to Work activities to keep your HIP benefits. **The Indiana Family Social and Services Administration (FSSA) will give you your Gateway to Work status.** Your status will be Reporting, Reporting Met or Exempt.

If your Gateway to Work status is "Reporting," you need to meet a required number of activity hours each month and report them. There are many things you can do to meet the requirement. Activity hours must be reported using the FSSA Benefits Portal or by calling your managed care entity also known as your health plan. Your health plan can answer questions or connect you with new activities.

At the end of the year, the state will look at all the hours you reported and determine if you met your required hours each month. **You will need to meet the required monthly hours 8 out of 12 months of the year to keep your HIP benefits.]**

Q11. Do you know if you are required to report Gateway to Work hours, or if you are exempt?

- ☐ I KNOW I AM EXEMPT → **GO TO Q16**
- ☐ I AM REQUIRED TO REPORT HOURS → **GO TO Q12**
- ☐ I DON'T HAVE TO REPORT HOURS BECAUSE I AM WORKING ENOUGH ALREADY → **GO TO Q16** ["Reporting Met" status]
- ☐ DON'T KNOW → **GO TO Q16**
- ☐ REFUSED → **GO TO Q16**

Q12. What, if anything, makes it difficult for you to meet these hour requirements?

Enter Text Here:

Q13. Have you reported or do you plan to report Gateway to Work hours?

- ☐ YES
- ☐ NO
- ☐ DON'T KNOW
- ☐ REFUSED

→ **GO TO Q16**

If no, why? Enter Text Here:

Q14. How do or will you report this information? [select all that apply]

- ☐ ONLINE/BENEFITS PORTAL
- ☐ CALLING MY HEALTH PLAN/MANAGED CARE ENTITY
- ☐ OTHER (PLEASE DESCRIBE)

Enter Text Here:

- ☐ DON'T KNOW
- ☐ REFUSED

Q15. What has your experience been like reporting this information?

- ☐ EXCELLENT
- ☐ VERY GOOD
- ☐ GOOD
- ☐ FAIR
- ☐ POOR

[inquire more regarding challenges and what is working well]

Enter Text Here:

Q16. Do you know what happens to your HIP coverage if you are not exempt and do not meet the reporting requirements?

- ☐ YES

  PLEASE DESCRIBE

  Enter Text Here:

- ☐ NO
- ☐ REFUSED

Q17. Can you describe how the Gateway to Work requirements have impacted you, if at all? Please describe.

Enter Text Here:

[Examples of issues that people might raise include: being connected to new resources, establishing an account on the website, hearing about more opportunities from the health plans, having increased stress due to the requirements, being worried about having continued coverage.

Inquire about future if interviewee doesn't share anything about the past.

If context needed: The number of activity hours required for Gateway to Work begins at zero in January 2019 to allow members time to learn about the program, find activities and set up a FSSA Benefits Portal account. It then increases according to this schedule:

- January 1, 2019 - June 30, 2019 — 0 hours per month
- July 1, 2019 - September 30, 2019 — 20 hours per month
- October 1, 2019 - December 31, 2019 — 40 hours per month
- January 1, 2020 - June 30, 2020 — 60 hours per month
- July 1, 2020 - ongoing — 80 hours per month]

Power Account

The next set of questions asks about your POWER Account experience.

Q18. Do you have a POWER Account as part of your HIP insurance?

- ☐ YES → GO TO Q19
- ☐ NO → GO TO Q30
- ☐ DON'T KNOW → GO TO Q30
- ☐ REFUSED → **GO TO Q30**

Q19. Do you make payments towards your HIP coverage?

- ☐ YES → GO TO Q21
- ☐ NO → GO TO Q20
- ☐ DON'T KNOW → GO TO Q30
- ☐ REFUSED → **GO TO Q30**

Q20. Do you know that if you pay a fixed monthly amount, you can change your coverage to "HIP Plus"? This program gives you access to more services and no copayment.

- ☐ YES → GO TO Q30
- ☐ NO → GO TO Q30
- ☐ REFUSED → **GO TO Q30**

Q21. How much is your monthly payment?

Enter Text Here:

Q22. To your knowledge, has anyone ever helped you make your payment, like an employer or a community organization?

- ☐ YES
  PLEASE DESCRIBE

Enter Text Here:

- ☐ NO
- ☐ DON'T KNOW
- ☐ REFUSED

Q23. Have you had any issues making a payment?

- ☐ YES
  PLEASE DESCRIBE [listen for issues related to payment being unaffordable, process issues or issues with MCEs being able to take the payment, late invoices]

Enter Text Here:

- ☐ NO
- ☐ REFUSED

Q24. Do you know what happens to your HIP coverage if you do not make a payment?

[For context: Members with incomes above the poverty level that choose not to make their POWER Account Contributions will be removed from the program and not be allowed to re-enroll for six months. This enrollment lockout will not apply if the member is medically frail or residing in a domestic violence shelter or in a state-declared disaster area. Members who have incomes below the federal poverty level who do not make their contributions will be moved to the HIP Basic plan.]

☐ YES
PLEASE DESCRIBE
Enter Text Here:

☐ NO
☐ REFUSED

Q25. Have you ever received a discount, rollover dollars, or a refund from HIP?

☐ YES
☐ NO
☐ DON'T KNOW
☐ REFUSED

Q26. Are you aware that any payments you make to the POWER Account are yours, and that if you leave the program early, any of those payments not spent on health care costs may be returned to you?

☐ YES
☐ NO
☐ DON'T KNOW
☐ REFUSED

Q27. Are you aware that if your annual health care expenses are less than $2,500 per year you may rollover your remaining payments to reduce your monthly payments for the next year?

☐ YES
PLEASE DESCRIBE
Enter Text Here:

☐ NO
☐ REFUSED

Q28. Are you aware that you could lower your monthly POWER Account payments in the future if you get preventive services now?

☐ YES
PLEASE DESCRIBE
Enter Text Here:

☐ NO
☐ REFUSED

Q29. How does having a POWER Account change how you use health care, if at all?

Enter Text Here:

Tobacco Cessation Services

The next set of questions asks about tobacco cessation services.

Q30. Do you use tobacco (for example, chewing tobacco, cigarettes, cigars, pipes, hookah, snuff, vape pens)?

- ☐ YES
- ☐ NO
- ☐ REFUSED

→ **GO TO Q35**

Q31. Do you know that you can get counseling and medications through HIP to help you quit?

- ☐ YES
- ☐ NO
- ☐ DON'T KNOW
- ☐ REFUSED

→ **GO TO Q35**

Q32. Have you used these tobacco cessation services?

- ☐ YES, WITHIN THE LAST YEAR
  PLEASE DESCRIBE
  Enter Text Here:
- ☐ YES, BUT OVER A YEAR AGO
  PLEASE DESCRIBE
  Enter Text Here:
- ☐ NO
- ☐ DON'T KNOW
- ☐ REFUSED

→ **GO TO Q35**

Q33. If you have used these services, how satisfied are you with them?

- ☐ VERY SATISFIED
- ☐ SOMEWHAT SATISFIED
- ☐ SOMEWHAT DISSATISFIED
- ☐ VERY DISSATISFIED
- ☐ DON'T KNOW
- ☐ REFUSED

[inquire: why or why not]

Enter Text Here:

Q34. Are you aware that Indiana can increase your monthly HIP payments if you continue to use tobacco products after one year? [skip this question if interviewee responds "NO" to Q18 and skipped POWER Account questions.]

[If context is needed: Tobacco users will have to pay more for health coverage than non-tobacco users. HIP Plus members have 12 months to stop using tobacco. If HIP Plus members do not quit, their POWER Account Contributions will be 50% higher for the next year.]

- ☐ YES
- ☐ NO
- ☐ REFUSED

Member Satisfaction With HIP

The next set of questions will ask about your satisfaction with HIP.

Q35. Thinking about your overall experience with HIP in the past six months, would you say you are:

- ☐ VERY SATISFIED
- ☐ SOMEWHAT SATISFIED
- ☐ SOMEWHAT DISSATISFIED
- ☐ VERY DISSATISFIED
- ☐ DON'T KNOW
- ☐ REFUSED

→ **GO TO Q37**

Q36. Why are you (FILL IN WITH PREVIOUS RESPONSE)? [OPEN-ENDED RESPONSE]
Enter Text Here:

DO NOT READ LIST BELOW; USE FOR CODING PURPOSES

- ☐ CAN'T SEE MY DOCTOR WITH HIP
- ☐ DISSATISFACTION WITH CHOICE OF DOCTORS IN HIP
- ☐ HIP DOES NOT COVER DENTAL
- ☐ HIP DOES NOT COVER VISION/OPTICAL
- ☐ HIP DOES NOT COVER PROCEDURE/ MEDICATION
- ☐ MANY DOCTORS DO NOT ACCEPT HIP
- ☐ DISSATISFIED WITH ADMINISTRATIVE ISSUE(S) OR PROCESS
- ☐ DISSATISFACTION WITH A PAYMENT RELATED ISSUE
- ☐ CAN'T AFFORD CO-PAY/ TOO HIGH
- ☐ CO-PAYMENT / MONTHLY/ ANNUAL PAYMENT TOO HIGH
- ☐ LIKE HAVING COVERAGE/ INSURANCE
- ☐ LIKE DOCTORS/ HOSPITALS / HEALTH CARE PROVIDERS
- ☐ LIKE PAYMENTS / PRICE
- ☐ LIKE THE PLAN/ PROVIDER
- ☐ LIKE SOME THINGS/ DISLIKE OTHER THINGS
- ☐ SOME THINGS NOT COVERED
- ☐ DON'T KNOW
- ☐ REFUSED
- ☐ OTHER REASON NOT LISTED ABOVE: (SPECIFY) **Enter Text Here:**

Q37. What would you change about the HIP program?

Enter Text Here:

Q38. Thank you again for taking the time to meet today, is there anything else you would like to add?

Enter Text Here:

CLOSE:	**On behalf of the Healthy Indiana Plan, we thank you for participating in this survey. Your answers will help improve the program. If you have any questions about HIP please call 1-877-438-4479.**