DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-25-26
Baltimore, Maryland 21244-1850

State Demonstrations Group

March 21, 2023

Allison Taylor
Medicaid Director
Indiana Family and Social Services Administration
402 W. Washington Street, Room W461, MS25
Indianapolis, IN 46204

Dear Ms. Taylor:

The Centers for Medicare & Medicaid Services (CMS) completed its review of the Eligibility and Coverage, Substance Use Disorder (SUD), and Serious Mental Illness/Serious Emotional Disturbance (SMI/SED) Evaluation Designs, which are required by the Special Terms and Conditions (STCs), specifically, STC #IX.8 of Indiana's section 1115 demonstration, "Healthy Indiana Plan (HIP)" (Project No: 11-W-00296/5), effective through December 31, 2030 with the SUD and SMI/SED components effective through December 31, 2025. CMS has determined that the Eligibility and Coverage Evaluation Design, which was submitted on June 23, 2021 and revised on February 24, 2022, the SUD Evaluation Design, which was submitted on July 23, 2021 and revised on December 29, 2022, and the SMI/SED Evaluation Design, which was submitted on June 23, 2021 and revised on February 28, 2022, all meet the requirements set forth in the STCs and CMS's evaluation design guidance, and therefore, approves the state's aforenamed three Evaluation Designs.

CMS has added the approved Eligibility and Coverage, SUD, and SMI/SED Evaluation Designs to the demonstration's STCs as Attachments K, E, and H, respectively. A copy of the STCs, which includes the new attachments, is enclosed with this letter. In accordance with 42 CFR 431.424, the approved Evaluation Designs may now be posted to the state's Medicaid website within thirty days. CMS will also post the approved Evaluation Designs as standalone documents, separate from the STCs, on Medicaid.gov.

Consistent with the approved SUD and SMI/SED Evaluation Designs, please note that the SUD and SMI/SED Interim Evaluation Reports, are due to CMS one year prior to the expiration of these policy components (i.e., December 31, 2024), or at the time of the extension applications, if the state chooses to extend these policies. Additionally, consistent with the approved Eligibility and Coverage Evaluation Design, the state is expected to submit three drafts of the HIP Interim Evaluation Reports, in which the last report (representing demonstration years 1–8)

is due one year prior to the expiration of the demonstration, or at the time of the extension applications, if the state chooses to extend the HIP demonstration. Likewise, the Summative Evaluation Reports, consistent with these approved Evaluation Designs, are due to CMS within 18 months of the end of the demonstration period. In accordance with 42 CFR 431.428 and the STCs, we look forward to receiving updates on evaluation activities in the Quarterly and Annual Monitoring Reports.

We appreciate our continued partnership with Healthy Indiana Plan section 1115 demonstration. If you have any questions, please contact your CMS demonstration team.

Sincerely,

Danielle Daly -S

Digitally signed by Danielle Daly -S
Date: 2023.03.21 09:56:06 -04'00'

Danielle Daly
Director
Division of Demonstration Monitoring and Evaluation

cc: Mai Le-Yuen, State Monitoring Lead, CMS Medicaid and CHIP Operations Group

Healthy Indiana Plan Evaluation Plan

Final

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.**

February 24, 2022

Healthy Indiana Plan
Evaluation Plan

Final

Prepared for: Indiana Family and Social Services Administration

Submitted by: The Lewin Group, Inc.

February 24, 2022

Note: This Evaluation Plan includes adjustments to reflect the impact of the COVID-19 PHE on HIP policies. The comprehensive approach for evaluating the entire demonstration approval period and all applicable demonstration components will be based on this Evaluation Plan. Since this Evaluation Plan is for the new demonstration period, the goals have been renumbered. If comparing results from previous reports, carefully compare the goal language rather than the goal number. This revised version addresses comments received from CMS on October 19, 2021 and February 1, 2022.

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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 ten years from January 1, 2021, through December 31, 2030. 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. In 2015, it 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 Special Terms and Conditions (STCs) to implement HIP requires 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, 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
- Section G: Goal Six – Workforce Bridge Account Evaluation Questions, Hypotheses, and Analytic Tables

In addition to the demonstration's STCs, this Evaluation Plan reflects, as feasible and appropriate, CMS feedback received on the 2018-2020 Evaluation Plan in February 2019; the CMS evaluation guidance released in March 2019;[1] CMS feedback received on the 2018-2020 Evaluation Plan in June 2019; CMS Evaluation Plan feedback received in March 2020; CMS feedback received in October 2021; CMS feedback on the 2021-2030 Evaluation Plan received in January 2022; and additional feedback received during calls with CMS and the State. Concerning CMS' evaluation guidance, this plan addresses that content 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 demonstration context. Once reactivated, this plan includes analyzing several policies (e.g., Personal Wellness and Responsibility (POWER) Account payment, tobacco surcharge) placed on hold due to the COVID-19 public health emergency (PHE). The extension of the HIP demonstration waiver includes structured monitoring with three interim and one summative evaluation over the demonstration period. Given the 10-year span of the waiver and the potential future programmatic changes (e.g., six-month non-eligibility period for non-payment of POWER Account contribution), this evaluation plan focuses on analysis for the first Interim Evaluation

[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

Report scheduled for submission to CMS in June 2024. The baseline and intervention periods for all hypotheses and research questions included in this evaluation plan span from 2015 to 2022 (relevant to the first Interim Evaluation Report). The State anticipates building on this plan to address any future programmatic changes. The analyses plan will be reviewed and updated, as required, for future evaluations (interims and summative) to incorporate any program changes and other specifications including intervention time period and analytic methods.

1. Demonstration Goals

Building on the successes and lessons learned from the original HIP implemented in 2008, HIP 2.0 implemented in 2015, and the 2018 HIP waiver renewal, the State used the 2021-2030 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 (January 2021 through December 2030), 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:

Exhibit A.1: Indiana 1115(a) Demonstration

Name of Demonstration:
Healthy Indiana Plan

Approval Date of Demonstration:
October 26, 2020

Demonstration Renewal Period: January 1, 2021 - December 31, 2030

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

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 the smoother beneficiary transition.[3]

[2] The WBA program is included in the Section 1115(a) demonstration waiver entitled "End Stage Renal Disease (ESRD)" as of January 2021. Indiana is currently working with CMS to move the WBA program into the HIP waiver with similar evaluation report timeframes and requirements. Refer to Section G for additional information on Goal 6: WBA will support HIP members transitioning to commercial with continuity of coverage, reduce benefit cliff, and churn.

[3] 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 POWER Account, which operates similarly to a health savings account.

The current HIP 1115 waiver renewal, approved October 26, 2020 and effective from January 1, 2021 through December 31, 2030, continues most components of HIP approved in 2018 (**Exhibit A.2**). That version added some new provisions to HIP 2.0 (approved in 2015). Changes for HIP, summarized from the State's amended 2018 waiver approval, include:[4,5]

- Adding a tobacco use surcharge by increasing users' POWER Account Contributions by 50% beginning in their second year of continuous enrollment;
- Changing POWER Account Contributions (PAC) to a tiered structure instead of a flat 2% of income (six-month non-eligibility for enrollment due to non-payment of PAC included in 2018-2020 waiver has been suspended indefinitely effective January 1, 2021);
- 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); and
- 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 HIP through a three-year waiver renewal expiring December 2020.
2021: CMS approved HIP through a ten-year waiver renewal expiring December 2030.

In addition to the changes outlined above, several policies were modified or put on hold in March 2020 in response to the COVID-19 PHE. These included policies related to member eligibility, cost-sharing,

[4] 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

[5] 2021-2030 STC technical changes summary in State acceptance of CMS approval. Retrieved from https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/in-healthy-indiana-plan-support-20-state-accept-ltr-hip-ext-11242020.pdf

tobacco surcharge, and prescription filling processes, among others. The details of these policy changes and their implications for the evaluation are noted throughout this document as appropriate. The State announced that any reinstatement of policies would occur after the COVID-19 PHE is lifted. Any reinstatement processes will be gradual to ensure members, MCEs, providers, and other stakeholders are aware.

Healthy Indiana Plan

In 2015, HIP's target population changed to all non-disabled, low-income adults between 19 and 64 years old with a 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. The following section outlines the intended policies; however, several policies noted below are currently on hold due to the COVID-19 PHE. Details of these policy changes are described throughout this section as applicable.

HIP Benefit Plans

Indiana's current section 1115(a) demonstration provides authority for the State to continue offering 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.[6] 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, hospital stays, non-emergency ED visits, and prescriptions.[7] 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.

[6] 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

[7] 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

- **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[8] 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[9] 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 (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[10] by the State or an MCE and have not met 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.

All HIP members pay $8 for a non-emergency ED visit. Members can switch between benefit plans as policies allow. Adults who meet all HIP's eligibility requirements but who are not U.S. citizens and not lawful permanent residents in the U.S. for at least five years or are not qualified aliens are entitled to "emergency services only" under HIP. The evaluator did not include this enrollment category in this evaluation due to the limited nature of covered services. Also, one other important policy change for the Evaluation Plan in response to the COVID-19 PHE is a pause on switches which result in a benefit downgrade between State Plan to regular (HIP Basic, HIP Plus) benefits; and HIP Plus to HIP Basic. The opposite switches not resulting in a downgrade (HIP Basic to HIP Plus or HIP regular to State Plan) were allowed. Monthly contributions were waived for HIP Plus members during the COVID-19 PHE. Members having HIP Basic (enrolled prior to the COVID-19 PHE) were eligible to change to HIP Plus.[11] New HIP members were and continue to be automatically enrolled in HIP Plus during the COVID-19 PHE. In addition, members were also not required to pay the $8 copay for a non-emergency ED visit since cost sharing was paused in response to the COVID-19 PHE.

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.

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8 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.

9 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.

10 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.

11 Based on information available during preparation of the Evaluation Plan.

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. However, 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 occur on the last day of a month unless a member dies.

During the COVID-19 PHE, the State adjusted eligibility policies to ensure uninterrupted access to coverage. Self-attestation of income was accepted for income verification at the time of application.[12] Additionally, the State announced that no members would have their health coverage terminated throughout the COVID-19 PHE unless it was voluntarily withdrawn or there was a relocation outside of Indiana. The information on presumptive eligibility and Fast Track outlined below represents the policy structure in use before the COVID-19 PHE changes went into effect. Throughout the COVID-19 PHE, completion of a full application for the Indiana Health Coverage Programs (including HIP) to continue benefits beyond the end of the month following the start of PE. The State also announced that member coverage started when eligibility was determined and initial payment to begin coverage was not required. Fast Track payments were also ceased.

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 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 PE coverage only once during a 12-month rolling period and only once per pregnancy.[13]

Individuals determined presumptively eligible can receive temporary coverage and 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

[12] Medicaid and CHIP Disaster Relief MAGI-Based Verification Plan Addendum. Retrieved from https://www.medicaid.gov/medicaid/eligibility/downloads/in-disaster-addendum.pdf

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

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.[14]

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.[15]

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.[16]

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, and State contributions. Members may also apply earned MCE incentives offered by their plan. The State fully funds the POWER Accounts for HIP Basic members and covers the member's $2,500 annual deductible.

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.

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[14] Ibid.

[15] Ibid.

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

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 recalculating the member's 2% of income and changing 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 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 this simplified tiered structure will increase member understanding, increase member compliance with payments, and 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 incomes less than 22% both pay a $1.00 POWER Account Contribution. Other income tiers split the amount; for example, two married adults with a 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. With the 2021 approval, the member contributions will be capped at 3% of household income, and the state will have the flexibility to change member contribution amounts up to the cap.

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**[17]	$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 as displayed in Table 4 of the STC. During the COVID-19 PHE, all new members were automatically enrolled into HIP Plus irrespective of income, and members were not required to make POWER Account Contributions.

[17] Retrieved from https://www.in.gov/fssa/hip/helpful-tools/federal-poverty-level-income-chart/

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

HIP Plus members with incomes from 101% to 138% of the FPL that did not make monthly POWER Account Contribution payments were disenrolled from HIP. For the 2018 – 2020 waiver, members disenrolled due to non-payment were not allowed to re-enroll for six months (also referred to as the six-month lockout or non-eligibility period). In January 2021, the State suspended the six-month non-eligibility criterion pending resolution of the stay in the federal lawsuit and in compliance with the newly approved waiver terms and conditions.[18] In addition, 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 to 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.

In response to the COVID-19 PHE, the State suspended all cost-sharing policies. Effective April 1, 2020, members with copayments no longer have copayments, including pharmacy copayments. Further, the State waived all POWER Account Contributions starting March 1, 2020, until further notice. Members who made contributions during the COVID-19 PHE (since March 2020) had those payments applied as credits to their accounts (i.e., for use as POWER Account Contributions when the policy is reinstated).

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.[19] Tobacco use is defined as tobacco use four or more times a week in the last six months, including 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 a tobacco user during this period. If the member continues to self-identify as using tobacco, the State increases 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.

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

[18] Waiver 4 (related to eligibility) in HIP STC. Accessible from https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/in-healthy-indiana-plan-support-20-ca-01012021.pdf

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

- **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.[20]
- **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.[21]

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 in 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.

Since the State suspended all cost-sharing during the COVID-19 PHE, no surcharge is collected. The Tobacco surcharge policy will be reinstated, with an implementation process that aligns with the initial implementation after the COVID-19 PHE is lifted.

Preventive Service Incentive and Rollover

The State provides all HIP members with incentives to receive preventive services and 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, 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 member 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

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

[21] 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

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

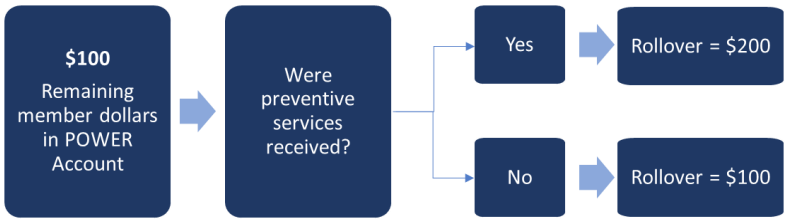
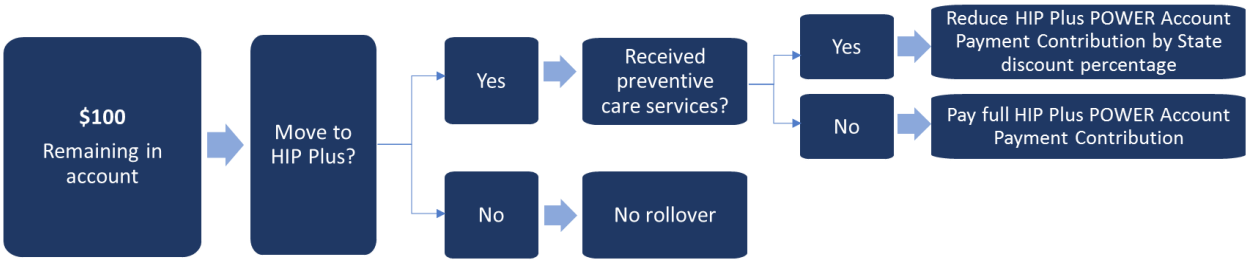


Exhibit A.5: HIP Rollover for HIP Basic Members



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 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.

During the COVID-19 PHE, rollover will not be impacted due to suspension of HIP policies and member contributions.

Workforce Bridge Account

Workforce Bridge Accounts (WBA) will become effective once the COVID-19 PHE restrictions are lifted. To receive a WBA, eligible individuals will be informed that they have access to financial resources, in an amount no greater than $1,000, to temporarily pay for health insurance premiums and cost-sharing, or for the direct costs of prescription drugs and services otherwise covered under Section 1905(a) of the Social Security Act. This assistance is expected to act as a bridge to commercial insurance coverage. While individuals would be made aware that this resource would be available to them if they took steps to raise their income enough to lose Medicaid eligibility, the accounts would only be activated when an individual is no longer Medicaid eligible. Individuals who recently disenrolled for failure to meet conditions of eligibility, such as payment of premiums, will not qualify.

This program will be available to eligible individuals based on the availability of State funding. Members eligible for WBA, once notified, must opt-in to the WBA program. To opt-in, the eligible individual must acknowledge an interest in participating by phone or mail to the state. Individuals will have 30 days once notified to opt-in to the account. As part of this 30-day opt-in process, individuals will have the

opportunity for referral to a "health care navigator" who will inform individuals about their health care options and provide choice counseling. Once individuals opt-in, the amount associated with the WBA will be available for 12 months or until the full amount has been expended, whichever comes first. Individuals can only use the account for premiums, cost-sharing, or the direct cost of services received within 12 months. Once the 12 months is finished, individuals will not be able to access the WBA. Reimbursement for health insurance premiums will be paid to the individual or at the request of the individual enrolled in a Marketplace health plan, the State will pay for the premiums directly on behalf of the individual to the health plan. In addition, beneficiaries of this program will receive an insurance card that will contain information for providers on how to submit a claim to the WBA for reimbursement of cost-sharing linked to the enrollees primary insurance or direct billing for enrollees who have not yet completed enrollment in primary insurance coverage. The funds available through the WBA can also be used for the direct payment of Medicaid-covered Section 1905(a) services that would otherwise be available to Medicaid beneficiaries. To receive reimbursement for these services, the services must be rendered by a Medicaid enrolled provider.

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.

To gain eligibility for the WBA, an individual (1) must be fully enrolled in HIP[22] and (2) would otherwise be eligible for HIP except for the increase in income. For example, an individual that lost coverage due to being over income and moving out of state would not be eligible for the WBA, since they no longer meet the HIP eligibility criteria due to state residency. Multiple individuals in the same household, who meet the eligibility requirements, will have access to their own account. These qualified individuals will be notified of their eligibility and opt-in opportunity consecutive with their notice of disenrollment. Accounts may be closed if an individual moves out of state, voluntarily withdraws, ages out, becomes incarcerated, enrolls in Medicare, or regains Medicaid or Presumptive Medicaid eligibility. Eligibility for the WBA program is for one 12-month period and is not eligible for renewal. After lifting the COVID-19 PHE and policies are reinstated, the State anticipates a surge in WBA enrollment due to income disenrollment.

Exhibit A.6: Eligibility Groups Included in the WBA Amendment of the End-Stage Renal Disease (ESRD) Demonstration

Eligibility Group Name	FPL Level and/or other qualifying criteria
WBA	1902(a)(10)(A)(ii)(VII) 42 CFR §435.218

[22] Members conditionally eligible or presumptively eligible for HIP benefits will not qualify for the HIP WBA benefit, nor will individuals that are only eligible for emergency services.

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 and 3, which are focused on evaluating the impact of a specific policy change. Logic models are not provided for Goals 1, 4, 5, and 6, which are descriptive in nature.

As a result of the COVID-19 PHE, metrics for some hypotheses and research questions were not applicable during scheduled data collection. For example, key informant interviews for 2021 will not capture data specific to understanding the tobacco surcharge or POWER Account Contributions, given both were on hold in response to the COVID-19 PHE. More details on policy changes implemented by the State during the COVID-19 PHE are described in **Section A**.

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 ED services will not rise over time for HIP members.	**Primary research question 2.1:** How have avoidable ED 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 – Discourage tobacco use among HIP members through a premium surcharge and the utilization of tobacco cessation benefits

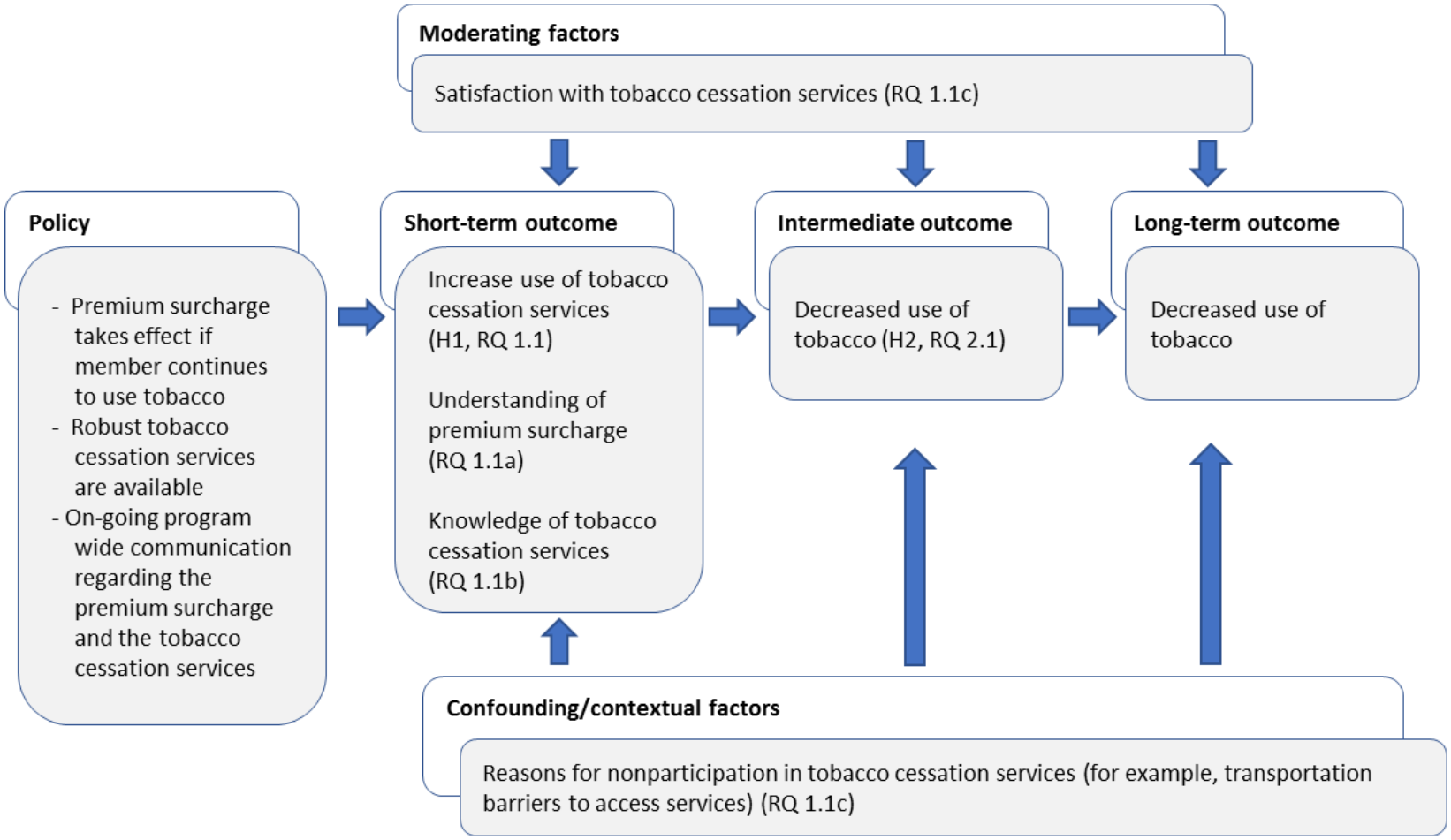
Indiana will test whether the POWER Account Contribution surcharge and utilization of tobacco cessation benefits will discourage tobacco use among HIP members. **Exhibit B.2** below lists the hypotheses and research questions corresponding to this goal. As State suspended all cost-sharing during the COVID-19 PHE (starting from March 2020), no surcharge will be collected during this time. The Tobacco surcharge policy will be reestablished after the COVID-19 PHE is lifted and all policies are reinstated.

Exhibit B.2: Hypotheses and Research Questions for Goal 2

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.3** depicts the expected short-term, intermediate, and long-term outcomes[23] for the premium surcharge and the utilization of tobacco cessation benefits.

Exhibit B.3: Logic Model for Goal 2



[23] 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 – 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[24] (**Subsection A.2** provides additional background on POWER Account policies). Research questions under Goal 1 cover the efficient use of health care services as defined by utilization. **Exhibit B.4** below lists the hypotheses and research questions corresponding to this goal. Members enrolled in HIP Basic prior to COVID-19 PHE could change to Plus. All new members were enrolled in HIP Plus irrespective of income status during the COVID-19 PHE, and members were not allowed to downgrade to Basic during the PHE. Additionally, the State suspended all cost-sharing during the COVID-19 PHE and thereby disenrollment due to non-payment of POWER Account Contribution. As no contribution was collected and other HIP policies were suspended, there will also be very limited dollars for rollover during the COVID-19 PHE. Starting from January 2021, the State suspended the six-month non-eligibility criterion pending resolution of the stay in the federal lawsuit and in compliance with the newly approved waiver terms and conditions.[25] Ability to analyze the research questions will depend on the timing of reinstatement of HIP policies.

Exhibit B.4: Hypotheses and Research Questions for Goal 3

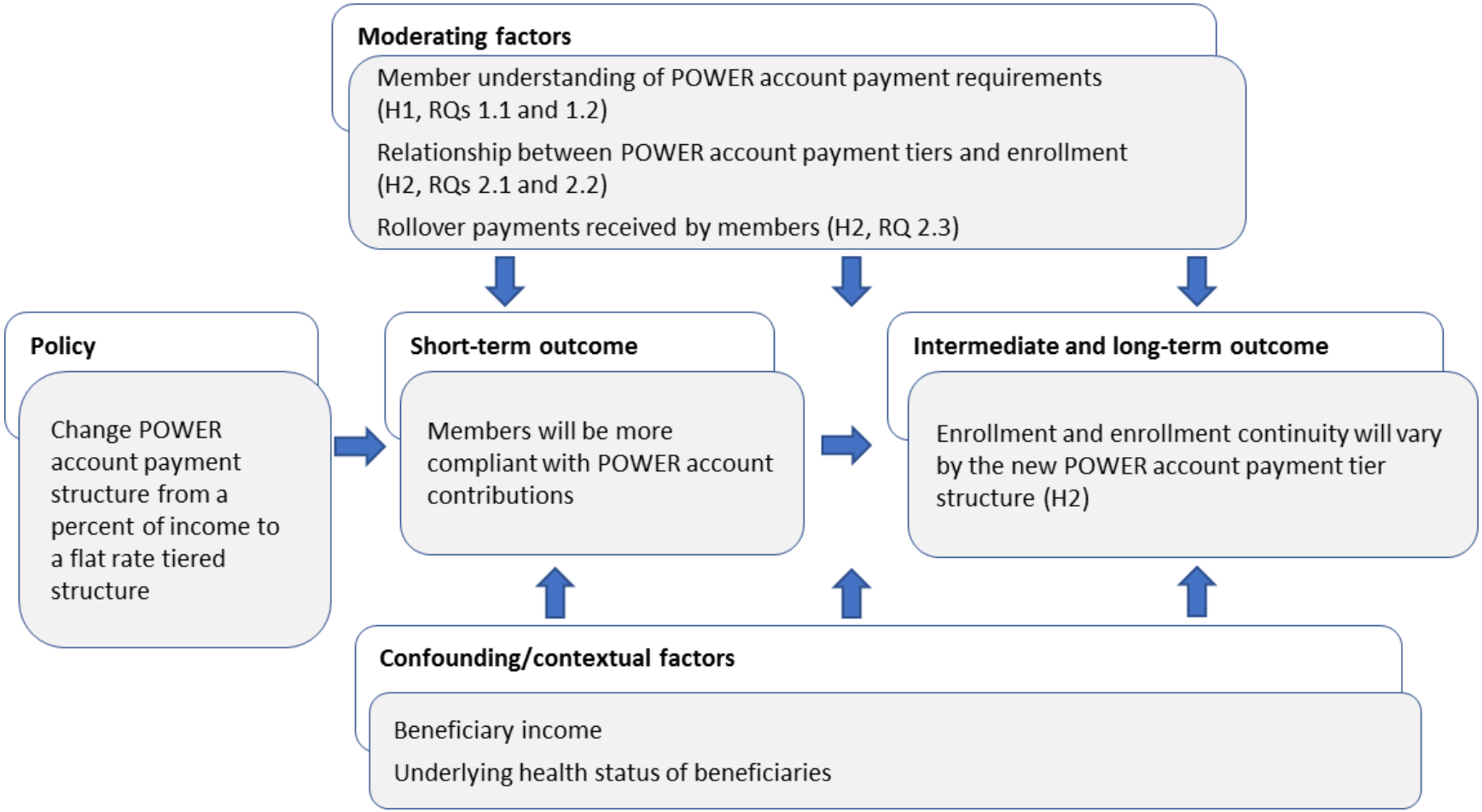
Hypotheses	Research Questions
Hypothesis 1 – HIP's new income tier structure for POWER Account Contributions will be clear to HIP members.	**Primary research question 1.1:** Do HIP members with POWER account payment requirements understand their payment obligations? **Primary research question 1.2:** 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?

[24] 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.

[25] Waiver 4 (related to eligibility) in HIP STC. Accessible from https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/in-healthy-indiana-plan-support-20-ca-01012021.pdf

The logic model in **Exhibit B.5** depicts the expected short-term, intermediate, and long-term outcomes[26] for the tiered structure of the monthly POWER Account payment.

Exhibit B.5: Logic Model for Goal 3



[26] 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 – 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.6** below lists the hypotheses and research questions corresponding to this goal. Starting from January 2021, the State suspended the six-month non-eligibility criterion pending resolution of the stay in the federal lawsuit and in compliance with the newly approved waiver terms and conditions.[27] Members will not be "locked" out for non-payment of POWER Account Contributions. Research questions related to non-eligibility will be addressed and analyzed only if the State reinstates the policy (pending lawsuit decision). Additionally, as HIP policies were "turned off" during the COVID-19 PHE (starting March 2020), the ability to analyze research questions related to member knowledge on HIP policies on POWER Account Contribution, preventive care, and rollover will depend on the timing of reinstatement of HIP policies.

Exhibit B.6: Hypotheses and Research Questions for Goal 4

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.[28]	**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?

[27] Waiver 4 (related to eligibility) in HIP STC. Accessible from https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/in-healthy-indiana-plan-support-20-ca-01012021.pdf

[28] 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.

Hypotheses	Research Questions
Hypothesis 4 – Eliminating or reducing retroactive eligibility will not reduce member enrollment or access to health care; decrease health status; or have adverse financial impact[29]	**Primary research question 4.1:** Do eligible people subject to retroactive eligibility waivers enroll in Medicaid at the same rates as other eligible people who have access to retroactive eligibility? (CMS Guidance Hypothesis 1, RQ 1.1) **Primary research question 4.2:** Do beneficiaries subject to the retroactive eligibility waiver understand that they will not be covered during enrollment gaps? (CMS Guidance Hypothesis 1, Subsidiary RQ 1.2a) **Primary research question 4.3:** Do beneficiaries subject to the retroactive eligibility waiver have better health outcomes than other beneficiaries who have access to retroactive eligibility? (CMS Guidance Hypothesis 3, RQ 3.1) **Primary research question 4.4:** Does the retroactive eligibility waiver lead to changes in the incidence of beneficiary medical debt? (CMS Guidance Hypothesis 4, RQ 4.1)

[29] The hypothesis was included to address CMS' recommendation (received on 03/24/2020) to include analyses of the impact of the waiver of retroactive eligibility on member access and health.

5. Goal Five – 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.7** below lists the hypotheses and research questions corresponding to this goal. To reduce the duplication of efforts, and thus cost, this analysis will be completed by Indiana's actuary, Milliman, Inc., and appended to the Interim Evaluation Report. The results will be incorporated into the overall evaluation analysis where relevant and as appropriate.

Exhibit B.7: Hypotheses and Research Questions for Goal 5

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 summarizes Indiana's evaluation design, including data sources, target and comparison populations, evaluation period, and analytic methods for the first Interim Evaluation Report scheduled for submission to CMS in June 2024.[30] Throughout the previous HIP 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,[31] most notably:

- Impact of tobacco surcharge – The evaluation includes interrupted time series (ITS) analyses of tobacco cessation service use and tobacco use among HIP members.
- HIP members' compliance with the tiered POWER Account structure – The evaluation includes analyses of enrollment outcomes pre/post-implementation of the new tiered account structure among HIP members.
- WBA – The evaluation includes descriptive statistics to analyze impact of WBA on continuity of coverage and benefit cliff among HIP members transitioning to commercial coverage.

Subsection C.1 describes the data sources and collection. **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 Interim evaluation, scheduled to be submitted to CMS in June 2024 (scope of this current Evaluation Plan) will be CYs 2015 to 2022. This time period includes three years before the HIP renewal took effect in 2018, all of the 2018-2020 waiver period, and two years of the 2021-2030 waiver renewal period. 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 when 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 Evaluation Report.

The ongoing COVID-19 PHE, which started in March 2020, continues to cause substantial changes to HIP policies, service utilization, and provider availability and will have both short- and long-term impacts on Indiana's health care system. Due to the COVID-19 PHE, the State suspended HIP policies including

[30] The State anticipates building on this plan to address any future programmatic changes. The analyses plan will be reviewed and updated, as required, for future evaluations (interims and summative) to incorporate any program changes and other specifications including intervention time period and analytic methods.

[31] 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

POWER Account payments, tobacco surcharge, and disenrollment, starting on March 17, 2020.[32] The policies are "turned off" as of the development of this Evaluation Plan, with an unknown timeline for reinstatement. This will likely impact the evaluation of HIP policies. **Section A** outlines the State's COVID-19 policy changes in more detail. Social distancing and prioritization of health care resources are anticipated to affect utilization of a wide variety of services in the immediate future, even as telehealth services increase. Additionally, Medicaid enrollment has increased substantially and is likely to continue to increase during the COVID-19 PHE[33]. Further, it is anticipated that some health care providers will experience financial stress resulting from PHE rules and changing utilization. Changes in payer mix are also expected as individuals lose employer-based coverage, while Medicaid enrollment and the number of uninsured increases. The ability to use data starting from CY 2020 to analyze the impact of the HIP policies will require careful consideration and be dependent on multiple factors including the timeframe for reinstatement of HIP policies and the economic impact of the COVID-19 PHE. During Interim Evaluation Report development, the evaluator will evaluate the research questions, data, and appropriate analytic methods.

1. Data Sources and Collection

The evaluator will compile data from federal surveys and 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 first Interim Report evaluation.[34]

[32] These policies were suspended March 17, 2020. Based on State "Medicaid Policy Changes: regarding COVID-19" updated on July 28, 2020 and in discussion with State as of May 2021.

[33] Based on enrollment summary report, there were approximately 583,000 members receiving HIP benefits end of December 2020. Member enrollment increased to 643,000 in May 2021 with an approximate 10,000 new members every month. Information retrieved from https://www.in.gov/fssa/ompp/forms-documents-and-tools2/medicaid-monthly-enrollment-reports/

[34] The data sources identified and information in Section F are specific to the first Interim Evaluation report for this demonstration. For future evaluations (two interims and a summative) the information will need to be reviewed and updated, as required, to incorporate any programmatic changes. The State does not anticipate significant changes to analytic data for future evaluations.

Exhibit C.1: Data Sources by Goal (Goal 1 to Goal 5)

Type	Data Sources	Goal 1 Access, Utilization, Health Outcomes	Goal 2 Tobacco Cessation	Goal 3 POWER Account	Goal 4 Positive Member Experience	Goal 5 Cost and Non-Cost
External – Quantitative	1. American Community Survey (ACS)	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
	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	-	-
	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[35]	-	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. Longitudinal Member Survey (2023, 2024)	X	X	X	X	-
	7. Leaver #1 – Income	-	-	-	X	-
	8. Leaver #2 – POWER Account Contribution non-payment (2024)	-	-	-	X	-

[35] Other sources of State administrative data may be leveraged as available.

Type	Data Sources	Goal 1 Access, Utilization, Health Outcomes	Goal 2 Tobacco Cessation	Goal 3 POWER Account	Goal 4 Positive Member Experience	Goal 5 Cost and Non-Cost
Indiana – Qualitative	1. Key Informant Interviews with FSSA Officials		X	X	X	-
	2. Key Informant Interviews with MCEs		-	X	X	-
	3. Key Informant Interviews with MCEs on Tobacco-Related Topics	-	X	-	-	-
	4. Key Informant Interviews with Providers	-	X	X	X	-
	5. Key Informant Interviews with Members	-	X	X	X	-

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 is 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 various 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 all HIP enrollees' health care utilization patterns and identify 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 (if reinstated for e.g., reporting of qualifying activities and exemptions by member), tobacco use status and items related to the use of the WBA to pay for premiums for enrollment in commercial coverage. These data will permit identification of individuals that have had HIP eligibility closed due to non-payment of POWER Account Contributions or had a WBA.
- *HIP Surveys:* Surveys will capture the perspectives of members regarding HIP during the intervention time-period covered by the evaluation. Member responses will contribute to addressing research questions across different goals for 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 for the first Interim Evaluation Report. **Section F** provides additional information by research question. There will be three types of member surveys:
    - A longitudinal survey capturing HIP member experience at two points in time 12 months apart. The evaluator will field the first round of the survey in 2023 with a follow up in 2024.
    - Survey of previous HIP members (leavers) who disenrolled due to increase in income.
    - Survey of previous HIP members (leavers) who disenrolled due to non-payment of POWER Account.

As appropriate and feasible, selecting 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 represents the larger population under study, reduces bias, and increases 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. The evaluator will leverage the most up-to-date contact information for sampled members using program administrative data to maximize the response rate.

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 – POWER Account Contribution non-payment	Leaver Survey – Increased Income
Individuals Surveyed	Members having HIP Basic or HIP Plus coverage in a specific month. The coverage status of these individuals will vary between the 2023 and 2024 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 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. The survey sample will include individuals participating in the WBA program and individuals who are not participating.
Timeframe	2023, 2024	2024	2024
Topics	• Access to care • Health status • Tobacco use and related surcharge • Satisfaction with HIP and knowledge of HIP policies • POWER Accounts • Medical debt • WBA	• Reasons for leaving HIP • Current insurance coverage/ employer 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 • WBA
Mode of Administration	Telephone Up to three attempts in 2023 and update five attempts in 2024	Telephone Up to three attempts	Telephone Up to three attempts
Sampling Strategy	Stratified Random	Random	Random
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 February 2023 • Select sample: April 2023 • Survey instrument test: May (2023, 2024) • Conduct survey: June – July 2023, June 2024	• Sampling Universe: HIP members who disenrolled between January 1, 2023 and December 31, 2023 • Select sample: March 2024 • Survey instrument test: April 2024 • Conduct survey: May – June 2024	Same as Leaver Survey – POWER Account Contribution non-payment

Area	Longitudinal Member Survey	Leaver Survey – POWER Account Contribution non-payment	Leaver Survey – Increased Income
Estimated number of completed surveys	2023: 4,500 2024: 650 to 900 (dependent on response rate among respondents in 2023)	250	400
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 2023 and 3.8% for 2024. The evaluator anticipates contacting all respondents in the 2023 survey for purposes of the 2024 longitudinal survey. The adequacy of the resulting 2024 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 and provided in the Interim Evaluation Report.	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 and provided in the Interim Evaluation Report.

*Note: The table includes details for surveys planned for the first Interim Evaluation report scheduled to be submitted to CMS in June 2024. This table (including information on type of surveys, sample sizes, time frame) will need to be updated in future for the other interim reports and summative evaluation.

(1) The population for sampling will depend on the timing of reinstatement of HIP policies and potential long term impact of the COVID-19 PHE.

(2) Due to the small population size and anticipated high non-response, the survey process will involve calling all available individuals until the target sample size has been achieved or until the evaluator has reached the maximum number of dialing attempts. The completed number of responses may be lower than the target.

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.

For the first Interim Evaluation Report, the evaluator anticipates leveraging the results from interviews conducted in 2021 under the pending 2018-2020 Summative Report and will conduct one round of key informant interviews in CY 2024. Key informant interview specifications including type of interviews, targeted number of interviewees and schedule of interview will be updated and included in future interim and summative evaluation reports for this demonstration.

Exhibit C.3: Summary of Indiana-Specific Qualitative Data Collection – Key Informant Interviews

Type	Potential Topics	Targeted Number of Interviewees
FSSA Officials	• Implementation of HIP POWER Account changes, tobacco surcharge, and WBA • 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
MCEs	• Implementation of HIP POWER Account changes, tobacco surcharge, and WBA • 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
Provider/Other Associations	• Understanding of and experience with HIP policies – POWER Accounts, tobacco surcharge, tobacco cessation services, and WBA ○ Member satisfaction with HIP	20 interviews *Note: To be determined based on provider/other association availability. Interviews will include provider associations and certified navigators*
HIP Members	• Access to care • Tobacco use • Satisfaction with HIP • Knowledge of HIP policies – POWER Accounts, tobacco surcharge, tobacco cessation services, and WBA	30 interviews *Note: To be determined based on member availability.*

Type	Potential Topics	Targeted Number of Interviewees
Other Stakeholders	• Topics to be determined based on key areas of interest from the State	5 to 8 interviews *Note: To be determined based on stakeholder availability. This will include an individual with a WBA.*

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,[36] 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. 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 Evaluation Reports why regression discontinuity designs using age, medical frailty, or parents with dependents were not used.

[36] Feedback received previously from CMS included considering use of regression discontinuity (RD) designs using age and medical frailty cutoffs, where feasible.

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 Interim Evaluation Report,[37] the evaluator will refine this set to two to three states, taking into account recent state-specific policy changes, if the state has a retroactive eligibility waiver in place, and/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.

Depending on the research question, ACS or BRFSS will be used for cross-state or cross-coverage type (Medicaid versus commercial) comparisons. In addition to age (19-64), income (138% FPL or less using FPL or reported income) the evaluator will leverage other available variables to approximate the HIP population (e.g., Medicaid eligible population). However, there are limitations to the ability to define these comparison groups, and Indiana's Interim Evaluation Report will include discussion of how these limitations affect the interpretation of the results.

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 the use of analysis results based on both approaches and include a comprehensive rationale and relevant analyses in Interim Evaluation Report on the choice of a specific population definition (e.g., why the enrolled population was used instead of the eligible population or vice-versa).

[37] Comparison group analyses are only included in the Summative Evaluation Report due to the timeframe of data required for analysis.

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 to leverage appropriate matching techniques (e.g., propensity score or Mahalanobis distance) to identity a matching comparison group of beneficiaries 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 Evaluation Report will include a description of the approach(es) and the rationale for selection.

The evaluator will use BRFSS data to analyze health status and medical debt of the Medicaid-eligible population as indicated in Section F (Goal 1 and Goal 4) for the Interim Evaluation Report. BRFSS data will only allow for the identification of the likely eligible Medicaid population; it is not possible to identify the enrolled Medicaid population. Indiana anticipates identifying the likely eligible Medicaid population using the following criteria:

- Include respondents age between 18 and 64 (AGE65YR – Reported age in five-year age categories)
- Exclude respondents that report household income of more than $15,000 (INCOME2 – income is reported in income categories such as “less than $10,000” instead of by FPL)
- Exclude respondents with self-reported employment status of “unable to work” (EMPLOY1)
- Exclude pregnant women (variable “PREGNANT)

Exhibit C.6 provides the anticipated sample sizes for likely eligible Medicaid population in BRFSS. The evaluator will explore additional options to identify the samples representing the likely eligible Medicaid population during Interim Evaluation Report development.

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.[38]

[38] Goal 4, 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)

Exhibit C.4: Summary of Key State Characteristics

Characteristic	Indiana	Colorado	Minnesota	New Mexico	Pennsylvania	Washington
Non-Elderly Adult Expansion FPL Percent[39]	138%	138%	138%	138%	138%	138%
Percent Unemployed[40]	3.6%	3.5%	3.2%	5.1%	3.9%	4.6%
Minimum Wage[41]	$7.25	$11.10	$9.86/$8.04[42]	$7.25	$7.25	$12.00
Percent Rural Households[43]	31%	24%	35%	35%	17%	16%
Percent Uninsured[44]	8.2%	7.6%	4.5%	9.1%	5.5%	6.1%
Percent Employees with Employer Offer[45]	82%	83%	83%	80%	88%	85%
Race (selected)[46]	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[47]	Federally-facilitated	State-based	State-based	State-based with Federal Platform[48]	Federally-facilitated	State-based

Note: All of the states listed expanded their Medicaid programs prior to 2015.

[39] 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/

[40] Bureau of Labor Statistics. Local Area Unemployment Statistics for March 2019. Retrieved May 3, 2019 from https://www.bls.gov/web/laus/laumstrk.htm

[41] 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

[42] 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.

[43] University of Minnesota. 2017 American Community Survey accessed through IPUMS USA. Retrieved May 3, 2019 from https://usa.ipums.org/usa/

[44] Ibid.

[45] 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

[46] 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

[47] 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/

[48] 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 Medicaid uptake in comparison to other states was assessed; 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.[49]

Definition	Year	Indiana	Colorado	Minnesota	New Mexico	Pennsylvania	Washington
Likely Eligible for Medicaid	**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

Exhibit C.6: BRFSS Sample Sizes for Key States

Note: The adequacy of the sample sizes for testing medical debt and health status in comparison to other states was assessed; the sample sizes support comparisons (detectable difference of 10% or more with confidence level of 95% and power level of 80%) between Indiana and other states. Current sample sizes will not allow for any robust statistical tests of differences between subgroups within a state.[50]

Definition	Year	Indiana	Colorado	Minnesota	New Mexico	Pennsylvania	Washington
Likely Eligible for Medicaid	**2015**	137	400	415	188	176	423
	2016	190	319	360	152	183	330
	2017	336	322	497	243	225	458

[49] University of Minnesota. 2017 American Community Survey accessed through IPUMS USA. Retrieved May 3, 2019 from https://usa.ipums.org/usa/

[50] Behavioral Risk Factor Surveillance System (BRFSS), Retrieved May 7, 2020 from https://nccd.cdc.gov/weat/#/analysis

3. Analytic Methods

Indiana will use a mixed-methods approach employing both quantitative and qualitative analyses to answer the research questions in this evaluation (first Interim Evaluation).[51] Qualitative analyses will support stakeholders' perspectives related to context, implementation, and outcomes and will identify contextual factors that help 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 explain the results of claims analysis. 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 observational inference on trends in outcomes of interest. The analyses will leverage data visualizations to identify underlying trends, seasonal patterns, and outliers where feasible (e.g., line chart showing disenrollment rate over time, clustered bar chart showing member composition over time). 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. These tests will use, as appropriate, regression based adjustments to control for changes in member characteristics to estimate changes in measures of interest across time. The descriptive statistics and related statistical analyses (test for difference or regression adjustments as appropriate) will be used to analyze the impact of HIP 2021 policies on member utilization of health care, health status, tobacco cessation services, and compliance with program policies.

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 are available to estimate the models. 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.

[51] The analytic methods for future evaluations (two interims and a summative) will need to be reviewed and updated, as required, to incorporate any programmatic changes. The State does not anticipate significant changes to analytic methods for future evaluations.

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: These analyses will be conducted as part of descriptive, cross-sectional, and interrupted time-series analyses (as listed in Section F). The type and number of subgroup analyses will be determined by appropriateness for the research question, and as data and sample sizes allow. The primary ITS or DiD analysis will produce 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). 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 independent evaluator will weigh the value of testing for differences among subgroups against having adequate sample size and power to do so precisely.

The evaluation will consider the impact of the COVID-19 PHE when looking at trends over time, with specific analysis related to the time period when the COVID-19 PHE declaration was in effect. Sensitivity analyses (e.g., regression, analysis of variance, predictive validity analysis) are typical analytical techniques leveraged to study the impact of specific factors or occurrence of events on outcome(s) of interest. As part of the analytics to evaluate the impact of the HIP demonstration on utilization of health care services for HIP beneficiaries (and other outcomes), the evaluator anticipates performing sensitivity

analyses to explore (or possibly somewhat parse out) the confounded impact of the COVID-19 PHE and suspension of HIP policies. The evaluator will determine the possible inclusion of data from the COVID-19 PHE time period for any quantitative analytics (e.g., estimated change of ED use over time, disenrollment rate) based on this sensitivity 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 and the potential impact of the COVID-19 PHE on the use of 2020 data for evaluation purposes. The Interim Evaluation Report 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. The report 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	Impact of the COVID-19 PHE	The ongoing COVID-19 PHE, which started in March 2020, is anticipated to cause substantial changes to: • HIP policies (e.g., all members were enrolled in HIP Plus irrespective of income, cost-sharing has been suspended) • Service utilization • Medicaid enrollment • Provider networks	• Use and inclusion of data from CY 2020 and beyond to analyze the impact of HIP policies will require careful analyses and be dependent on multiple factors, including the time frame for reinstatement of HIP policies, phase-in time period once the COVID-19 PHE is lifted, policies reinstated and COVID-19's economic impact.
	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 of the differences that cannot be accounted for 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. • Use interviews with key provider associations in lieu of individual providers as necessary
	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, BRFSS data fields do not allow for a full identification of 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.	• Use regression-based adjustments as data is available and appropriate and necessary for analyses across time.
	Number of respondents for leaver surveys (due to increased income, due to non-payment of POWER Account Contribution)	The completed number of responses may be lower than the target sample size. Obtaining responses from previous members is dependent on the non-response rate and total population of leavers. Additionally, the population size of leaver for sampling will depend on the timing of reinstatement of HIP policies and potential long term impact of the COVID-19 PHE.	• The survey process will involve calling all available individuals until the target sample size has been achieved or until the evaluator has reached the maximum number of dialing attempts.

Area	Issue	Description	Anticipated Approaches to Minimizing Limitations
Overall issues, continued	Survey length/ respondent burden and corresponding response rates 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 available for the evaluation of the demonstration can be 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.
	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 reports if there is a possibility that data analyzed contains duplicated HIP members.

Area	Issue	Description	Anticipated Approaches to Minimizing Limitations
Overall issues, continued	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 for the 2018 – 2020 waiver evaluation, 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. • Provide 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 2018 – 2020 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.	• Provide context for interpretation of results in the report, 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: 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.
	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 3: 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.

Area	Issue	Description	Anticipated Approaches to Minimizing Limitations
Goal 4: Ensure that HIP policies promote a positive member experience for all HIP members	Distinguishing impact of retroactive eligibility waiver	• Due to the inclusivity of HIP coverage, there is no comparable in-state population that can be used to measure the impact of the retroactive eligibility waiver. HIP 2.0 has covered all non-disabled, low-income adults between 19 and 64 years old with household income at or below 138% of the FPL since 2015. During that same time period, only pregnant women and individuals with disabilities have retroactive coverage. • Medicaid programs across states can be very different in policies and implementation. Any differences in measures of interest when comparing with other states will likely not purely be due to the impact of the retroactive eligibility waiver and may include the impact of other policy differences. • Comparing program experience pre- and post-2015 will likely not capture impact of retroactive eligibility waiver due to the multiple program policies that have been implemented over time.	Provide context for interpretation of results in the Summative Evaluation Reports, including the need for caution in interpreting and presenting results for impact of retroactive eligibility waiver on member access to care, health status and medical debt.
Goal 5: 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 5, 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

Due to the COVID-19 PHE issued in Indiana, and the impact of COVID-19 on the State's budget, an independent evaluator was not procured in time for the initial Evaluation Design submission. However, Indiana has selected an independent evaluator and is in the process of finalizing a contract. The State is committed to securing an independent evaluator in a timely fashion to work through iterations of this Plan with CMS. Indiana will ensure no conflicts of interest as stated in Section XVI, Paragraph 1 of CMS' STCs for this Waiver Evaluation.

To ensure an independent evaluation, the evaluation process will be independent of any process involving program policy-making, management, or activity of the waiver demonstration implementation. 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 important for the evaluation.

CMS recommended inclusion of cost analysis to understand how the demonstration affected health care spending. Accordingly, analyses developed by the State's actuary, Milliman Inc., will be included for this portion of the evaluation.

Exhibit E.1: Organizational Conflict of Interest

Indiana Department of Administration
Healthy Indiana Plan 1115 Waiver Evaluation

Professional Services Contract #00000000000000000000029036

Organizational Conflict of Interest Disclosure

The Lewin Group, Inc. ("Lewin") is performing Professional Services Contract #00000000000000000000029036 entitled, "Health Indiana Plan 1115 Waiver Evaluation" ("Contract"), for the Indiana Department of Administration, Indiana Family and Social Services Administration ("FSSA").

In accordance with the Centers for Medicare and Medicaid ("CMS") Special Terms and Conditions ("STC") 11-W-00296/5 (as extended through December 31, 2030), 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 OCI disclosure ("Disclosure") is an explanation of why Lewin's performance as the HIP Evaluation Contractor under the Contract does 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 of 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 six businesses. Three of those businesses — UnitedHealthcare Community & State, UnitedHealthcare Medicare & Retirement and UnitedHealthcare Employer & Individual — provide network-based health care benefits and related services under the "UnitedHealthcare" brand. The other three businesses operate under the "Optum" brand and include OptumHealth, OptumRx, and OptumInsight. Amongst its services, the Optum businesses offer a large variety of services that include but are not limited to third party administration of specialty benefits, pharmacy benefit management, disease and care management, direct care delivery, consulting, health technology and innovation support to government agencies and external third party insurers and health plans as well as to UnitedHealthcare plans. Although UHG provides certain shared services across the enterprise, Optum and UnitedHealthcare 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 a current OCI analysis, Lewin identified three (3) affiliated businesses relevant for discussion, and are as follows:

- *UnitedHealthcare Community and State ("UHC C&S"):* UHC C&S is one of the nation's largest health benefits companies dedicated to providing diversified solutions to states that care for the economically disadvantaged, the medically underserved and those without employer-funded health care coverage. C&S Managed Care Organizations ("MCOs") contract with networks of participating providers and facilities to serve more than 5 million beneficiaries covered under Medicaid (Title 19), CHIP (the Title 21, Children's Health Insurance Program), Dually Eligible (Medicaid-Medicare enrollees), Long Term Care and Children with Special Care Needs (a Title V Program) and other federal and state health care programs. UHC C&S is also a government programs Administrative Services Organization where it acts in the capacity of an administrator on a non-risk basis. C&S participates in Medicaid programs throughout the country. Presently, UHC C&S is not an MCO in the State of Indiana. However, UHC C&S is intending to bid on FSSA Request for Proposal RFP #22-68152 Risk-Based Managed Care Services for Medicaid Beneficiaries (Hoosier Healthwise and Healthy Indiana Plan Programs) (hereby referred to as the "RFP") for which proposals are due August 9, 2021.

- *MedExpress:* MedExpress, which is part of OptumHealth, includes primary and urgent care centers in multiple states that provide walk-in neighborhood care, wellness and prevention service. MedExpress

currently provides services to eligible Indiana Medicaid recipients in seven (7) locations throughout the State which include Anderson, Bloomington, Indianapolis, Kokomo, Lafayette, and Muncie.

- *OptumRx:* OptumRx is one of the three largest pharmacy benefit managers and specializes in the delivery, clinical management and affordability of prescription medications and consumer health products. OptumRx provides full-service pharmacy benefits management services, including mail order and specialty pharmacy benefits, and a synchronized pharmacy care experience that combines member engagement with health data and analytics. Its additional 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 serves customers in multiple markets and government programs, including commercial, managed care, Medicaid, Medicare, labor and trust, workers compensation and others. OptumRx is presently under contract with FSSA to provide pharmacy benefit management services for the Indiana Health Coverage Program.

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 developed or assisted FSSA in the procurement of the Contract. Accordingly, no Biased Ground Rules OCI exists.

B. Impaired Objectivity

An Impaired Objectivity OCI commonly occurs when a company's work under one government contract 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 the Contract would create an actual or potential Impaired Objectivity OCI. Where it might be perceived that the risk of a potential OCI might exist, Lewin will explain why that perceived risk would not become an actual or potential OCI.

Lewin's OCI analysis determined that primary purpose of proposed 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. Lewin's OCI analysis concluded that Optum's MedExpress and OptumRx affiliates do not present any risk of an Impaired Objectivity OCI in the conduct of this evaluation. Lewin also established that should its UHC C&S affiliate be awarded a future roles as a Managed Care Entity ("MCE") it might be perceived that Lewin would conduct the HIP evaluation in such a manner that could financially and/or contractually benefit UHC C&S. However, after conducting a thorough review of the facts surrounding the scope of Lewin's evaluation support to FSSA, it was determined that no such OCI risk would be created for the following reasons:

- *The Objective Focus of the Evaluation:* The evaluation of the HIP is to support FSSA's continuous effort to assure Indiana Medicaid recipients are receiving the best possible health care as defined by CMS' Triple Aim for better access to care, better health care outcomes, and reduced cost to beneficiaries. At no time during the course of the evaluation will Lewin be required to evaluate the performance of any HIP MCE including its UCH C&S affiliate as an awarded MCE under the RFP.

- *Lewin's Significant Limitations to Exercise Subjective Judgment:* Lewin will execute all evaluation tasks 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. Any recommended changes to the evaluation design made by Lewin must go through a review by FSSA and its stakeholders and must be approved by CMS. Combined, these FSSA/CMS mandated requirements and parameters, 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 to Indiana Medicaid recipients. As such, no Impaired Objectivity OCI exists.

- *Transparency:* FSSA will have complete oversight of Lewin's in-progress work and through the review of required evaluation deliverables. Additionally, FSSA has final approval of all Lewin's work with CMS being the ultimate approver.

Given these facts and circumstances as they have been presented above, Lewin's ability to perform its HIP evaluation work will not create any risk of an actual or potential Impaired Objectivity OCI should UHC C&S serve FSSA as an MCE under the RFP.

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.

In the performance of the Contract, Lewin has 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 under the current RFP and future MCE bid opportunities. However, any such OCI concerns are 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, including without limitation MedExpress, OptumRx, and UHC C&S. 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 area accessible only to Lewin employees on a need to know basis.

- *Separate Staffing:* The personnel that Lewin uses for the Contract are separate and distinct from the staff used by Lewin's MedExpress, OptumRx, and C&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 policies and procedures regarding the way employees are to handle and disclose confidential information. This includes, 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 Section 12 of the Contract (Confidentiality, Security and Privacy of Personal Information), Lewin is required to abide by HIPAA Rules as such Rules apply to Business Associates.

IV. Conclusion

For all the foregoing reasons, Lewin's continued performance of the Contract does not create an actual or potential OCI nor adversely affect or impact FSSA. Lewin understands that 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. Since the State is bounded by three-year contracts, the evaluation budget includes costs through 2023 and does not account for costs for the entire waiver evaluation period. 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 State will leverage its existing contract with Milliman Inc. for the required cost analysis (Goal 5).

Exhibit E.2: Evaluation Budget-Total Costs

Deliverable / Payment Schedule	SFY 2021	SFY 2022	SFY 2023	SFY 2024	SFY 2025	Total
Task 1: Conduct Project Kick-off and Project Management and Status Meetings						
Subtotal	*$ 6,883*	*$ 6,874*	*$ 7,166*	*$ 25,668*	*$ 31,378*	**$ 77,969**
Task 2:Develop Draft and Final Evaluation Plan for DYs 2021-2030						
Subtotal	*$ 53,001*					**$ 53,001**
Task 3: Perform Key Informant Interviews for the 2021-2023 Interim Evaluation Report						
SFY 2024 (August/Sept of 2023				$ 127,619		$ 127,619
Subtotal		$ -	$ -	$ 127,619	$ -	**$ 127,619**
Task 4: Perform HIP Beneficiary Surveys for the 2021-2023 Interim Evaluation Report						
1st Longitudinal Survey		$ 5,464	$ 418,527			$ 423,992
2nd Longitudinal Survey and Two Leaver Surveys				$ 178,630		$ 178,630
Subtotal		*$ 5,464*	*$ 418,527*	*$ 178,630*	$ -	**$ 602,621**
Task 5: Develop Draft 2021-2023 Interim Evaluation Report						
Subtotal					*$ 725,688*	**$ 725,688**
Task 6: Incorporate CMS Feedback into 2021-2023 Interim Evaluation Report						
Final Interim Evaluation Report for CMS					$ 171,455	$ 171,455
Subtotal					*$ 171,455*	***$ 171,455***
Task 7: Support FSSA in Presenting the Team's Findings and Recommendations						
Subtotal					*$ 42,646*	***$ 42,646***
Task 8: Conduct Ad Hoc Analyses						
Ad Hoc Analyses		$ 76,199	$ 78,485	$ 161,680	$ 166,530	$ 482,895
Subtotal		*$ 76,199*	*$ 78,485*	*$ 161,680*	*$ 166,530*	***$ 482,895***
Total without Optional tasks 7 and 8	**$ 59,884**	**$ 12,338**	**$ 425,693**	**$ 331,917**	**$ 928,520**	**$ 1,758,353**
Total with Optional Tasks 7 and 8	**$ 59,884**	**$ 88,538**	**$ 504,179**	**$ 493,596**	**$ 1,137,697**	**$ 2,283,894**

Attachment E.3. Timeline and Major Milestones

Exhibit E.3: Timeline and Milestones

	State Fiscal Year	2021				2022				2023				2024				2025				2026
	Calendar year	2021				2022				2023				2024				2025				
Task / SubTask		Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	
Task 1	**Conduct Project Kick-off and Project Management and Monitoring Activities**																					
1.1	Conduct project kick off meeting																					
1.2	Provide updated workplan																					
1.3	Conduct status meetings																					
1.4	Provide monthly progress reports	*Covered under base HIP contract*																				
Task 2	**Develop Draft and Final Evaluation Plan for DYs 2021-2030**																					
2.1	Develop draft 2021-2030 Evaluation Plan for FSSA review																					
2.2	Revise draft 2021-2030 Evaluation Plan based on FFSA review (for submission to CMS)																					
2.3	Revise draft 2021-2030 Evaluation Plan based on CMS feedback and provide final version for CMS approval																					
Task 3	**Perform Key Informant Interviews for the 2021-2023 Interim Evaluation Report**																					
3.1	Develop interview guides																					
3.2	Perform key informant interivews																					
3.3	Provide summaries of key informant interviews																					
Task 4	**Perform HIP Beneficiary Surveys for the 2021-2023 Interim Evaluation Report**																					
4.1	Submit member data request to draw survey samples																					
4.2	Develop survey guides																					
4.3	Conduct surveys																					
4.4	Summarize survey 2023 survey results																					
4.5	Summarize 2024 survey results as part of the draft Interim Report development																					
Task 5	**Develop Draft 2021-2023 Interim Evaluation Report**																					
5.1	Collect and prepare data for analysis																					
5.2	Conduct data analyses																					
5.3	Review results of data analytics with FSSA																					
5.4	Develop draft outline for FSSA review; incorporate feedback																					
5.5	Develop draft 2021-2023 Interim Evaluation Report for FSSA review																					
5.6	Provide revised draft 2021-2023 Interim Evaluation Report for public commnet																					
5.7	Provide revised draft 2021-2023 Interim Evaluation Report for submission to CMS																					
Task 6	**Incorporate CMS Feedback into 2021-2023 Interim Evaluation Report**																					
6.1	Develop revised 2021-2023 Interim Evaluation Report for FSSA review																					
6.2	Provide revised 2021-2023 Interim Evaluation Report for submission to CMS																					
Task 7	**Support FSSA in Presenting Findings and Recommendations**																					
7.1	Presentation #1																					
7.2	Presentation #2																					
Task 8	**Conduct Ad Hoc Analyses**																					
8.1	Conduct ad hoc analysis (1)																					
8.2	Conduct ad hoc analysis (1)																					
8.3	Conduct ad hoc analyses (2)																					
8.4	Conduct ad hoc analyses (2)																					

Attachment E.4. Variable Descriptions for ACS Data to be Used in this Evaluation

Exhibit E.4: American Community Survey Variable Descriptions[52]

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.

[52] 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.

Domain	Name	Variable	Description
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.
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.

Domain	Name	Variable	Description
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.
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

The reporting schedule and data source timeline included in the tables in this Section are related to the 2024 Interim Evaluation Report. The analysis plan for future intervention periods will be revisited and additional detail will be included for subsequent reporting.

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

Due to COVID-19 PHE, starting March 2020, all new members were enrolled in HIP Plus benefit plan irrespective of income status and the State suspended any disenrollment. Additionally, due to COVID-19 PHE and requirement for social distancing, certain services were not accessible. Analysis of impact of HIP policies on access to care, utilization and health outcome will require careful consideration.

Exhibit F.1: Goal 1[53]

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?[54] • 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[55] • Proportion of members using primary care[56] • Proportion of members using specialty care[57] • Enrollment in disease management programs by MCE • Adherence to prescription drugs • Proportion of members with urgent care visits[58] • Proportion of members with ED visit	• Claims data (2015-2022) • Annual MCE reporting on enrollment in chronic disease management programs (2015-2022)	Descriptive quantitative analysis with subgroup analysis	n.a.	Interim Evaluation 2024

[53] 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 months. The exact definition of the measures will be included in the evaluation report.

[54] 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.

[55] 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.

[56] 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.

[57] The evaluator anticipates identifying these services using provider specialty.

[58] 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."

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 (2015-2022)[59]	n.a.	n.a.	Interim Evaluation 2024
H.2 – Unnecessary ED services will not rise over time for HIP members.	**Primary RQ 2.1** – How have avoidable ED visits among HIP members changed over time?	Proportion of members with preventable/avoidable ED visits in a year[60]	Claims data (2015-2022)	Descriptive quantitative analysis; identification of visits based on the New York University (NYU) ED algorithm	n.a.	Interim Evaluation 2024
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 and Leaver Survey (2023,2024)	Descriptive quantitative analysis across time	n.a.	Interim Evaluation 2024

[59] Indiana's 2018 HEDIS measures, for example, can be found online at: https://www.in.gov/fssa/ompp/5534.htm (accessed May 9, 2019).
[60] The evaluator anticipates using place of service and revenue code to identify ED visits.

Hypothesis	Research Question	Outcome Measure(s)	Data Sources	Analytic Approach	Comparison Strategy	Reporting Schedule
H.3, continued		Reported health status	BRFSS (2015 – 2022)[61]	Descriptive quantitative analysis Interrupted time series analysis of health status among likely eligible population in Indiana[62]	n.a.	Interim Evaluation 2024
				Findings from Goal 4, Primary RQ 4.3 difference-in-difference estimation of impact of HIP on member health status compared to Medicaid members in other states	Low-income adults (19-64) enrolled in/eligible for Medicaid in Indiana compared to similar adults during the same time period in states that provide retroactive coverage[63]	Interim Evaluation 2024

[61] 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 (low-income (<138% FPL), non-disabled adults aged 19-64; medically frail, TMA participants, and low-income parents and caretakers). As such, analyses will reflect changes among the likely eligible population rather than changes among HIP enrolled members.

[62] The objective of the hypothesis and the research question is to assess impact of HIP policy on HIP member health status over time (not as compared to other states). As such, the primary analytic approach will use an interrupted time series to assess changes in HIP member health status over time.

[63] Goal 4 primary RQ 4.3 is "Do beneficiaries subject to the retroactive eligibility waiver have better health outcomes than other beneficiaries who have access to retroactive eligibility?" For purposes of this question, we plan to analyze the impact of HIP demonstration using a difference-in-difference estimation technique comparing reported health status of Medicaid covered members in Indiana during same period to states that provide retroactive coverage. HIP 2.0 demonstration included retroactive coverage

Hypothesis	Research Question	Outcome Measure(s)	Data Sources	Analytic Approach	Comparison Strategy	Reporting Schedule
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*	Member Survey (2023, 2024)	Descriptive quantitative analysis	n.a.	Interim Evaluation 2024
	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 (2017-2022)	Descriptive quantitative analysis by number of months	n.a.	Interim Evaluation 2024

waiver from its inception in 2015 (this evaluation is for demonstration period 2021-2030). It is to be noted that there is variance in Medicaid program policy, member composition and state healthcare systems and economies across states. Hence, differences in outcome measure using a difference-in-difference approach can be due to multiple reasons that might be inextricably linked. The details associated with the analytics will be included in Goal 4. The Goal 4 RQ 4.3 findings will be leveraged in conjunction with ITS analyses proposed for this research questions to provide a response to primary RQ3.1.

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 (2012-2022)	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 selected Medicaid expansion states (27) and selected states without 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.	Interim Evaluation 2024

Goal 2: Reduce tobacco use among HIP members, through a premium surcharge and the utilization of tobacco cessation benefits

As the State suspended all cost-sharing during the COVID-19 PHE (starting from March 2020), no surcharge will be collected during this time. The tobacco surcharge policy will be reestablished after COVID-19 PHE is lifted and all policies are reinstated. The ability to develop analysis for this goal will depend on the lift of the COVID-19 PHE and reinstatement of HIP policies.

Exhibit F.6: Goal 2[64]

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 (2023, 2024)	Descriptive quantitative analysis	n.a.	Interim Evaluation 2024
			Claims data (2015-2022)	ITS analysis of tobacco cessation services among likely eligible population in Indiana	n.a.[65]	Interim Evaluation 2024
	Subsidiary RQ 1.1a – Do HIP members understand the premium surcharge policy?	Themes related to member knowledge of surcharge	Key informant interviews with members (2021, 2024)	Descriptive qualitative analysis	n.a.	Interim Evaluation 2024
		Proportion of members who are tobacco users and report knowledge of the premium surcharge	Longitudinal Member Survey (2023, 2024)	Descriptive quantitative analysis on proportion of tobacco users reporting knowledge of premium surcharge.	n.a.	Interim Evaluation 2024

[64] 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 months. The exact definition of the measures will be included in the Interim and Summative report.

[65] 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 1.1b** – 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 (2021, 2024)	Descriptive qualitative analysis	n.a.	Interim Evaluation 2024
		Proportion of members who are tobacco users and report knowledge of cessation services offered through HIP	Longitudinal Member Survey (2023, 2024)	Descriptive quantitative analysis	n.a.	Interim Evaluation 2024
	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 (2021, 2024)	Descriptive qualitative analysis	n.a.	Interim Evaluation 2024
		Themes related to reasons for nonparticipation in cessation services	Key informant interviews with members, providers, MCEs, and State officials (2021, 2024)	Descriptive qualitative analysis	n.a.	Interim Evaluation 2024

Hypothesis	Research Question	Outcome Measure(s)	Data Sources	Analytic Approach	Comparison Strategy	Reporting Schedule
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 (2023, 2024) • State administrative data (2018-2022)	Quantitative descriptive analyses of proportion of respondents identifying as using tobacco across time. *Note: Analyses based on member survey data will provide a point in time estimate. Analyses of use across time will be based on State administrative data.*	n.a.	Interim Evaluation 2024

Goal 3: Promote member understanding and increase compliance with payment requirements by changing the monthly POWER Account payment requirement to a tiered structure

Members enrolled in HIP Basic prior to COVID-19 PHE could change to Plus. All new members were enrolled in HIP Plus irrespective of income status during COVID-19 PHE and members were not allowed to change to Basic. Additionally, the State suspended all cost-sharing during the COVID-19 PHE and thereby disenrollment due to non-payment of POWER Account Contribution. As no contribution was collected and other HIP policies were suspended, there will also be limited rollovers during the COVID-19 PHE. Starting from January 2021, the State suspended the six-month non-eligibility criterion pending resolution of the stay in the federal lawsuit and in compliance with the newly approved waiver terms and conditions.[66] Ability to analyze the research questions will depend on timing of reinstatement of HIP policies.

Exhibit F.7: Goal 3[67,68,69]

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	**Primary RQ 1.1 –** Do HIP members with POWER account payment requirements understand their payment obligations?[71]	Themes regarding member understanding of payment obligations	Key informant interviews with members, providers, MCEs, and State officials (2021, 2024)	Descriptive qualitative analysis	n.a.	Interim Evaluation 2024

[66] Waiver 4 (related to eligibility) in HIP STC. Accessible from https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/in-healthy-indiana-plan-support-20-ca-01012021.pdf

[67] 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.

[68] 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.

[69] 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 months. The exact definition of the measures will be included in the Interim and Summative report.

[71] 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
will be clear to HIP members.[70]	*Note: Goal 4, H.1, RQ 1.2 also addresses this question.*	Proportion of members who are knowledgeable of payment obligations	Longitudinal Member Survey (2023, 2024)	Descriptive quantitative analysis	n.a.	Interim Evaluation 2024
H.1, continued	**Subsidiary RQ 1.1a** — Do HIP members that are subject to POWER Account payment requirements have different disenrollment compared to other HIP members?	Proportion of members who disenroll overall, and by: • Plan type (Basic versus Plus) • Under and over 100% of the FPL for HIP Plus members • HIP Plus with and without medically frail status	Enrollment data (2015-2022)	Descriptive quantitative analyses across time for disenrollment overall and by relevant reason codes, and by: • Plan type • Under and over 100% of the FPL for HIP Plus members • HIP Plus with and without medically frail status Interrupted time series analyses of disenrollment pre- and post-2021 – evaluator will develop approach based on results of descriptive analyses.	n.a.	Interim Evaluation 2024

[70] 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.

Hypothesis	Research Question	Outcome Measure(s)	Data Sources	Analytic Approach	Comparison Strategy	Reporting Schedule
H.1, continued	**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?[72]	• 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[73] • Proportion of members that moved from HIP Plus to HIP Basic due to nonpayment by year	Enrollment data (2015-2022)	Descriptive quantitative analysis	n.a.	Interim Evaluation 2024

[72] 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.

[73] 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 3, Hypothesis 2[74]

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.[75]	**Primary RQ 2.1 –** Is there a relationship between POWER Account payment tiers and total and new enrollment in Medicaid?[76]	Reported enrollment in Medicaid among the likely eligible population (take-up)	IPUMS ACS, variable HINSCAID (2015-2022)	Descriptive analysis by income level[77]	n.a.	Interim Evaluation 2024
			IPUMS ACS, variable HINSCAID (2015-2022)[78]	Interrupted time series analyses of enrollment pre and post 2018[79]	n.a.[80]	Interim Evaluation 2024
		• Number of individuals enrolled in Medicaid annually • Number of new enrollees in Medicaid annually	Enrollment data (2015-2022)	Descriptive analysis of enrollment	n.a.	Interim Evaluation 2019 Interim Evaluation 2024

[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 months. The exact definition of the measures will be included in the Interim and Summative report.

[75] 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.

[76] 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.

[77] Initial analyses of the data indicate sufficient sample size by income level within Indiana.

[78] 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. Enrollment in 2020 may also be affected by the COVID-19 PHE.

[79] 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.

[80] 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?[81]	Probability of disenrollment due to non-payment[82]	Enrollment data (2015-2022)	Descriptive quantitative analysis of disenrollment	n.a.	Interim Evaluation 2024
			Enrollment data (2015-2022)[83]	Regression model of outcome controlling for enrollment year[84]	n.a.[85]	Interim Evaluation 2024
		Probability of moving from HIP Plus to Basic	Enrollment data (2015-2022)	Descriptive analysis of movement to Basic	n.a.	Interim Evaluation 2024
			Enrollment data (2015-2022)[86]	Regression model of outcome controlling for enrollment year[87]	n.a.[88]	Interim Evaluation 2024

[81] 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.

[82] 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).

[83] This analysis will leverage available data (2015 – 2022) to account for the trend in disenrollment across time, even prior to 2018 implementation of POWER Account tiered payment, due to other policy or program changes.

[84] 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.

[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. 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.

[86] This analysis will leverage available data (2015 – 2022) 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.

[87] 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.

[88] 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 (2015-2022)	Descriptive analysis of movement to Plus	n.a.	Interim Evaluation 2024
			Enrollment data (2015-2022)[89]	Regression model of outcome controlling for enrollment year[90]	n.a.[91]	Interim Evaluation 2024
		Number of months with Medicaid coverage during year	Enrollment data (2015-2022)	Descriptive analysis of coverage months	n.a.	Interim Evaluation 2024
			Enrollment data (2015-2022)[92]	Regression model of outcome controlling for enrollment year[93]	n.a.[94]	Interim Evaluation 2024
	Primary RQ 2.3 – Do HIP members who receive rollover have greater coverage continuity than HIP members who do not receive rollover?[95]	• Number of months with Medicaid coverage • Probability of disenrollment	Enrollment data (2018-2022)	Regression model of outcomes controlling for enrollment year	Members who do not receive rollover	Interim Evaluation 2024

89 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.

90 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.

91 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.

92 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.

93 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.

94 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.

95 This is a state-specific question that is not included in CMS guidance.

Goal 4: Ensure HIP program policies align with commercial policies, are understood by members, and promote positive member experience and minimize coverage gaps

Starting from January 2021, the State suspended the six-month non-eligibility criterion pending resolution of the stay in the federal lawsuit and in compliance with the newly approved waiver terms and conditions.[96] Members will not be "locked" out for non-payment of POWER Account Contribution. Research questions related to non-eligibility will be addressed and analyzed only if State reinstates the policy (pending decision on lawsuit). Additionally, as HIP policies were turned off during COVID-19 PHE (starting March 2020), ability to analyze for the research questions related to member knowledge on HIP policies on POWER Account Contribution, preventive care, rollover will depend on timing of reinstatement of HIP policies.

[96] Waiver 4 (related to eligibility) in HIP STC. Accessible from https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/in-healthy-indiana-plan-support-20-ca-01012021.pdf

Exhibit F.9: Goal 4[97,98]

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.[99]	**Primary RQ 1.1 –** Are HIP members knowledgeable about policies on payment of POWER Account Contributions, preventive care and rollover?[100]	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 (2023, 2024) • Program administrative data (2017-2022) • Key informant interview with members (2021, 2024)	Descriptive quantitative and qualitative analysis (depending on data source)	n.a.	Interim Evaluation 2024
	Primary RQ 1.2 – Do HIP members subject to non-eligibility periods understand program requirements and how to comply with them? *Note: Goal 3, H.1, RQ 1.1 also addresses this question.*	Reported knowledge of program requirements and how to comply with them	• Key informant interview with members (2021, 2024) • Longitudinal Member Survey (2023, 2024)	Descriptive quantitative and qualitative analysis (depending on data source)	n.a.	Interim Evaluation 2024

[97] 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 4, 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).

[98] 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 months. The exact definition of the measures will be included in the Interim and Summative report.

[99] This is a state-specific hypothesis. The research questions included here focus on non-eligibility periods. Goals 2 and 3 address member understanding of and experiences with policies related to the tobacco surcharge and POWER accounts.

[100] 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 1.3 –** 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	• Key informant interview with members (2021, 2024) • Longitudinal Member Survey (2023, 2024)	Descriptive quantitative and qualitative analysis (depending on data source)	n.a.	Interim Evaluation 2024
	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	• Key informant interview with members, MCE and FSSA officials interviews (2021, 2024)	Descriptive qualitative analysis	n.a.	Interim Evaluation 2024
H.2 – Beneficiaries will be satisfied with the HIP program.[101]	**Primary RQ 2.1 –** What is the level of satisfaction with HIP among HIP members?[102]	Themes related to member satisfaction	• Key informant interview with members, provider, MCE and FSSA officials interviews (2021, 2024)	Descriptive qualitative analysis	n.a.	Interim Evaluation 2024

[101] This is a State-specific hypothesis.
[102] This is a State-specific question.

Hypothesis	Research Question	Outcome Measure(s)	Data Sources	Analytic Approach	Comparison Strategy	Reporting Schedule
H.2, continued		• Proportion of members having high satisfaction with the program • Proportion of members considering HIP a good value relative to its costs	• Longitudinal Member Survey (2023, 2024) • All Leaver Surveys (Non-payment of POWER Account Contribution, income) (2024)	Descriptive quantitative analysis	n.a.	Interim Evaluation 2024
H.3 – Individuals subject to the non-eligibility/lockout periods (payment and redetermination) and retroactive eligibility are no different from commercial market populations.[103]	**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 (2015-2022) Program administrative data (2015-2022)	Descriptive quantitative analysis	Adults ≤138% FPL enrolled in commercial coverage (2015-2022)	Interim Evaluation 2024
	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 (2015-2022) Program administrative data (2015-2022)	Descriptive quantitative analysis	Adults ≤138% FPL enrolled in commercial coverage (2015-2022)	Interim Evaluation 2024

[103] 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.

Hypothesis	Research Question	Outcome Measure(s)	Data Sources	Analytic Approach	Comparison Strategy	Reporting Schedule
H.4 – Eliminating or reducing retroactive eligibility will not reduce member enrollment or access to health care; decrease health status; or have adverse financial impact	**Primary RQ 4.1** – Do eligible people subject to retroactive eligibility waivers enroll in Medicaid at the same rates as other eligible people who have access to retroactive eligibility? (CMS Guidance Hypothesis 1, RQ 1.1)	Proportion of eligible population enrolled in Medicaid	IPUMS ACS data, variables HINSCAID, HCOVANY and HINSCARE (2012-2022)	Regression model of eligible population enrolling in Medicaid (IN and other selected states with expansion)	Low-income adults (19-64) enrolled in/eligible for Medicaid in Indiana compared to similar adults during the same time period in selected Medicaid expansion states that provide retroactive coverage[104]	Interim Evaluation 2024
	Primary RQ 4.2 – Do beneficiaries subject to the retroactive eligibility waiver understand that they will not be covered during enrollment gaps? (CMS Guidance Hypothesis 1, Subsidiary RQ 1.2a)	Reported knowledge of consequence due to coverage gaps for not renewing in a timely manner	Longitudinal Member Survey (2023, 2024)	Descriptive quantitative analysis	n.a.	Interim Evaluation 2024

[104] Indiana has retroactive waiver from 2015. Only pregnant women and individuals with disability have retroactive coverage. Hence, there are no comparable beneficiary group for Indiana HIP, given how inclusive eligibility is for this program. Comparing program experience pre- and post-2015 will likely not capture impact of retroactive eligibility waiver as multiple changes were implemented in Medicaid coverage for HIP 2.0.

Hypothesis	Research Question	Outcome Measure(s)	Data Sources	Analytic Approach	Comparison Strategy	Reporting Schedule
H.4, continued	**Subsidiary RQ 4.2a** – What are common barriers to timely renewal for those subject to the retroactive eligibility waiver? (CMS Guidance Hypothesis 1, Subsidiary RQ 1.2b)	Reported barriers to timely renewal	Key informant interview with members, provider, MCE and FSSA officials interviews (2021, 2024)	Qualitative descriptive analysis	n.a.	Interim Evaluation 2024
	Primary RQ 4.3 – Do beneficiaries subject to the retroactive eligibility waiver have better health outcomes than other beneficiaries who have access to retroactive eligibility? (CMS Guidance Hypothesis 3, RQ 3.1)	Reported health status	BRFSS (2013 – 2022)[Error! Bookmark not defined.] Variable GENHLTH	Difference-in-differences regression model of self-reported health status/healthy days among the likely eligible population[105]	Low-income adults (19-64) enrolled in/eligible for Medicaid in Indiana compared to similar adults during the same time period in states that provide retroactive coverage	Interim Evaluation 2024

[105] Differences in outcome measure between low-income adults (19-64) enrolled in/eligible for Medicaid in Indiana compared to similar adults during the same time period in states that provide retroactive coverage can be due to multiple reasons including differences in Medicaid coverage policies across states (including retroactive waiver).

Hypothesis	Research Question	Outcome Measure(s)	Data Sources	Analytic Approach	Comparison Strategy	Reporting Schedule
H.4, continued	**Primary RQ 4.4** – Does the retroactive eligibility waiver lead to changes in the incidence of beneficiary medical debt? (CMS Guidance Hypothesis 4, RQ 4.1)	Reported medical debt (medical bills)	BRFSS (2013 – 2022)[Error! Bookmark not defined.], variable MEDBILL1	Difference-in-differences regression model of medical debt among the likely eligible population[105]	Low-income adults (19-64) enrolled in/eligible for Medicaid in Indiana compared to similar adults during the same time period in states that provide retroactive coverage	Interim Evaluation 2024

Goal 5: Assess the costs to implement and operate HIP and other non-cost outcomes of the demonstration

Exhibit F.10: Goal 5[106]

Note: In order to reduce the duplication of efforts, and thus cost, Goal 5 analyses will be completed by Indiana's actuary, Milliman, Inc., and appended to the Interim Evaluation Report. 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 2018-2022	Descriptive analysis of administrative costs	n.a.	Interim Evaluation 2024

[106] 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 months. 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 2016-2022 Medicaid funded-health care expenditures (in total and PMPM): • All HIP members • Expansion members only • Basic members • Plus 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)	Interim Evaluation 2024

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 2018-2022 • 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	Interim Evaluation 2024

G. Goal Six – Workforce Bridge Account Evaluation Questions, Hypotheses, and Analytic Tables

G. Goal Six – Workforce Bridge Account Evaluation Questions, Hypotheses, and Analytic Tables

Workforce Bridge Account Background Information

Workforce Bridge Accounts (WBA) will become effective once the COVID-19 PHE restrictions are lifted. To receive a WBA, eligible individuals will be informed that they have access to financial resources, in an amount no greater than $1,000, to temporarily pay for health insurance premiums and cost-sharing, or for the direct costs of prescription drugs and services otherwise covered under Section 1905(a) of the Social Security Act. This assistance is expected to act as a bridge to commercial insurance coverage. While individuals would be made aware that this resource would be available to them if they took steps to raise their income enough to lose Medicaid eligibility, the accounts would only be activated when an individual is no longer Medicaid eligible. Individuals who recently disenrolled for failure to meet conditions of eligibility, such as payment of premiums, will not qualify.

This program will be available to eligible individuals based on the availability of State funding. Members eligible for WBA, once notified, must opt-in to the WBA program. To opt-in, the eligible individual must acknowledge an interest in participating by phone or mail to the state. Individuals will have 30 days once notified to opt-in to the account. As part of this 30-day opt-in process, individuals will have the opportunity for referral to a "health care navigator" who will inform individuals about their health care options and provide choice counseling. Once individuals opt-in, the amount associated with the WBA will be available for 12 months or until the full amount has been expended, whichever comes first. Individuals can only use the account for premiums, cost-sharing, or the direct cost of services received within 12 months. Once the 12 months is finished, individuals will not be able to access the WBA. Reimbursement for health insurance premiums will be paid to the individual or at the request of the individual enrolled in a Marketplace health plan, the State will pay for the premiums directly on behalf of the individual to the health plan. In addition, beneficiaries of this program will receive an insurance card that will contain information for providers on how to submit a claim to the WBA for reimbursement of cost-sharing linked to the enrollees primary insurance or direct billing for enrollees who have not yet completed enrollment in primary insurance coverage. The funds available through the WBA can also be used for the direct payment of Medicaid-covered Section 1905(a) services that would otherwise be available to Medicaid beneficiaries. To receive reimbursement for these services, the services must be rendered by a Medicaid enrolled provider.

Population Groups Impacted by the Demonstration

To gain eligibility for the WBA, an individual (1) must be fully enrolled in HIP[107] and (2) would otherwise be eligible for HIP except for the increase in income. For example, an individual that lost coverage due to being over income and moving out of state would not be eligible for the WBA, since they no longer meet the HIP eligibility criteria due to state residency. Multiple individuals in the same household, who meet the eligibility requirements, will have access to their own account. These qualified individuals will be notified of their eligibility and opt-in opportunity consecutive with their notice of disenrollment. Accounts may be closed if an individual moves out of state, voluntarily withdraws, ages out, becomes incarcerated, enrolls in Medicare, or regains Medicaid or Presumptive Medicaid eligibility. Eligibility for the WBA program is for one 12-month period and is not eligible for renewal. After lifting the COVID-19

[107] Members conditionally eligible or presumptively eligible for HIP benefits will not qualify for the HIP WBA benefit, nor will individuals that are only eligible for emergency services.

PHE and policies are reinstated, the State anticipates a surge in WBA enrollment due to income disenrollment.

Exhibit G.1: Eligibility Groups Included in the WBA Amendment of the End-Stage Renal Disease (ESRD) Demonstration

Eligibility Group Name	FPL Level and/or other qualifying criteria
WBA	1902(a)(10)(A)(ii)(VII) 42 CFR §435.218

WBA Evaluation Questions and Hypotheses

Goal 6 – WBA will support HIP members transitioning to commercial with continuity of coverage, reduce benefit cliff, and churn

The WBA program is included in the Section 1115(a) demonstration waiver entitled "End Stage Renal Disease (ESRD)" as of January 2021. Indiana is currently working with CMS to move the WBA program into the HIP waiver with similar evaluation report timeframes and requirements. At the time of submitting this evaluation draft plan, the WBA was not approved beyond December 31, 2021. The State anticipates receiving approval by the time the COVID-19 PHE is lifted, and all HIP policies are reinstated; hence the reason for inclusion in the draft Evaluation Plan. Ability to analyze any of the research questions will depend on implementation of the WBA.

Goal 6.1. Reduce the benefit cliff faced by individuals transitioning from HIP to commercial coverage

The evaluation determines whether the WBA had an impact in reducing the benefit cliff faced by individuals transitioning from HIP to commercial coverage. **Exhibit G.2** below lists the hypothesis and research questions corresponding to this goal.

Exhibit G.2: Hypothesis and Research Questions for Goal 6.1

Hypotheses	Research Questions
Hypothesis 1 – The HIP WBA will reduce the amount of out-of-pocket costs (copayments, coinsurance, deductible, and premium costs) for individuals who transition into commercial health insurance	**Primary RQ 1.1:** Does the WBA result in reductions of out-of-pocket costs for individuals who transition into commercial health insurance?
Hypothesis 2 –The HIP WBA will support members who face a coverage gap when transitioning to commercial insurance	**Primary RQ 2.1:** Does the WBA support members when transiting to commercial insurance?

Goal 6.2. Support successful uptake of and continued enrollment in commercial coverage

This evaluation explores the impact of the WBA to increase uptake of, and continued enrollment in, commercial insurance. **Exhibit G.3** below lists the hypothesis and research questions corresponding to this goal.

Exhibit G.3: Hypothesis and Research Questions for Goal 6.2

Hypotheses	Research Questions
Hypothesis 1 – The HIP WBA will increase the number of successful enrollments in Marketplace insurance among individuals leaving HIP and eligible for the Account.	**Primary research question 1.1:** Does the WBA increase the number of successful enrollments in Marketplace insurance?
Hypothesis 2 – The HIP WBA and contribution policies will increase the number of successful enrollments in employer-sponsored insurance among individuals leaving HIP and eligible for the WBA	**Primary research question 2.1:** Does the WBA increase the number of successful enrollments in employer-sponsored insurance among individuals who disenroll HIP due to increased income?

Goal 6.3. Increase insurance uptake and reduce the number of individuals who leave HIP and are uninsured

This evaluation explores the impact of the WBA to increase insurance uptake and reduce the number of individuals who leave HIP and are uninsured. **Exhibit G.4** below lists the hypotheses and research questions corresponding to this goal.

Exhibit G.4: Hypothesis and Research Questions for Goal 6.3

Hypotheses	Research Questions
Hypothesis 1 – The HIP WBA will reduce the number of individuals who disenroll due to increased income and are uninsured following disenrollment	**Primary RQ 1.1:** Does the WBA reduce the number of individuals who disenroll due to increased income and are uninsured following disenrollment?

Goal 6.4. Reduce churn between HIP and commercial coverage or uninsured status

This evaluation explores the impact of the WBA to reduce churn between HIP and commercial coverage or uninsured status. **Exhibit G.5** below lists the hypotheses and research questions corresponding to this goal.

Exhibit G.5: Hypothesis and Research Questions for Goal 6.4

Hypotheses	Research Questions
Hypothesis 1 – The HIP WBA will reduce churn back to HIP among eligible individuals	**Primary RQ 1.1:** Does the WBA reduce churn back to HIP among eligible members?
Hypothesis 2 – Individuals with a WBA will report satisfaction of health care access	**Primary RQ 2.1:** What percentage of HIP members report getting care as soon as needed after they disenrolled from HIP?

WBA Methodology

For goals related to WBA, the target population for analyses are HIP beneficiaries that would opt-in to receiving the WBA after being disenrolled from HIP solely due to increased income. In 2018, the State estimated 27,000 individuals would qualify for the WBA. The WBA program has not been implemented at the time of this Evaluation Plan development. Indiana anticipates a higher number of HIP members will be eligible for WBA following the COVID-19 PHE and upon reinstatement of all HIP policies. With this in mind, the state will explore the use of a quasi-experimental design, including difference-in-difference and interrupted time series (ITS) with comparison groups. Potential comparison populations of interest would be: those individuals who disenrolled from HIP for any other reason except increased income, or; HIP members who were eligible for WBA but did not opt-in, or; if the HIP had more individuals disenroll solely for increased income than the available number of WBA accounts. Comparison groups will be carefully considered and revisited if the amendment were extended after the current demonstration approval period ends. **Exhibit G.6** identifies the data sources for Goal 6 and **Exhibit G.7** provides a summary of the anticipated quantitative surveys. The Longitudinal Member Survey, Leaver #1 – Income Survey, and Leaver #2 – POWER Account Contribution Non-Payment Survey will include sub-questions related to the WBA. These will not be separate or additional surveys to what was described in the HIP Evaluation Plan. **Exhibit G.8** includes a summary of the key informant interviews. Note that the WBA questions will be embedded within the existing key informant interviews as described in the HIP Evaluation Plan.

Exhibit G.6: Data Sources for Goal 6

Type	Data Sources	Goal 6.1 Reduce Benefit Cliff	Goal 6.2 Enrollment and Uptake of Commercial Insurance	Goal 6.3 Increase Insurance Uptake	Goal 6.4 Reduce Churn and Access
Indiana – Quantitative	1. Member Eligibility, Application, and Enrollment/Disenrollment Data *Note: Enrollment data will be used to draw member survey samples that are applicable across goals.*	X	X	-	X
	2. Claims Data	X	X	-	X
	3. State administrative data—for example, WBA information, POWER Account contributions, etc. [108]	X	X	X	-
	4. Longitudinal Member Survey (2023, 2024)*	X	-	X	X
	5. Leaver #1 – Income*	X	-	X	X
	6. Leaver #2 – POWER Account Contribution non-payment (2024)*	X	-	X	X

[108] Other sources of State administrative data may be leveraged as available.

Type	Data Sources	Goal 6.1 Reduce Benefit Cliff	Goal 6.2 Enrollment and Uptake of Commercial Insurance	Goal 6.3 Increase Insurance Uptake	Goal 6.4 Reduce Churn and Access
Indiana – Qualitative	7. Key Informant Interviews with HIP members[109]	X	X	X	X
	8. Key Informant Interviews with State Officials	X	X	X	X
	9. Key Informant Interviews with MCEs	X	-	X	-
	10. Key Informant Interviews with Other Stakeholders (including consumer advocates)	X	X	X	X
	11. Key Informant Interviews with Providers	X	X	X	X

*Availability of data will depend on multiple factors including sample size, number of individuals having WBA in the study period, response received from leaver who had WBA and implementation timing of WBA

Exhibit G.7: Summary of Indiana-Specific Surveys*

Area	Longitudinal Member Survey	Leaver Survey – POWER Account Contribution non-payment	Leaver Survey – Increased Income
Individuals Surveyed	Members having HIP Basic or HIP Plus coverage in a specific month. The coverage status of these individuals will vary between the 2023 and 2024 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 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. The survey sample will include individuals participating in the WBA program and individuals who are not participating.
Timeframe	2023, 2024	2024	2024
Topics	• Access to care • Health status • Tobacco use and related surcharge • Satisfaction with HIP and knowledge of HIP policies • POWER Accounts • Medical debt • WBA	• Reasons for leaving HIP • Current insurance coverage/ employer 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 • WBA

[109] HIP member focus groups may also be utilized in qualitative data research

Area	Longitudinal Member Survey	Leaver Survey – POWER Account Contribution non-payment	Leaver Survey – Increased Income
Mode of Administration	Telephone Up to three attempts in 2023 and update five attempts in 2024	Telephone Up to three attempts	Telephone Up to three attempts
Sampling Strategy	Stratified Random	Random	Random
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 February 2023 • Select sample: April 2023 • Survey instrument test: May (2023, 2024) • Conduct survey: June – July 2023, June 2024	• Sampling Universe: HIP members who disenrolled between January 1, 2023 and December 31, 2023 • Select sample: March 2024 • Survey instrument test: April 2024 • Conduct survey: May – June 2024	Same as Leaver Survey – POWER Account Contribution non-payment
Estimated number of completed surveys	2023: 4,500 2024: 650 to 900 (dependent on response rate among respondents in 2023)	250	400

Area	Longitudinal Member Survey	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 2023 and 3.8% for 2024. The evaluator anticipates contacting all respondents in the 2023 survey for purposes of the 2024 longitudinal survey. The adequacy of the resulting 2024 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 and provided in the Interim Evaluation Report.	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 and provided in the Interim Evaluation Report.

*Note: The table includes details for surveys planned for the first Interim Evaluation report scheduled to be submitted to CMS in June 2024. This table (including information on type of surveys, sample sizes, time frame) will need to be updated in future for the other interim reports and summative evaluation.

(1) The population for sampling will depend on the timing of reinstatement of HIP policies and potential long term impact of the COVID-19 PHE.

(2) Due to the small population size and anticipated high non-response, the survey process will involve calling all available individuals until the target sample size has been achieved or until the evaluator has reached the maximum number of dialing attempts. The completed number of responses may be lower than the target

Exhibit G.8: Summary of Indiana-Specific Qualitative Data Collection – Key Informant Interviews

Type	Potential Topics	Targeted Number of Interviewees
FSSA Officials	• Implementation of HIP POWER Account changes, tobacco surcharge, and WBA • 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
MCEs	• Implementation of HIP POWER Account changes, tobacco surcharge, and WBA • 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
Provider/Other Associations	• Understanding of and experience with HIP policies –POWER Accounts, tobacco surcharge, tobacco cessation services, and WBA ○ Member satisfaction with HIP	20 interviews *Note: To be determined based on provider/other association availability. Interviews will include provider associations and certified navigators*
HIP Members	• Access to care • Tobacco use • Satisfaction with HIP • Knowledge of HIP policies – POWER Accounts, tobacco surcharge, tobacco cessation services, and WBA	30 interviews *Note: To be determined based on member availability.*
Other Stakeholders	• Topics to be determined based on key areas of interest from the State	5 to 8 interviews *Note: To be determined based on stakeholder availability. This will include an individual with a WBA.*

WBA Methodological Limitations

Exhibit G.9 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.

Exhibit G.9: Summary of Methodological Limitations and Approach to Minimizing Limitations

Area	Issue	Description	Anticipated Approaches to Minimizing Limitations
Overall issues	Impact of the COVID-19 PHE	The ongoing COVID-19 PHE, which started in March 2020, is anticipated to cause substantial changes to: • HIP policies (e.g., all members were enrolled in HIP Plus irrespective of income, cost-sharing has been suspended) • Service utilization • Medicaid enrollment • Provider networks	• Use and inclusion of data from CY 2020 and beyond to analyze the impact of HIP policies will require careful analyses and be dependent on multiple factors, including the time frame for reinstatement of HIP policies, phase-in time period once the COVID-19 PHE is lifted, policies reinstated and COVID-19's economic impact.
	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 of the differences that cannot be accounted for given available evaluation resources and data limitations. • Use appropriate methods (e.g., matching) to account for observable differences.
	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. • Use interviews with key provider associations in lieu of individual providers as necessary

Area	Issue	Description	Anticipated Approaches to Minimizing Limitations
Overall issues, continued	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, BRFSS data fields do not allow for a full identification of 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.	• Use regression-based adjustments as data is available and appropriate and necessary for analyses across time.
	Number of respondents for leaver surveys (due to increased income, due to non-payment of POWER Account Contribution)	The completed number of responses may be lower than the target sample size. Obtaining responses from previous members is dependent on the non-response rate and total population of leavers. Additionally, the population size of leaver for sampling will depend on the timing of reinstatement of HIP policies and potential long term impact of the COVID-19 PHE.	• The survey process will involve calling all available individuals until the target sample size has been achieved or until the evaluator has reached the maximum number of dialing attempts.
	Survey length/ respondent burden and corresponding response rates 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.

Area	Issue	Description	Anticipated Approaches to Minimizing Limitations
Overall issues, continued	Quality of MCE encounter data	MCE encounter data is self-reported, and the procedure codes and units recorded in the encounter data available for the evaluation of the demonstration can be 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.
	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 reports if there is a possibility that data analyzed contains duplicated HIP members.

Area	Issue	Description	Anticipated Approaches to Minimizing Limitations
Overall issues, continued	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 for the 2018 – 2020 waiver evaluation, 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. • Provide 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 2018 – 2020 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.	• Provide context for interpretation of results in the report, including the need for caution in interpreting and presenting results for take-up and continued enrollment in HIP.
	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.
	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
	Variability in FPL amounts	Discussed as an overall methodological limitation above	• Refer to description above.

WBA Analytic Tables

Goal 6: WBA will support HIP members transitioning to commercial with continuity of coverage, reduce benefit cliff, and churn

Exhibit G.10: Goal 6.1

Hypothesis	Research Question	Outcome Measure(s)	Data Sources	Analytic Approach	Comparison Strategy	Reporting Schedule
H.1 – The HIP WBA will reduce the amount of out-of-pocket costs (copayments, coinsurance, deductible, and premium costs) for individuals who transition into commercial health insurance	**Primary RQ 1.1**: Does the WBA result in reductions of out-of-pocket costs for individuals who transition into commercial health insurance?	• Number and percentage of members with WBA expenditures paid with coordination of benefits to a primary commercial plan by month of Bridge Account enrollment (month 1 to 12)	• Enrollment data (2015-2022) • Claims data (2015-2022)	• Descriptive quantitative analysis	n.a.	Interim Evaluation Report 2024
		• Amount paid from WBA for member claims and premiums • Amount paid from WBA by category of service	• State Administrative data for WBA	• Descriptive quantitative analysis	n.a.	Interim Evaluation Report 2024

Hypothesis	Research Question	Outcome Measure(s)	Data Sources	Analytic Approach	Comparison Strategy	Reporting Schedule
H.2 –The HIP WBA will support members who face a coverage gap when transitioning to commercial insurance	**Primary RQ 2.1** – Does the WBA support members when transiting to commercial insurance?	• Number and percentage of members with WBA expenditures paid without coordination of benefits to a primary commercial plan by month of Bridge Account enrollment (month 1 to 12) • Number of claims applied to accounts without coordination of benefits	• Enrollment data (2015-2022) • Claims data (2015-2022)	• Descriptive quantitative analysis	n.a.	Interim Evaluation Report 2024
		• Member perceptions of access and affordability of coverage when in a coverage gap. • Member knowledge and perceptions of the WBA • WBA impact on access and affordability. • Member decisions to seek or delay health care, or enroll in health insurance, as a result of HIP WBA access.	• Key informant interviews with WBA holders, State staff, MCOs, providers, and other stakeholders (including consumer advocates)	• Qualitative analysis to identify themes associated with the effectiveness of demonstration activities for reducing the benefit cliff faced by individuals transition from HIP to commercial coverage.	n.a.	Interim Evaluation Report 2024

Exhibit G.11: Goal 6.2

Hypothesis	Research Question	Outcome Measure(s)	Data Sources	Analytic Approach	Comparison Strategy	Reporting Schedule
H.1 – The HIP WBA will increase the number of successful enrollments in Marketplace insurance among individuals leaving HIP and eligible for the Account.	**Primary RQ 1.1:** Does the WBA increase the number of successful enrollments in Marketplace insurance?	• Track use of Account to pay for premiums for enrollment in commercial insurance	• Claims/encounter data • Enrollment data	• Descriptive quantitative analysis of trends over time during the demonstration	n.a.	Interim Evaluation Report 2024
		• Member self-report of Marketplace health insurance coverage *Note: Analysis will depend on number of respondents having a WBA*	• Member survey data	• Descriptive quantitative analysis	n.a.	Interim Evaluation Report 2024
H.2 – The HIP WBA and contribution policies will increase the number of successful enrollments in employer-sponsored insurance among individuals leaving HIP and eligible for the Account.	**Primary RQ 2.1 –** Does the WBA increase the number of successful enrollments in employer-sponsored insurance among individuals who disenroll HIP due to increased income?	• Track use of Account to pay for premiums for enrollment in commercial insurance • Number of third-party coverage policies that allow individuals that already have other coverage to request contrition waivers.	• Claims/encounter data • Enrollment data • State administrative data	Descriptive quantitative analysis of trends over time during the demonstration	n.a.	Interim Evaluation Report 2024

Hypothesis	Research Question	Outcome Measure(s)	Data Sources	Analytic Approach	Comparison Strategy	Reporting Schedule
H.2, continued		• Member self-report of employer health insurance coverage *Note: Analysis will depend on number of respondents having a WBA*	• Member survey data	Qualitative analysis to identify associated themes	n.a.	Interim Evaluation Report 2024

Exhibit G.12: Goal 6.3

Hypothesis	Research Question	Outcome Measure(s)	Data Sources	Analytic Approach	Comparison Strategy	Reporting Schedule
H.1 – The HIP WBA will reduce the number of individuals who disenroll due to increased income and are uninsured following disenrollment.	**Primary RQ 1.1:** Does the WBA reduce the number of individuals who disenroll due to increased income and are uninsured following disenrollment?	• Number of payments from WBA for health services incurred without coordination of benefits	State administrative data	Descriptive quantitative analysis of trends over time during the demonstration	Baseline assessment at the start of the demonstration	Interim Evaluation Report 2024
		• Member self-report of health insurance coverage *Note: Analysis will depend on number of respondents having a WBA*	Member survey data	Qualitative analysis to identify associated themes	n.a.	Interim Evaluation Report 2024

Exhibit G.13: Goal 6.4

Hypothesis	Research Question	Outcome Measure(s)	Data Sources	Analytic Approach	Comparison Strategy	Reporting Schedule
H.1 – The HIP WBA will reduce churn back to HIP among eligible individuals.	**Primary RQ 1.1:** Does the WBA reduce churn back to HIP among eligible members?	• Number and percentage of individuals who return to HIP after disenrollment due to increased income	• Claims/encounter data • Enrollment data	ITS, analyzing churn pre and post WBA implementation	n.a.	Interim Evaluation Report 2024
		• Member perceptions of the causes of churn *Note: Analysis will depend on number of respondents having a WBA*	• Member survey data	• Qualitative analysis to identify associated themes	n.a.	Interim Evaluation Report 2024
H.2 – Individuals with a WBA will report satisfaction of health care access	**Primary RQ 2.1 –** What percentage of HIP members report getting care as soon as needed after they disenrolled from HIP?	Proportion of members reporting that they access care as soon as needed *Note: Analysis will depend on number of respondents having a WBA. Also, Survey length constraints will determine how many questions might be asked to determine access by type of service*	• Member survey data	Descriptive quantitative analysis of trends over time during the demonstration	n.a.	Interim Evaluation Report 2024