Healthy Indiana Plan

Final Evaluation Plan

11/13/2018; Version 6

Submitted by The Lewin Group

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Demonstration Overview

Program History

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

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

In 2014, following several one-year extensions of the original HIP waiver, Governor Mike Pence opted to seek expansion of Indiana's successful HIP program to cover individuals in the new adult group. Following a landmark agreement with the Indiana hospitals, which secured funding for the costs of expansion beyond the existing cigarette tax revenue, the State submitted a fiscally sustainable waiver to expand its existing demonstration waiver, called "HIP 2.0".

The HIP 2.0 waiver built on the early HIP experiences and outcomes to improve the program and strengthen the core values of personal responsibility and consumer driven health care. In January 2015, CMS approved the HIP 2.0 program through a three-year waiver expiring in January 2018. Following implementation of HIP 2.0 on February 1, 2015, the Indiana General Assembly codified HIP 2.0 at Ind. Code §12-15-44.5. Through the 2016 codification efforts, the state legislature once again reinforced its support of HIP by expressly prohibiting the continuation of Medicaid expansion in the State except through HIP, operated in a manner consistent with the statutory provisions.

Current Operation

Indiana's current section 1115(a) demonstration provides authority for the State to continue to offer HIP. Under HIP, members who make required monthly contributions to their POWER account maintain access to an enhanced benefit plan, known as "HIP Plus", which includes enhanced health care benefits such as coverage for dental, vision, and chiropractic services. HIP Plus is intended to encourage personal responsibility, improve healthy behaviors, and develop cost conscious consumer behaviors among all beneficiaries.

Beneficiaries with income at or below 100 percent of the federal poverty level (FPL) who do not make monthly POWER account contributions will default to a more limited benefit plan, known as "HIP Basic". The HIP Basic plan offers a more limited benefit package (e.g., not covering vision or dental services) and applies copayments to all health care services. By contrast, members with family income above the poverty level will be terminated from HIP for non-payment of required monthly contributions, consistent with commercial market policies. These members do not have access to the HIP Basic plan and cannot re-enroll for six months. Notwithstanding the foregoing, individuals determined medically

frail, regardless of income, are exempt from non-payment penalties and do not lose benefits due to non-payment of POWER account contributions.

Unlike traditional premiums or copayments, HIP members own their POWER account contributions and are entitled to their portion of unused contributions when they leave the program. Due to the direct financial investment in the POWER account, HIP members are incentivized to manage their accounts judiciously and to take advantage of free preventive care services offered by the plan outside of the member's POWER account. For this reason, POWER accounts remain a critical feature of HIP provided to every HIP member, regardless of their benefit plan. To further incentivize healthy behaviors, members who obtain preventive services are eligible to reduce their future POWER account contribution amounts.

Key Enhancements from HIP 2.0

The current HIP demonstration includes several key enhancements from the previous "HIP 2.0" demonstration. In particular, HIP includes an initiative to reduce tobacco use, and a policy to promote employment and activities leading to employment.

Tobacco Cessation Initiative

HIP includes a tobacco-user surcharge for HIP Plus members. All HIP members are required to contribute two percent (2%) of income per month to their POWER account to maintain access to the enhanced HIP Plus plan. However, to discourage tobacco use, members who are known tobacco users will pay monthly contributions equal to three percent (3%) of income in their second year of eligibility.

For individuals identified as a tobacco user, HIP waives the tobacco surcharge for the first year of enrollment to provide the individual with the opportunity to take advantage of the robust tobacco cessation benefits offered through HIP. If after a year, the member continues to be a tobacco user, then their monthly premiums will increase from two percent (2%) to three percent (3%) of their monthly income beginning in the first month of their renewed benefit period.

Employment, Education and Gateway to Work Policy

All able-bodied HIP participants, not otherwise meeting an exemption, will be required to either:

a) Work on average 20 hours per week over eight (8) months during the eligibility period;
b) Be enrolled in full-time or part-time education; or
c) Participate in Gateway to Work.

This requirement will be operationalized during the first year of the current demonstration, and phased in during the program's second year with a member grace period of six (6) months.

Gateway to Work will connect unemployed and under-employed HIP members to available job training, work search, and employment programs that will assist members in securing gainful employment.

Program Goals

Over the demonstration period, the state seeks to achieve several demonstration goals. The state's goals will inform the state's evaluation design hypotheses, subject to CMS approval, as described in the HIP special terms and conditions. The state's goals include, but are not limited to, the following:

1. Improve health care access, appropriate utilization, and health outcomes among HIP members;
2. Increase community engagement leading to sustainable employment and improved health outcomes among HIP members;
3. Discourage tobacco use among HIP members, through a premium surcharge and the utilization of tobacco cessation benefits.
4. Determine whether moving the monthly POWER account payment to a tiered structure will result in more efficient use of health care services, be easier for beneficiaries to understand, and increase compliance with payments;
5. Ensure that HIP policies promote a positive member experience for all HIP members.

These five goals address key objectives of section 1115 demonstrations, including improving access to high-quality services that produce positive health outcomes for individuals; strengthening beneficiary engagement in their personal health care plan, including incentive structures that promote responsible decision-making; and enhancing alignment between Medicaid policies and commercial health insurance products to facilitate smoother beneficiary transition.[1] The success of the goals of this current 1115 demonstration will be evaluated through the research questions detailed in Table 1.

Table 1. HIP Goals and Research Questions

#	Goal	Research Questions
1	Improve health care access, appropriate utilization, and health outcomes among HIP members.	1.1. How has the implementation of HIP impacted health care access and utilization? How does utilization vary among HIP members?
		1.2. How has the implementation of HIP impacted health outcomes? How do outcomes vary among HIP members?
2	Increase community engagement leading to sustainable employment among HIP members.	2.1. What impact has the Community Engagement (CE) had on employment-related training and education among the target population?
		2.2. What impact has the CE requirement had on employment among the target population?
		2.3. What impact has the CE had on income among the target population?
		2.4. What impact has the CE requirement had on health outcomes among the target population?
3	Reduce tobacco use among HIP members, through a premium surcharge and the utilization of tobacco cessation benefits.	3.1 What impact has the premium surcharge had on the use of tobacco cessation benefits among the target population?
		3.2 Will tobacco use decease among the target population?

[1] CMS. About Section 1115 Demonstration Waivers. Available at https://www.medicaid.gov/medicaid/section-1115-demo/about-1115/index.html. Accessed 03/29/18.

#	Goal	Research Questions
4	Determine whether moving the monthly POWER account payment to a tiered structure will result in more efficient use of health care services, be easier for beneficiaries to understand, and increase compliance with payments.	4.1 How do the new Power account contribution (PAC) income tiers impact member compliance with making contributions?
5	Ensure that HIP policies promote a positive member experience for all HIP members	5.1 What is the level of satisfaction with HIP among members?

Evaluation Approach

Evaluation Overview

Throughout the previous HIP demonstration (HIP 2.0), the State tracked meaningful measures of health care access, utilization, health outcomes, and member satisfaction. The State looks to leverage this experience and data as a part of its evaluation of the current demonstration. The State will gather and review many of the same data metrics it used in the previous HIP demonstration, modifying previous evaluation tools such as the member survey and retaining the direct question and response wording, as appropriate. Data collected as a part of the previous HIP demonstration will serve as baseline data against which this current demonstration will be compared, and will provide insights on the generalizability of core program goals.

In addition to previous HIP demonstration data, the State will also use data from national studies and other publicly available data. These data will serve as additional points of comparison to evaluate the demonstration's success in meeting its goals. The evaluation will also look at current data sources and collect its own data to evaluate processes and outcomes throughout the demonstration.

Data Sources and Collection

This section includes a discussion of the data sources and data collection strategies that will be employed throughout this demonstration.

The evaluation plans to collect data from a variety of data sources from both external and internal entities. Example external data sources include information generated by federal and local authorities that are not affiliated with the State, such as the Current Population Survey (CPS), the American Community Survey (ACS), and the Consumer Assessment of Healthcare Providers and Systems (CAHPS) Surveys. Example internal data sources include data generated and/or housed by the State, such as enrollment and claims data, managed care entity (MCE) plan network and geo-access data, administrative data, and internal financial data. In addition, member surveys; key informant interviews with Family and Social Services Administration (FSSA) staff, MCEs, and providers; and key informant interviews and focus groups with HIP members will be conducted. The combination and comparison of these different data sources will contribute to a detailed analysis plan that will assist in answering the research questions associated with each demonstration goal and hypothesis.

External Data Sources

A description of potential external data sources is provided below.

Current Population Survey

The CPS is a monthly survey of households in the United States (U.S.), and is sponsored jointly by the U.S. Census Bureau and the U.S. Bureau of Labor Statistics (BLS). The CPS is the source of numerous significant socioeconomic statistics, including employment rates. The CPS also collects extensive demographic data that complements and enhances the State's understanding of health insurance coverage within Indiana, and across many different populations according to race, ethnicity, sex, education, income, and geographic location.[2]

American Community Survey

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. Information from the survey generates data that help determine how more than $400 billion in federal and state funds are distributed each year.[3]

Consumer Assessment of Healthcare Providers and Systems Surveys

CAHPS Surveys, developed and implemented by the Agency for Healthcare Research and Quality (AHRQ), ask patients about their health care providers and benefit plans, including hospitals, home health care agencies, pharmacy plans, and others. CAHPS Surveys follow scientific principles in survey design and development. By design, the surveys reliably assess the experiences of a large sample of patients. The surveys also use standardized questions and data collection protocols to ensure information can be compared across health care settings, and are statistically adjusted to correct for differences in the mix of patients across providers and the use of different survey modes.[4] CAHPS Survey data will be collected by MCEs.

Internal Data Sources

Since the inception of the previous HIP demonstration, Indiana has maintained a multitude of datasets to track and monitor the program's success. Below is a description of each of the internal State data sources and a high-level summary of how the data will be used. More details on how the data sources will address research questions and hypotheses is included under the Evaluation Structure section.

[2] U.S. Census. Current Population Survey. Available at http://www.census.gov/cps/. Accessed 04/02/18.
[3] American Community Survey Information Guide. Available at https://www.census.gov/programs-surveys/acs/about/information-guide.html. Accessed 04/02/18.
[4] CMS. CAHPS Surveys and Guidance. Available at https://www.ahrq.gov/cahps/surveys-guidance/index.html. Accessed 04/02/18.

Indiana Medicaid Historical Data

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

HIP Benefit Plan Data

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

Managed Care Entity Health Plan Network and Geo-access Data

HIP MCE health plan network and geo-access data will be used to identify beneficiary subgroups of interest based on geographic characteristics (e.g., rural versus urban).

Member Eligibility, Application, and Enrollment Data

Member application and enrollment data will be used to understand the size, location, and socio-demographic makeup of HIP enrollees (e.g., beneficiaries with household income under 138% FPL).

Surveys

Surveys will play a significant role in the evaluation process, as they will capture the perspectives of members regarding HIP. The surveys will contribute to addressing research questions across the evaluation. In total, the evaluation will survey three distinct population groups. Figure 1 describes the survey populations and the purpose of each survey. This survey design builds upon prior HIP survey methods and is subject to modification based on the overall final evaluation design.

Figure 1. Summary of HIP Surveys

Member	Community Engagement	Previous Member
•The member survey will collect data from both HIP Basic and HIP Plus members. •Questions will cover topics such as access to care, POWER account affordability, tobacco use, and member experiences. •Many of the same questions from the previous (HIP 2.0) demonstration will be included for comparison.	•The community engagement survey will collect data from individuals who were required to participate in the program. •Questions will cover participation in community engagement activities, employment, reasons for nonparticipation, obstacles to employment, and income.	•The previous member survey will collect data from individuals who had been fully enrolled in HIP, but who left the program (e.g., moved out of state, failed to make required POWER account contributions) •The goal of this survey is to understand the reasons why individuals leave HIP, and to access their health coverage experiences outside of HIP (e.g., "Does HIP prepare individuals for commercial coverage?").

As appropriate and feasible, survey data collection will be based on probability sampling methods, such as simple random sampling or stratified random sampling, to ensure that the sample is representative of the larger population under study, reduce bias, and increase validity of study findings. In implementing each survey, the State will ensure that all informed consent procedures are followed, so that respondents are aware of the reason behind the survey and have the information they need to fully participate. Further, the evaluation will implement rigorous data capture tools to collect the most meaningful data, including contacting potential survey participants via mail prior to the survey, using computer-assisted telephone interviewing (CATI) to promote data consistency and accuracy, offering surveys in both English and Spanish, and monitoring the survey interview process for quality.

Figure 2. Summary of Survey Assumptions

2020 Community Engagement Survey Assumptions	2021 Community Engagement Survey Assumptions	2021 Member Survey Assumptions	Previous Member Survey Assumptions
• Assuming a population of 85,000, this survey estimate provides a confidence interval of 95% with a margin of error of +/-2.43%.	• Assuming a population of 85,000, this survey estimate provides a confidence interval of 95% with a margin of error of +/-2.35%.	• Assuming a population of 450,000, this survey estimate provides a confidence interval of 95% with a margin of error of +/-2.14%.	• Assuming a population of 5,000 for the non-payment group, this survey estimate provides a confidence interval of 80% with a margin of error of +/-9% to +/-6% depending on number of completed interviews. • Assuming a population of 28,000 for the over income group, this survey estimate provides a confidence interval of 95% with a margin of error of +/- 4.86% or at 80% confidence interval +/-3% margin of error. • We anticipate that the denominator for leavers due to supsension will be too low to survey. Instead, we will conduct focus gropus or key informant interviews.

Member and Community Engagement Survey Data

Participants for the member surveys will be selected at random and the sample size will be statistically sound for appropriate comparison of study groups. The sample size for each of the survey groups was determined to ensure statistically valid samples for each of the populations. The sample size for each of the survey groups was determined to ensure statistically valid samples for each of the populations. The sampling strategy for the member survey will ensure a predetermined number of responses for each subcategory of HIP health plan participation (Basic and Plus). In total, the evaluation will complete 5,300 surveys of existing members. A sample size of 2,000 is estimated for the 2021 member survey. While the size of the community engagement population is not yet determined, we have targeted a sample size of 1,600 for the 2020 community engagement survey[5] and 1,700 for the 2021 survey to allow for bivariate and multivariate analyses.

[5] Future reports will include Indiana-specific terminology and will refer to the community engagement survey as the Gateway to Work survey.

The HIP Basic and HIP Plus member survey will address items such as:

- Access to care
- Education
- Health status
- Tobacco use (e.g., cigarettes, smokeless tobacco, e-cigarettes)
- Satisfaction
- Satisfaction with HIP
- Use of Fast Track payments
- POWER accounts
- Use of preventive services
- Cost sharing, payment of copays, and perceptions on affordability
- Knowledge of HIP policies

The previous HIP demonstration (HIP 2.0) evaluation employed surveys to address most of these topics and this current HIP evaluation uses many of the same questions to ensure survey continuity when possible and allow for more accurate comparisons between the previous and current demonstrations. The new survey instruments, however, will include sections to address the policies unique to this current demonstration, such as the tobacco cessation initiative.

The community engagement member surveys will focus on members who are required to participate in the program and will address items such as:

- Community engagement activities
- Employment
- Satisfaction with community engagement resources provided by State
- Reason for non-compliance
- Obstacles to employment

Previous Member (Leaver) Survey Data

Previous members (Leavers) refer to individuals who left the program for any reason, including individuals with household income over 100% FPL who made at least one initial POWER account contribution and were locked out of the program after failing to make their required PAC; individuals whose coverage is terminated due to changes in income eligibility; and individuals whose coverage is suspended due failing to comply with the community engagement program.

In addition to relevant metrics from the current member survey, the previous member survey will address items such as:

- Reasons for leaving HIP
- Current insurance coverage
- POWER accounts
- Cost sharing, payment of copays, and perceptions on affordability
- Knowledge of HIP policies
- Access to care

The contents of the survey will focus on why the individual left HIP, probing specifically around employment and affordability. The evaluation will complete 400 previous member surveys of the leavers due to eligibility and 50 to 100 surveys of non-payment/lockout. Since sample size is likely to be very low for leavers due to suspension, we will conduct focus groups or key informant interviews at the direction of the state.

Key Informant Interviews with FSSA Staff, MCEs, and Providers

Eight semi-structured interviews (including group interviews) with State officials from the Indiana FSSA will be conducted each year over the course of the evaluation, as well as four interviews with representatives from the four MCEs. The purpose of these interviews (on-site or via telephone) will be to collect information about the implementation of HIP POWER account changes, the CE requirement, and the tobacco surcharge. Interviews will also identify factors related to member enrollment and participation in/compliance with program enhancements. Telephone interviews will also be conducted with 202 providers spread across the six regions.

Focus Groups and Key Informant Interviews with HIP Members

Focus groups will allow stakeholders to use their own words to describe their experiences. The discussion among participants may elicit themes that are not captured in surveys. The specific cohorts for the focus groups and sampling design are defined separately for each goal and associated research question, but in general, the two cohorts are HIP Basic versus HIP Plus and/or compliant community engagement members versus non-compliant members. Focus groups will be stratified by the six geographic regions to ensure representation throughout the state: Northwest, Northeast, Central-Marion County Only, Central-Non-Marion County, Southwest, and Southeast.

Focus groups will be supplemented with a total of 50 key informant interviews. Areas of interest that arise from the focus group analysis will be probed in greater detail during the phone interviews.

Claims Data

The claims records that the MCEs submit to the State will be a critical source of information about the health care utilization patterns of all HIP enrollees, and will help assess several of the demonstration hypotheses. Information about how HIP enrollees and comparable Medicaid beneficiaries use care, the type of care they receive, and their diagnoses will be used to assess several HIP goals. In addition, information from these records will be used to identify eligible HIP providers for telephone surveys in order to better understand the provider effects of the programs. The evaluation strategy also combines claims data with member eligibility and POWER account data to look for health care utilization patterns associated with particular socio-demographic groups.

Administrative Data

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

POWER Account Data

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

The evaluation will examine the link between the different types of rollover incentives and preventive service utilization, as well as the link between rollover and changes in benefit plan enrollment from HIP Basic to HIP Plus. To complete planned analyses, the evaluation requires several types of secondary data, much of which will come from the participating health plans and several State offices, including health plan procedural data and plan monitoring reports to assess plans' operational performance.

Gateway to Work Data

Gateway to Work (GTW) data refer to data collected to support the community engagement requirement. GTW data will be collected through community engagement surveys, interviews, and focus groups. The GTW data that will be used within this evaluation include, but are not limited to:

- Number of members who are subject to community engagement requirement
- Number of members who complied with community engagement requirement
- Types of non-employment activities in which members engage (e.g., GED classes, volunteering)
- Number of hours members participate in non-employment activities
- Number of hours members participate in employment
- Number of members who are exempt from community engagement requirement
- Types of exemptions which members receive
- Number of members who experience a risk of suspension
- Number of members who automatically meet the requirement due to current employment

Analyzing Data

The evaluation will use a series of univariate, bivariate, multivariate, and longitudinal analyses to address the research questions associated with the goals of the HIP. When applicable, statistical tests of significance will be performed.

- **Univariate analyses** will be used to compute measures such as central tendency (e.g., mean, median, mode), dispersion (e.g., range, variance, max, min, quartiles, standard deviation), and frequency distributions.[6]

- **Bivariate analyses** will be used to describe the relationship between two variables (e.g., the effect that a change in variable X has on variable Y).[5]

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

- **Multivariate analyses** will be used to describe the relationship between two variables, while accounting for the effects of other (confounding) variables on the responses of interest. Multiple logistic regressions will be used to assess a dichotomous outcome variable across more than one independent variable. In this model, the log odds of the outcome is modeled as a linear combination of the predictor variables. This approach is analogous to multiple linear regression, which is used for continuous dependent outcomes. [7]

- **Longitudinal analyses** will be used to assess changes in measures over time. Mixed effects regression (MER) is one of the most flexible approaches to analyzing longitudinal data, and as appropriate, may be used to describe the regression relationship between independent variables and repeated dependent variables.[8]

Mechanisms to Ensure Quality Data and Reporting

Adjusting for Confounders

Adjusting the data for confounders will increase the internal validity of the evaluation, which will help ensure the accuracy of the findings. Examples of the types of confounding factors for which the HIP evaluation will control include, but are not limited to:

- Health status (determined by Medically Frail Indicator);
- Socio-demographic factors (e.g., income, geographic region, age, sex, race, ethnicity, education, employment status – as derived from administrative data); and
- HIP benefit status (Plus, Basic or State Plan)

Excluded Populations

American Indian/Alaska Native members and pregnant members will be excluded from most samples, as neither group is subject to the cost sharing requirements. Women who are selected and become pregnant will be removed from the sample, as they will have no copayments applied for the remainder of their pregnancy. However, the evaluation may conduct an analysis to examine pregnancy coverage, as there were operational changes in the administration of the pregnancy benefit between the previous and current demonstration periods.

Availability of Claims Data

Claims data MCEs are submitting to the State will underpin many of the planned analyses within the evaluation, particularly those that assess HIP's effects on health care utilization and health outcomes. Delays in submission of claims information produce data deficiencies that can impact reporting.

[7] Symmetry® EBM Connect® is an Optum decision support software that compares medical and pharmacy claim, lab result and enrollment data with evidence-based best practices for clinical conditions and preventive measures. EBM Connect drives the identification of data used to improve provider and patient compliance with proven evidence-based treatment standards.
[8] Garcia T and Marder K. Statistical Approaches to Longitudinal Data Analysis in Neurodegenerative Diseases: Huntington's Disease as a Model. Curr Neurol Neurosci Rep. 2017 Feb; 17(2): 14. Available at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5633048/. Accessed April 5, 2018.

Generalizability of Results

Evaluations of the previous HIP demonstration (HIP 2.0) indicated success in applying commercial health care concepts to Medicaid enrollees. This current demonstration will extend upon those principles, adding new policies—such as a community engagement requirement and tobacco cessation initiative—that may demonstrate that the outcomes and experiences associated with HIP members are generalizable to Medicaid populations throughout the U.S.

Evaluation Deliverables

While the general reporting time frame is known and indicated in the following section, the evaluation will utilize and adhere to all specified due dates as indicated within the HIP demonstration special terms and conditions, including revisions to these timelines as applied by CMS. These deadlines will be centered on quarterly and annual reports to be completed by the State, as well as an Interim and Summative Evaluation to be completed by the State's contracted evaluator. In addition, the State expects to hold regular calls with CMS to discuss, among other possible topics, data metrics that will be produced as a part of the State's compliance with rapid cycle assessment requirements.

Interim & Summative Evaluations

The Interim and Summative Evaluations will provide a comprehensive assessment of key metrics presented within the quarterly and annual reports, as well as any other key component of the demonstration. The Interim Evaluation will provide a summary assessment of the previous demonstration period (HIP 2.0), which can be also be described as the "first three years" of this current demonstration. This information will be derived from reports that received prior approval from the state. The Summative Evaluation will provide a complete evaluation of each demonstration year of HIP to date. Table 2 lists the due dates for the HIP Interim and Summative Evaluations.

Table 2. Due Dates for Interim and Summative Evaluations

Report	Report Due Date
Interim Evaluation	12/31/19*
Summative Evaluation	06/24/22*
*Exact dates and content to be discussed with Indiana and CMS.	

Evaluation Structure

The evaluation strategy considers a variety of factors for data collection, including the target populations and comparison groups for each data metric, to ensure that the evaluation draws accurate and meaningful conclusions from the data. Subgroups of HIP members of interest will be based on the following characteristics:

- HIP plan (Plus or Basic)
- Income (above and below FPL)
- Demographics: (e.g., race, age, sex, rural/urban, as available)
- Insurance coverage prior to HIP

A key comparison group will be HIP 2.0 members (previous 2015-2018 demonstration). In addition, as data are available (e.g., summary data available from Federal surveys), the evaluation will compare HIP members with:

- Uninsured individuals with comparable income
- Individuals with private/commercial health insurance with comparable income
- Medicaid members in comparable Medicaid expansion states

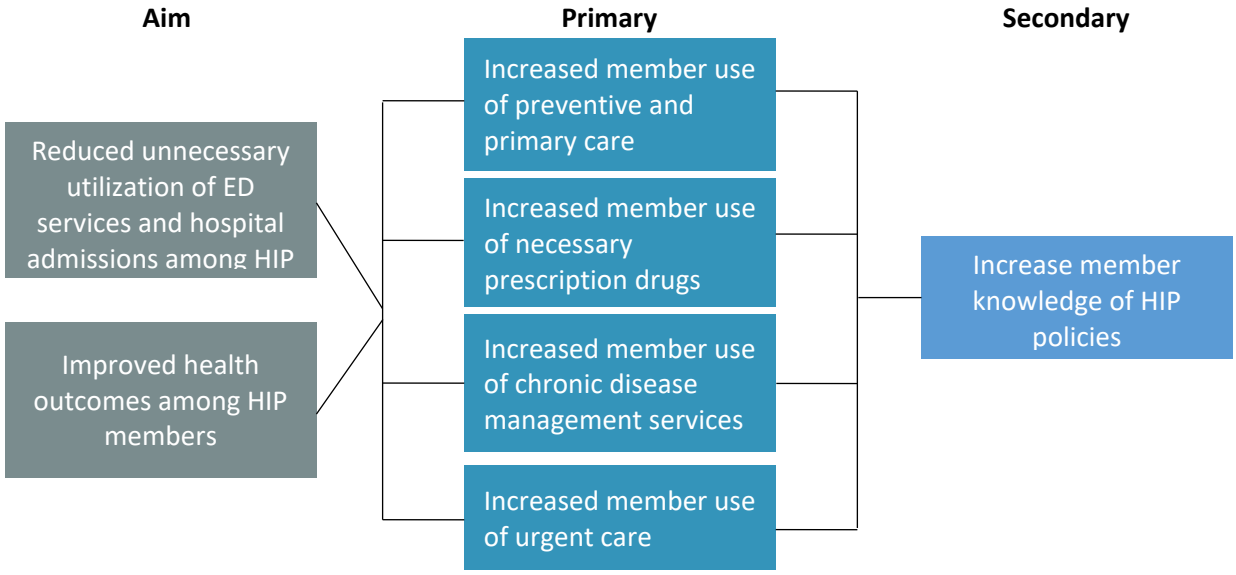
The evaluation will analyze each of the five research goals and associated research questions within this current HIP demonstration. Each goal and sub-goal is described in narrative form and listed in Tables 3-10 and 12-13, according to the following structure: (a) research questions, (b) primary hypothesis; (c) metrics, (d) subgroups/comparison groups, (e) data sources, and (f) analytic approach. The first column of the table lists the research question for the goal or sub-goal. The second column lists the primary hypothesis or hypotheses that serve as a starting point for the evaluation. The third column lists the metrics that will be used for the analysis. The fourth column lists the subgroups and/or comparison groups to be analyzed for the associated metrics. The fifth column lists the data sources from which the required data elements will likely be obtained. The sixth column describes the analytical approaches that will be used to answer the research questions.

Goal 1: Improve Health Care Access, Appropriate Utilization, and Health Outcomes among HIP Members

During the previous demonstration, HIP expanded coverage to individuals with income below 138% FPL, thereby providing health care for hundreds of thousands previously uninsured Indiana residents, and reducing the state's uninsurance rate. While the previous demonstration succeeded in increasing health care enrollment, a chief focus of this current demonstration is to ensure that enrollment in HIP leads to increased health care access, appropriate health care utilization, and positive health outcomes (as summarized in Figure 3). To assess this goal, the State will analyze two research questions:

1.1. How has the implementation of HIP impacted health care access and utilization? How does utilization vary among HIP members?
1.2. How has the implementation of HIP impacted health outcomes? How do outcomes vary among HIP members?

Figure 3. Goal 1 Driver Diagram



1.1. How has the implementation of HIP impacted health care access and utilization? How does utilization vary among HIP members?

Ensuring that enrollment in HIP translates to better health care access among HIP members is essential. To identify the program's success in achieving this goal, the evaluation will research the following hypotheses, which are as follows:

- Enrollment in HIP will promote member use of preventive, primary, needed prescription drugs, chronic disease management care, and urgent care.
- Enrollment in HIP will discourage unnecessary emergency department (ED) services and hospital admissions.

1.2. How has the implementation of HIP impacted health outcomes? How do outcomes vary among HIP members?

In addition to better health care access, assuring that enrollment in HIP corresponds with better health outcomes is critical. To identify the program's success in achieving this goal, the evaluation will research the following hypothesis:

- Health outcomes will be the same or higher under HIP compared to HIP 2.0 (2015-2018).

Table 3: Summary Evaluation Table for Goal 1.1

#	RESEARCH QUESTIONS	PRIMARY HYPOTHESIS	METRICS	SUBGROUPS/ COMPARISON GROUPS	DATA SOURCES	ANALYTIC APPROACH*
Goal 1: Improve health care access, appropriate utilization, and health outcomes among HIP members.						
1.1	How has the implementation of HIP impacted health care access and utilization? How does utilization vary among HIP members?	Enrollment in HIP will promote member use of preventive, primary, needed prescription drugs, chronic disease management care, and urgent care. Enrollment in HIP will discourage unnecessary ED services and hospital admissions.	• #/% of members who are knowledgeable about HIP policies related to health care access (survey) • #/% of HIP members reporting getting health care "as soon as needed" (survey) • #/% of members using MCE nurse hotline (survey) • #/% of members utilizing primary and specialty care services (claims) • #/% of members utilizing preventive services (e.g., screenings, vaccinations) (claims) • #/% of members accessing urgent care services (claims) • Utilization rates of chronic disease care services (claims)	HIP subgroups of interest: • Plus/Basic • >FPL/<FPL • Demographic (e.g., race, age, sex, rural/urban, as available) • Previous insurance coverage (survey) HIP 2015-2018 (where data are available) Uninsured adults within Indiana (using existing summary Federal survey data, as available)	Claims data from FSSA MCE Data 2021 member survey Existing summary Federal survey data regarding: health care access and utilization (e.g., National Health Interview Survey (NHIS), Behavioral Risk Factor Surveillance System (BRFSS)) for Indiana and other states, as available	• Descriptive statistics (e.g., frequencies, averages) • Descriptive analysis by groups of interest (e.g., $\chi 2$, t-test) • Multivariate regression analysis

#	RESEARCH QUESTIONS	PRIMARY HYPOTHESIS	METRICS	SUBGROUPS/ COMPARISON GROUPS	DATA SOURCES	ANALYTIC APPROACH*
			• #/% of members with preventable hospital admissions and readmissions (claims) • Rate of non-emergency use of ED services (claims) • #/% of members with prescription drug utilization codes (claims) • Existing Federal survey data measures regarding health care access and utilization (e.g., had doctor visit in past year)	Privately insured adults within Indiana (using existing summary Federal survey data as available) Medicaid members in other comparable states (using existing summary Federal survey data or summary MSIS data as available)		

*Analyses indicated will be conducted whenever possible.

Table 4: Summary Evaluation Table for Goal 1.2

#	RESEARCH QUESTIONS	PRIMARY HYPOTHESIS	METRICS	SUBGROUPS/ COMPARISON GROUPS	DATA SOURCES	ANALYTIC APPROACH*
Goal 1: Improve health care access, appropriate utilization, and health outcomes among HIP members.						
1.2	How has the implementation of HIP impacted health outcomes? How do outcomes vary among HIP members?	Health outcomes will be the same or better under HIP compared to not being enrolled (i.e., uninsured) or being enrolled in other health care (e.g., Medicaid in other states).	• HIP member risk (claims) • # of chronic conditions (claims) • #/% of members reporting "excellent," "fair" or "poor" health (survey) • Existing Federal survey data measures regarding health outcomes (e.g., self-reported health status)	HIP subgroups of interest: • Plus/Basic • >FPL/<FPL • Demographic (e.g., race, age, sex, rural/urban, as available) • Previous insurance coverage (survey) HIP 2015-2018 (where data are available) Uninsured adults within Indiana (using existing summary Federal survey data, as available)	Claims data from FSSA CAHPS data from MCEs 2021 member survey Existing summary Federal survey data regarding health outcomes (e.g., NHIS, CPS, BRFSS) for Indiana and other states as available	• Descriptive statistics (e.g., frequencies, averages) • Descriptive analysis by groups of interest (e.g., $\chi 2$, t-test) • Multivariate regression analysis

#	RESEARCH QUESTIONS	PRIMARY HYPOTHESIS	METRICS	SUBGROUPS/ COMPARISON GROUPS	DATA SOURCES	ANALYTIC APPROACH*
				Privately insured adults within Indiana (using existing summary Federal survey data as available) Medicaid members in other comparable states (using existing summary Federal survey data as available)		

*Analyses indicated will be conducted whenever possible.

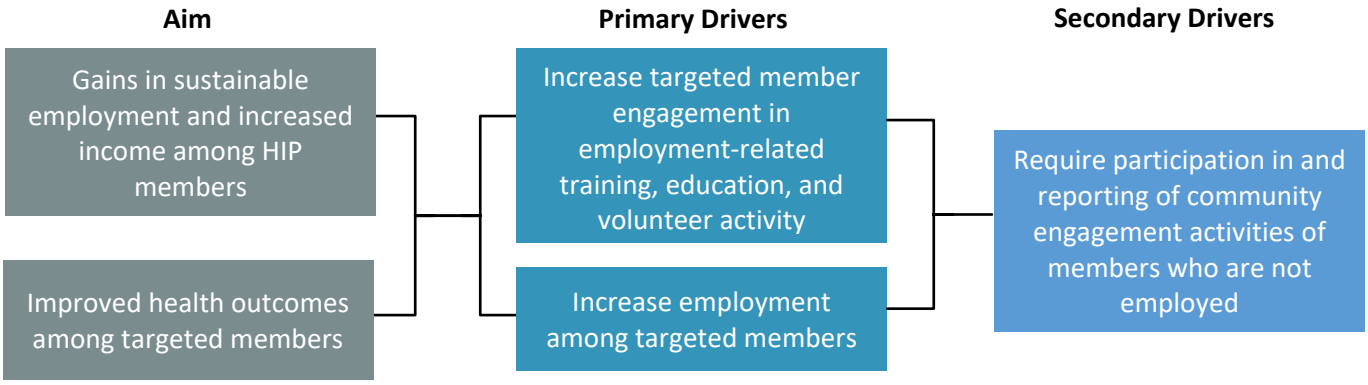
Goal 2: Increase Community Engagement leading to Sustainable Employment among HIP members

A substantial body of evidence demonstrates that employed individuals have better physical and mental health and wellbeing compared to unemployed individuals.[9,10] Further, people who are unemployed have higher rates of morbidity and mortality, with longitudinal studies finding the consequences of unemployment persist despite accounting for pre-existing health conditions.[11]

Due to the strong connection between employment and health, HIP seeks to promote employment, and activities leading to employment, among its members (see Figure 4). The evaluation will examine the following three research questions in assessing whether HIP is meeting its goals:

2.1. What impact has the CE had on employment-related training and education among the target population?
2.2. What impact has the CE requirement had on employment among the target population?
2.3. What impact has the CE had on income among the target population?
2.4. What impact has the CE requirement had on health outcomes among the target population?

Figure 4. Goal 2 Driver Diagram



2.1. What impact has the CE had on employment-related training and education among the target population?

Education and training are important precursors to employment. To identify the program's success in promoting training and education, the evaluation will research the following hypotheses:

- *The CE requirement will promote engagement in employment-related training and education.*
- *The proportion of members engaged will be higher among compliant members than non-compliant members.*

[9] F.M. McKee-Ryan, Z. Song, C.R. Wanberg, and A.J. Kinicki. (2005). Psychological and physical well-being during unemployment: a meta-analytic study. Journal of Applied Psychology, 90 (1), 53-76.
[10] K.I. Paul, E. Geithner, and K. Moser. (2009). Latent deprivation among people who are employed, unemployed, or out of the labor force. Journal of Psychology, 143 (5), 477-491.
[11] Robert Wood Johnson Foundation—Commission to Build a Healthier America. Work Matters for Health. Available at http://www.commissiononhealth.org/PDF/0e8ca13d-6fb8-451d-bac8-7d15343aacff/Issue%20Brief%204%20Dec%2008%20-%20Work%20and%20Health.pdf. Accessed 04/12/18.

2.2. What impact has the CE requirement had on employment among the target population?

Employment is one of the most influential determinants of health and wellbeing. The evaluation will research the following hypothesis:

- *The CE requirement will increase employment among targeted members.*

2.3. What impact has the CE had on income among the target population?

As employment among the target population increases, this should result in an increase in income among the target population. The evaluation will research the following hypothesis:

- *The CE requirement will increase the income of participating members.*

2.4 What impact has the CE requirement had on health outcomes among the target population?

As community engagement and employment increases, this should result in an increase in health outcomes. The evaluation will research the following hypothesis:

- *The CE requirement will improve health outcomes among targeted members.*

Table 5: Summary Evaluation Table for Goal 2.1

#	RESEARCH QUESTIONS	PRIMARY HYPOTHESIS	METRICS	SUBGROUPS/ COMPARISON GROUPS	DATA SOURCES	ANALYTIC APPROACH*
Goal 2: Increase Community Engagement leading to Sustainable Employment among HIP members.						
2.1	*What impact has the CE had on employment-related training and education among the target population?*	*The CE requirement will promote engagement in employment-related training and education:* *The proportion of members engaged will be higher among compliant members than non-compliant members.*	• *#/% searched for employment-related training, education, volunteer activity (survey)* • *#/% applied for employment-related training, education, volunteer activity (survey)* • *#/% engaged in employment-related training, education, and volunteer activity (survey, program administrative data)* • *Member reasons for nonparticipation in training/education (survey, focus groups)* • *Obstacles to participation (survey, focus groups)*	*Reporting subgroups of interest:* • *Compliant/non-compliant* • *> FPL/<FPL* • *Demographic (e.g., race, age, sex, rural/urban, as available)* *HIP 2015-2018 (where prior data are available)*	*Program administrative data, as available* *2020 and 2021 community engagement survey (post referral and following compliance determination)* *Member focus groups (post referral and following compliance determination)*	• *Descriptive statistics (e.g., frequencies, averages)* • *Descriptive analysis by groups of interest (e.g., χ2, t-test)* • *Multivariate regression analysis* • *Pre/post analysis as feasible (program administrative data)* • *Thematic analysis of qualitative data*

**Analyses indicated will be conducted whenever possible.*

Table 6: Summary Evaluation Table for Goal 2.2

#	RESEARCH QUESTIONS	PRIMARY HYPOTHESIS	METRICS	SUBGROUPS/ COMPARISON GROUPS	DATA SOURCES	ANALYTIC APPROACH*
Goal 2: Increase Community Engagement leading to Sustainable Employment among HIP members.						
2.2	*What impact has the CE requirement had on employment among the target population?*	*The CE requirement will increase employment among targeted members.*	• *#/% applied for employment (survey)* • *#/% unemployed, any (full or part-time) employment (survey, program administrative data)* • *#/% with an increase/decrease in work hours (survey)* • *Member satisfaction with CE employment resources provided by State (survey, focus groups)* • *Member reasons for nonparticipation in labor market (survey, focus groups)* • *Obstacles to employment (survey, focus groups)* • *Existing Federal survey data measures regarding employment (e.g., employment status)*	*Reporting subgroups of interest:* • *Compliant/non-compliant* • *>FPL/<FPL* • *Demographic (e.g., race, age, sex, rural/urban, as available)* *HIP 2015-2018 (where data are available)* *Uninsured adults within Indiana (using existing summary Federal survey data as available* *Privately insured adults within Indiana (using existing summary Federal survey data, as available)*	*Program administrative data, as available* *2020 and 2021 community engagement survey (post referral and following compliance determination)* *Member focus groups (post referral and following compliance determination)* *Existing summary Federal survey data regarding employment (e.g., ACS) for Indiana and other states, as available*	• *Descriptive analysis (e.g., frequencies, averages)* • *Descriptive analysis by groups of interest (χ2, t-test, etc.)* • *Multivariate regression analyses* • *Pre/post analysis as feasible (program administrative data)* • *Thematic analysis of qualitative data*

#	RESEARCH QUESTIONS	PRIMARY HYPOTHESIS	METRICS	SUBGROUPS/ COMPARISON GROUPS	DATA SOURCES	ANALYTIC APPROACH*
				Medicaid members in other comparable states (using existing summary Federal survey data as available)		

**Analyses indicated will be conducted whenever possible.*

Table 7: Summary Evaluation Table for Goal 2.3

#	RESEARCH QUESTIONS	PRIMARY HYPOTHESIS	METRICS	SUBGROUPS/ COMPARISON GROUPS	DATA SOURCES	ANALYTIC APPROACH*
Goal 2: Increase Community Engagement leading to Sustainable Employment among HIP members.						
2.3	*What impact has the CE had on income among the target population?*	*The CE requirement will increase the income of participating members.*	• *#/% who have an increase in income (survey)* • *#/% of HIP members with disenrollment reason codes related to increased income (HIP administrative data)* • *Existing Federal survey data measures regarding income*	*Reporting subgroups of interest:* • *Compliant/non-compliant* • *> FPL/<FPL* • *Demographic (e.g., race, age, sex, rural/urban, as available)* *HIP 2015-2018 (where data are available)* *Uninsured adults within Indiana (using existing summary Federal survey data, as available)*	*Program administrative data, as available* *2020 and 2021 community engagement survey (post referral and following compliance determination)* *Existing summary Federal survey data regarding income (e.g., ACS) for Indiana and other states, as available*	• *Descriptive analysis (e.g., frequencies, averages)* • *Descriptive analysis by groups of interest (e.g., χ2, t-test)* • *Multivariate regression analyses* • *Pre/post analysis as feasible (program administrative data)*

#	RESEARCH QUESTIONS	PRIMARY HYPOTHESIS	METRICS	SUBGROUPS/ COMPARISON GROUPS	DATA SOURCES	ANALYTIC APPROACH*
				Privately insured adults within Indiana (using existing summary Federal survey data, as available) *Medicaid members in other comparable states (using existing summary Federal survey data, as available)*		

**Analyses indicated will be conducted whenever possible.*

Table 8: Summary Evaluation Table for Goal 2.4

#	RESEARCH QUESTIONS	PRIMARY HYPOTHESIS	METRICS	SUBGROUPS/ COMPARISON GROUPS	DATA SOURCES	ANALYTIC APPROACH*
Goal 2: Increase Community Engagement leading to Sustainable Employment among HIP members.						
2.4	*What impact has the CE requirement had on health outcomes among the target population?*	*The CE requirement will improve health outcomes among targeted members.*	• *HIP member risk (claims)* • *# of chronic conditions (claims)* • *#/% of members reporting "excellent," "fair" or "poor" health (survey)*	*Reporting subgroups of interest:* • *Compliant/non-compliant* • *>FPL/<FPL* • *Demographic (e.g., race, age, sex, rural/urban, as available)* *HIP 2015-2018 (where data are available)*	*Claims data from FSSA* *2020 and 2021 community engagement survey (post referral and following compliance determination)*	• *Descriptive analysis (e.g., frequencies, averages)* • *Descriptive analysis by groups of interest (χ2, t-test, etc.)* • *Multivariate regression analyses* • *Pre/post analysis as feasible (claim data)*

**Analyses indicated will be conducted whenever possible.*

Goal 3: Reduce Tobacco Use among HIP Members, through a Premium Surcharge and the Utilization of Tobacco Cessation Benefits

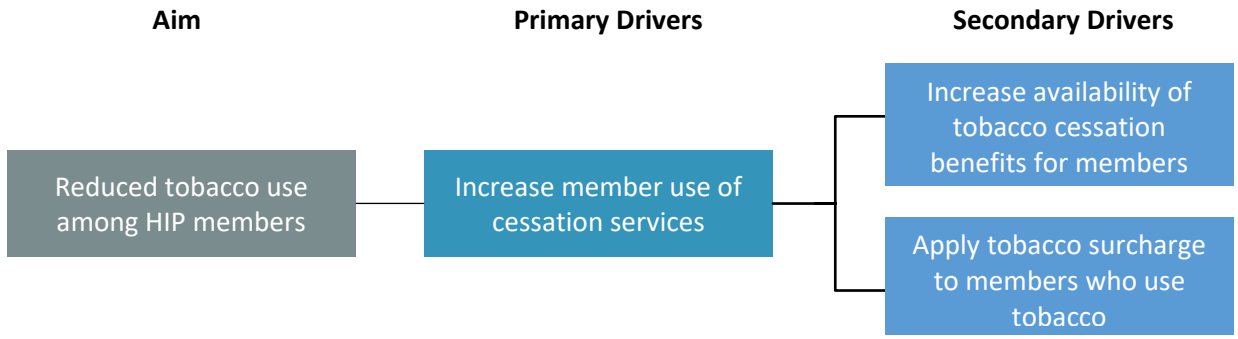
Tobacco use remains the leading cause of preventable disease and death in the U.S., with a disproportionate impact on Medicaid beneficiaries, the uninsured, American Indian/Alaska Natives and multiracial adults, and those living in poverty.[12] It contributes to increased risk for cancers, cardiovascular disease, strokes, and lung diseases. Tobacco use also contributes to health risks for pregnant women and their babies; impacts bone, teeth, and gum health; increases the risk for cataracts, diabetes, and inflammation; and decreases immune function. In addition, family members and friends of smokers can be adversely impacted, as secondhand smoke exposure has been shown to cause serious disease and death.[13]

In Indiana, the adult cigarette smoking rate in 2014 was nearly 23 percent, which is over six percent higher than the national average.[14] A recent report from the Centers for Disease Control and Prevention (CDC) also indicated that smoking prevalence among Indiana Medicaid beneficiaries was over 48 percent as of December 2015, which is one of the highest rates in the nation.[15] Moreover, Indiana has the fourth highest secondhand smoke exposure rate in the country, with over half of Indiana residents reporting weekly exposure to secondhand smoke in 2012.[16]

Because of the deleterious impact of tobacco use and the high rates of smoking in Indiana, HIP seeks to reduce tobacco use as shown in Figure 5. The evaluation will examine two research questions in determining whether HIP is meeting its goals:

3.1. What impact has the premium surcharge had on the use of tobacco cessation benefits among the target population?
3.2. Will tobacco use decrease among the target population?

Figure 5. Goal 3 Driver Diagram



[12] Robert Wood Johnson Foundation. Stable Jobs = Healthier Lives. Available at https://www.rwjf.org/content/dam/files/rwjf-web-files/Infographics/Better%20Jobs%20Healthier%20Lives%20Infographic.pdf. Accessed April 04/13/18.
[13] U.S. Department of Health and Human Services. The Health Consequences of Smoking. Available at https://www.surgeongeneral.gov/library/reports/50-years-of-progress/full-report.pdf. Accessed 04/16/18.
[14] Centers for Disease Control and Prevention. Behavioral Risk Factor Data: Tobacco Use (2011 – Present). Available at https://chronicdata.cdc.gov/Survey-Data/Behavioral-Risk-Factor-Data-Tobacco-Use-2011-to-pr/wsas-xwh5. Accessed 04/16/18.
[15] A. DiGiulio et al., State Medicaid Expansion Tobacco Cessation Coverage and Number of Adult Smokers Enrolled in Expansion Coverage—United States, 2016, 65 Morbidity and Mortality Weekly Report 1364.
[16] Centers for Disease Control and Prevention. Smoking and Tobacco Use State Highlights: Indiana. Available at https://www.cdc.gov/tobacco/data_statistics/state_data/state_highlights/2012/states/indiana/index.htm. Accessed 04/16/18.

3.1. What impact has the premium surcharge had on the use of tobacco cessation benefits among the target population?

The utilization of tobacco cessation products and services, provided through HIP and other sources, represents an important step towards reducing and eliminating tobacco use. The evaluation will research the following hypothesis:

- The tobacco surcharge will increase use of tobacco cessation services.

3.2. Will tobacco use decrease among the target population?

In addition to serving as the third primary goal of the current demonstration, reducing tobacco use is also critical to the program's first goal – to improve health outcomes among HIP members – thus, reducing tobacco use is essential to the success of HIP. The evaluation will research the following hypothesis:

- The rate of tobacco use will be lower under the new program.

Table 9: Summary Evaluation Table for Goal 3.1

#	RESEARCH QUESTIONS	PRIMARY HYPOTHESES	METRICS	SUBGROUPS/ COMPARISON GROUPS	DATA SOURCES	ANALYTIC APPROACH*
Goal 3: Reduce Tobacco Use among HIP Members, through a Premium Surcharge and the Utilization of Tobacco Cessation Benefits.						
3.1	What impact has the premium surcharge had on the use of tobacco cessation benefits among the target population?	The tobacco surcharge will increase use of tobacco cessation services.	• #/% of members reporting knowledge of the tobacco surcharge (survey) • #/% of members reporting knowledge of cessation services offered through HIP (survey) • #/% of members reporting knowledge of cessation services offered through other sources (survey)	Subgroups of interest: • Tobacco users/non users • Age groups • >FPL/<FPL • Demographics (e.g., race, age, sex, rural/urban, as available)	2021 member survey	• Descriptive analysis (e.g., frequencies, averages) • Descriptive analysis by groups of interest (e.g., χ2, t-test) • Multivariate regression analyses
			• #/% of members using tobacco cessation services (CAHPS) • #/% of members utilizing tobacco cessation services offered through HIP (survey, claims data)	Subgroups of interest: • >FPL/<FPL • Demographics (e.g., race, age, sex, rural/urban, as available) HIP 2015-2018 (where data are available)	Program administrative data, as available CAHPS data from MCEs Claims data 2021 member survey Key informant interviews	• Descriptive analysis (e.g., frequencies, averages) • Descriptive analysis by groups of interest (e.g., χ2, t-test) • Multivariate regression analyses • Pre/post analysis as feasible (claims data) • Thematic analysis of qualitative data

#	RESEARCH QUESTIONS	PRIMARY HYPOTHESES	METRICS	SUBGROUPS/ COMPARISON GROUPS	DATA SOURCES	ANALYTIC APPROACH*
			• #/% of members utilizing tobacco cessation services offered through other sources (survey, claims data) • #% of HIP members with tobacco cessation utilization codes (Claims data) • Satisfaction with tobacco cessation services (interviews) • Reasons for nonparticipation in cessation services (interviews) • Obstacles to participation (interviews)			

*Analyses indicated will be conducted whenever possible.

Table 10: Summary Evaluation Table for Goal 3.2

#	RESEARCH QUESTIONS	PRIMARY HYPOTHESES	METRICS	SUBGROUPS/ COMPARISON GROUPS	DATA SOURCES	ANALYTIC APPROACH*
Goal 3: Reduce Tobacco Use among HIP Members, through a Premium Surcharge and the Utilization of Tobacco Cessation Benefits.						
3.2	Will tobacco use decrease among the target population?	The rate of tobacco use will be lower under the new program.	• #/% of members using tobacco (MCE health needs assessment data, CAHPS survey) • #/% of HIP members with utilization codes related to tobacco use (claims data) • Existing Federal survey data measures regarding tobacco use	Subgroups of interest: • >FPL/<FPL • Demographics (e.g., race, age, sex, rural/urban, as available) • Previous insurance coverage HIP 2015-2018 (where data are available) Uninsured adults within Indiana (using existing summary Federal survey data, as available) Privately insured adults within Indiana (using existing summary Federal survey data, as available) Medicaid members in other comparable states (using existing summary Federal survey data, as available)	• Program administrative data as available • Claims data • CAHPS data from MCEs • 2021 member survey • Existing summary Federal survey data regarding tobacco use (e.g., BRFSS) for Indiana and other states, as available	• Descriptive analysis (e.g., frequencies, averages) • Descriptive analysis by groups of interest (e.g., $\chi 2$, t-test) • Multivariate regression analyses • Pre/post analysis as feasible (claims data)

*Analyses indicated will be conducted whenever possible.

Goal 4: Determine whether moving the monthly POWER account payment to a tiered structure will result in more efficient use of health care services, be easier for beneficiaries to understand, and increase compliance with payments

One of the hallmarks of HIP is the POWER account, a health savings-like account valued at $2,500, which pays for the full cost of the member's deductible. In addition to contributions made by the State, the POWER account contains the required monthly contributions from the member, equal to two percent (2%) of income. Evidence from the previous demonstration (HIP 2.0) demonstrates that the POWER account provides a financial incentive for members to become more invested and engaged in their health care. Nonetheless, in the interest of continuously seeking to improve upon the success of the HIP program, the State replaced the two percent (2%) of monthly income contribution requirement with new tiered member contributions based on FPL, which are roughly equivalent to percent (2%) of income.

The State made this change for several reasons. Most importantly, the tiered structure provides more stability for members as it results in fewer changes to contribution requirements than the current structure. The current structure requires a change in contribution amount as a result of even a small change in monthly income. Additionally, this modification reduces burden on the State from both a systems administration perspective, allowing the State to divert more resources to member engagement. The tiered member contribution amounts are listed in Table 11 below:

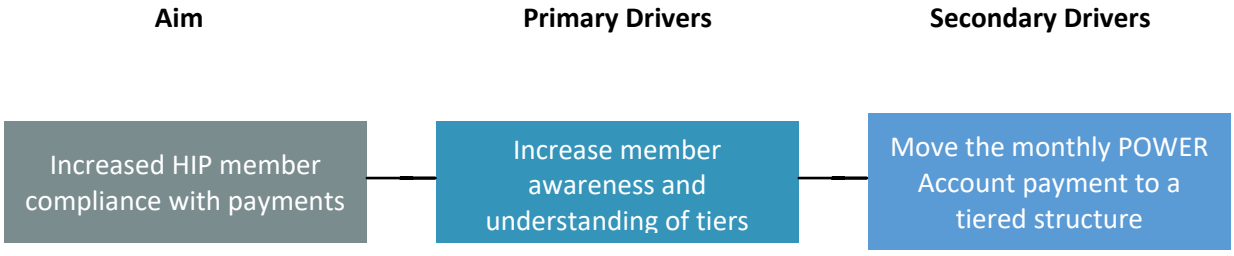
Table 11. HIP Tiered Member Contribution Amounts

FPL	Monthly PAC Single Individual	Monthly PAC Spouses
<22%	$1.00	$1.00
23-50%	$5.00	$2.50
51-75%	$10.00	$5.00
76-100%	$15.00	$7.50
101-138%	$20.00	$10.00

To assess the impact of the tiered payment structure, the State will analyze the following research question:

4.1. How do the new PAC income tiers impact member compliance with making contributions?

Figure 6. Goal 4 Driver Diagram



4.1. How do the new PAC income tiers impact member compliance with making contributions?

Ensuring that members comply with required POWER account payments is central to the operation and success of the HIP program. To identify the program's success in achieving this goal, the evaluation will research the following hypotheses:

- HIP's new income tier structure for POWER account contributions will be easier for members to understand than under HIP 2.0.
- HIP's new income tier structure for POWER account contributions will result in higher member compliance with POWER account payments than under HIP 2.0.

Table 12: Summary Evaluation Table for Goal 4.1

#	RESEARCH QUESTIONS	PRIMARY HYPOTHESES	METRICS	SUBGROUPS/ COMPARISON GROUPS	DATA SOURCES	ANALYTIC APPROACH*
Goal 4: Determine whether moving the monthly POWER account payment to a tiered structure will result in more efficient use of health care services, be easier for beneficiaries to understand, and increase compliance with payments.						
4.1	How do the new PAC income tiers impact member compliance with making contributions?	HIP's new income tier structure for POWER account contributions will be easier for members to understand than under HIP 2.0.	• Members' awareness of requirements (survey) • Members' understanding of the tiers (survey)	HIP subgroups of interest: • Plus/Basic • >FPL/<FPL • Demographics (e.g., race, age, sex, rural/urban, as available) HIP 2015-2018 (where prior comparable survey data are available)	2021 member survey	• Descriptive statistics (e.g., frequencies, averages) • Descriptive analysis by groups of interest (e.g., $\chi 2$, t-test) • Multivariate regression analysis
		HIP's new income tier structure for POWER account contributions will result in higher member compliance with POWER account payments than under HIP 2.0.	• #/% of enrollees who make contribution before end of grace period (enrollment) • #/% of members (>100% FPL) disenrolled for non-payment (enrollment data) • #/% of members (<100% FPL) who move from HIP Plus to Basic (enrollment data)	HIP subgroups of interest: • Plus/Basic • >FPL/<FPL • Demographics (e.g., race, age, sex, rural/urban, as available) HIP 2015-2018 (where data are available)	Enrollment data	• Descriptive statistics (e.g., frequencies, averages) • Descriptive analysis by groups of interest (e.g., $\chi 2$, t-test) • Multivariate regression analysis • Pre/post analysis as feasible (enrollment data)

*Analyses indicated will be conducted whenever possible.

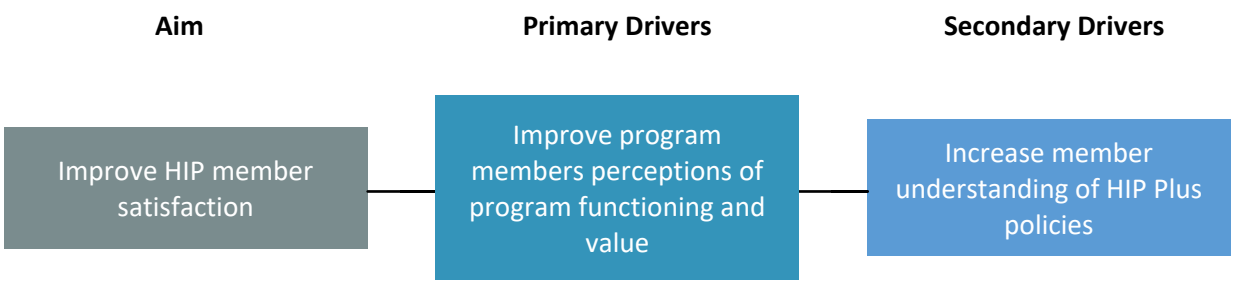
Goal 5: Ensure that HIP policies promote a positive member experience for all HIP members.

Assuring that all HIP members enjoy a positive program experience is the belief that lays the foundation for all of the policies and procedures related to the program. Evidence from HIP 2.0 demonstrates that 71 percent of HIP Basic members, and 86 percent of HIP Plus members are satisfied with the program. Moreover, 80 percent of HIP Plus members report that they would pay more to stay in the program, while 95 percent of HIP Plus members report that they would try to re-enroll in the program if they left, and became eligible again.

To examine whether HIP promotes a positive member experience, the State will analyze one research question:

5.1. What is the level of satisfaction with HIP among members?

Figure 7. Goal 5 Driver Diagram



5.1. What is the level of satisfaction with HIP among members?

Continuing the high level of member satisfaction from the previous demonstration (HIP 2.0) to the current demonstration is a chief priority. The evaluation will research the following hypothesis:

- Members enrolled in HIP Plus will have higher satisfaction compared to members enrolled in HIP Basic.

Table 13: Summary Evaluation Table for Goal 5.1

#	RESEARCH QUESTIONS	PRIMARY HYPOTHESES	METRICS	SUBGROUPS/ COMPARISON GROUPS	DATA SOURCES	ANALYTIC APPROACH*
Goal 5: Ensure that HIP policies promote a positive member experience for all HIP members						
5.1	What is the level of satisfaction with HIP among members?	Members enrolled in HIP Plus will have higher satisfaction compared to members enrolled in HIP Basic.	• #/% of members who understand HIP policies and procedures (including rollover, contributions, tobacco cessation, community engagement) (survey) • #/% of members who consider HIP a good value relative to its costs (survey) • #/% of members who consider HIP to be efficient and high-functioning program (survey) • #/% of members with high satisfaction with the program (survey)	HIP subgroups of interest: • Plus/Basic • > FPL/<FPL • Demographics (e.g., race, age, sex, rural/urban, as available) • Previous insurance coverage HIP 2015-2018 (where prior comparable survey data are available)	2021 member survey	• Descriptive statistics (e.g., frequencies, averages) • Descriptive analysis by groups of interest (e.g., $\chi 2$, t-test) • Multivariate regression analysis

*Analyses indicated will be conducted whenever possible.